

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

***RE: CMS-1785-P, 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 Provider and Supplier Disclosure of Ownership, (Vol. 88, No. 83), May 1, 2023.***

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including 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 Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2024. We are submitting separate comments on the agency's proposed changes to the long-term care hospital PPS.

**We support a number of the inpatient PPS (IPPS) proposed rule provisions, such as those that help support rural hospitals care for its communities by allowing rural emergency hospitals (REHs) to be designated as a non-provider site for Medicare graduate medical education purposes and by allowing sole community hospitals (SCHs) to gain their status in a timely manner. We also support several aspects of CMS' quality-related proposals, including CMS' proposal to include a health equity adjustment in the Hospital Value-Based Purchasing Program**



**(HVBP), and to modernize the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.**

**At the same time, we have 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 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. Finally, we have concerns about several of the agency's quality-related proposals. A summary of our key recommendations follows.

### **IPPS Payment Update**

CMS proposes a market basket update of 3.0% less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. This update, especially when taken together with the FY 2022 payment update of 2.7%, 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 have 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, we urge 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 (ATRA) documentation and coding adjustments.**

### **Disproportionate Share Hospital Payments**

The AHA 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.**

### **Hospital Quality and Value-based Programs**

AHA supports CMS' proposal to adopt a health equity adjustment for the HVBP, and thanks CMS for recognizing the complex interplay between quality performance and the

social drivers of health. We also applaud CMS' proposal to modernize the HCAHPS survey by permitting the use of web-based surveys. While the AHA shares CMS' goal of improving sepsis care, we are concerned that the inclusion of the well-intentioned but flawed sepsis bundle measure in the HVBP may have too many negative unintended consequences. We instead urge CMS to focus its efforts on the development of a sepsis outcome measure. The AHA also continues to support COVID-19 vaccination for health care workers and communities. However, we recommend that CMS phase in the required reporting of "up to date" vaccination status with the anticipated shift to once-yearly COVID-19 vaccinations.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA senior associate director for policy, at (202) 626-2963 or [swu@aha.org](mailto:swu@aha.org).

Sincerely,

/s/

Stacey Hughes  
Executive Vice President

**American Hospital Association  
Detailed Comments on the Inpatient Prospective Payment System Proposed Rule  
for Fiscal Year 2024**

**Table of Contents**

IPPS Payment Update.....	5
Medicare Disproportionate Share Hospital Payment .....	12
Graduate Medical Education (GME).....	17
Area Wage Index (AWI).....	18
Rural Hospital Provisions.....	19
Physician-Owned Hospitals Proposals .....	21
Changes to MS-DRG Classifications .....	22
Promoting Interoperability Program for Hospitals .....	39
Hospital Value-based purchasing .....	41
Hospital-acquired Condition (HAC) Reduction Program .....	45
Hospital IQR Program.....	47
Disclosures of Ownership and Additional Disclosable Parties Information .....	53
Request for Public Comments: Safety-Net Providers .....	54

## IPPS PAYMENT UPDATE

For FY 2024, CMS proposes a market basket update of 3.0% less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. This update, especially when taken together with the FY 2022 payment update of 2.7%, 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 have continued to face sustained financial pressures. **We, once again, urge 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% — 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 historical 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% from 2019 through 2022, yet Medicare IPPS reimbursement grew at less than half that rate.<sup>1</sup> In fact, over half of hospitals ended 2022 operating at a financial loss.<sup>2</sup> 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 hospitals in over a decade.<sup>3</sup>

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<sup>1</sup> 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/costsofcaaring>

<sup>2</sup> Kaufman Hall (January 2023). National Hospital Flash Report. [https://www.kaufmanhall.com/sites/default/files/2023-01/KH\\_NHFR\\_2023-01.pdf](https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf)

<sup>3</sup> Becker’s Hospital Review (April 2023). Hospitals See Most 1<sup>st</sup>-Quarter Defaults Since 2011. <https://www.beckershospitalreview.com/finance/hospitals-see-most-1st-quarter-defaults-since-2011.html>.

Workforce shortages continue to create outsized pressures on hospitals and health systems.<sup>4</sup> 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 (FTEs) jumped 139% from 2019 through 2022.<sup>5</sup> Accordingly, hospitals' contract labor expenses increased a staggering 257.9% in 2022 relative to 2019 levels.<sup>6</sup> This, in part, drove up overall hospital labor expenses during the same time period by 20.8%. 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% on a per patient basis.<sup>7</sup> For example, hospital supply expenses per patient increased 18.5% 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.<sup>8</sup>

**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% of hospital costs on average according to our latest analysis.<sup>9</sup> In 2021, Medicare margins fell to *negative* 8.2% without COVID-19

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<sup>4</sup> 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>

<sup>5</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. [https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

<sup>6</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. [https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

<sup>7</sup> 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>

<sup>8</sup> 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>

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

relief funds,<sup>10</sup> after hitting an all-time low of *negative* 12.3% 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%, the *20th straight year* of Medicare paying below costs.

## Market Basket

For FY 2022, CMS finalized a market basket of 2.7%, based on estimates from historical data through March 2021. As we detailed in our [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% 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 2021 into calendar year 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 healthcare field.** Specifically, CMS uses the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.<sup>11</sup> 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 and as we describe in detail in the Appendix, 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 to contract labor in order to meet patient demand. Contract hours as a percentage of worked hours rose 133%

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<sup>10</sup> 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](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)

<sup>11</sup> 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.”

in 2022 compared to 2019<sup>12</sup> 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% from 2019 to 2022.

Indeed, CMS itself recognizes that the ECI does not capture these shifts in occupation.<sup>13</sup> 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.<sup>14</sup> 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,<sup>15</sup> 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.<sup>16</sup>

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.<sup>17</sup> 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 we urge CMS to use its "special exceptions and adjustments" authority to correct for the**

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<sup>12</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends.

[https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

<sup>13</sup> 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."

<sup>14</sup> U.S. Bureau of Labor Statistics. National Compensation Measures.

<https://www.bls.gov/opub/hom/ncs/calculation.htm#computing-the-employment-cost-index-eci>

<sup>15</sup> 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.

<sup>16</sup> 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.

<sup>17</sup> U.S. Bureau of Labor Statistics. National Compensation Measures.

<https://www.bls.gov/opub/hom/ncs/calculation.htm#employer-costs-for-employee-compensation-ecec>



**market basket forecast error that occurred in FY 2022 — the 3.0 percentage point difference in what was finalized in FY 2022 at 2.7% and what the market basket actually is at 5.7%.** 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,<sup>18</sup> 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 (ACA), 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).<sup>19</sup> 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.

**The AHA 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 we explained in our [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 demand and supply shocks, this assumption generates significant departures from economic reality. Indeed, the nonfarm business sector labor productivity decreased 2.7% in the first quarter of 2023 compared to the previous quarter.<sup>20</sup> Compared to the same quarter a year ago, it has decreased 0.9%, 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.

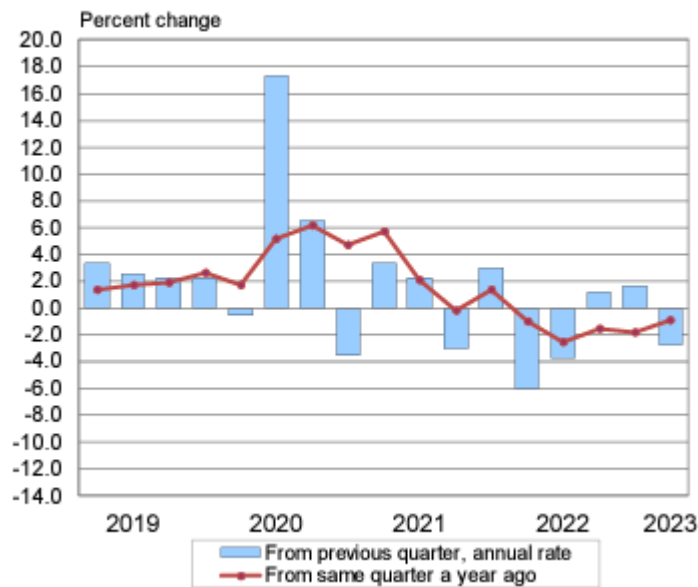
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<sup>18</sup> In December 2022, the ECI was updated to weights using the composition of labor in 2021. <https://www.bls.gov/eci/notices/2022/eci-2021-fixed-weights-and-2018-soc-update.htm>

<sup>19</sup> 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>

<sup>20</sup> 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>

Chart 1. Labor productivity, nonfarm business, 2019Q1 – 2023Q1



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

### ATRA/MACRA Documentation and Coding Adjustment Restoration

In FY 2008, CMS adopted MS-DRGs under the IPPS. CMS indicated that the adoption of the MS-DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. CMS finalized a policy to maintain budget neutrality by adjusting the national standardized amount to eliminate the estimated effect of changes in coding or classification that did not reflect real changes in case-mix. CMS estimated that an adjustment of -4.8% to the national standardized amount was necessary and phased in this adjustment over 3 years (-1.2% in FY 2008, -1.8% in FY 2009, and -1.8% in FY 2010). Congress then enacted the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (TMA) that reduced the adjustment to -0.6% for FY 2008 and -0.9% for FY 2009. However, the TMA further required that CMS estimate the change in expenditures in these years due to documentation and coding and make additional adjustments to IPPS rates between FY 2010 and FY 2012 to ensure that aggregate spending in FY 2008 and FY 2009 was neither higher nor lower than otherwise would have occurred had CMS not adopted the MS-DRGs.

Subsequently, the American Taxpayer Relief Act of 2012 (ATRA) required the Secretary to make a recoupment adjustment totaling \$11 billion by FY 2017. This adjustment represented the amount of the increase in aggregate payment that occurred as a result of not completing the prospective adjustments for additional spending in FY 2008 and FY 2009 between FY 2010 and FY 2012. CMS had planned to make annual recoupment

adjustments of -0.8 percentage points each year for four years from FY 2014 to FY 2017 consistent with ATRA for a cumulative reduction of -3.2 percentage points.

For FY 2018, CMS planned to restore +3.2 percentage points to the IPPS standardized amounts consistent with section 7(b)(2) of the TMA that states “an adjustment made under paragraph (1)(B) for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges in a subsequent year.” However, MACRA was enacted in 2015 and required CMS to make adjustments of +0.5 percentage points annually to the IPPS standardized amounts over 6 years from FY 2018 through FY 2023 or 3.0 percentage points in total over this period. The remaining 0.2 percentage point difference, therefore, would be restored to the standardized amounts beginning in FY 2024 under the requirements of section 7(b)(2) of the TMA.

After MACRA was enacted, CMS adopted an FY 2017 recoupment adjustment of -1.5 percentage points rather than -0.8 percentage points making the cumulative recoupment adjustment -3.9 percentage points while MACRA only allowed 3.0 percentage points to be returned to IPPS rates from FY 2018 through FY 2023. The 21<sup>st</sup> Century Cures Act later changed the first-year restoration adjustment from 0.5 to 0.4588 percentage points.

**Therefore, as a result of the -3.9 percent ATRA adjustment and a 2.9588 percent MACRA and Cures Act restoration, 0.9412 percentage points has not been restored to IPPS standardized rates through FY 2023.**

We appreciate that CMS does not dispute this fact. Indeed, in the FY 2023 final rule, the agency stated “[a]long with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.”<sup>21</sup> As indicated above, section 7(b)(2) of the TMA requires any adjustments for documentation and coding not be carried forward into subsequent years. The TMA was originally enacted in 2007 and paragraph (7)(b)(1)(B) was subsequently amended by the ATRA, MACRA and the 21<sup>st</sup> Century Cures Act to modify the adjustments for documentation and coding occurring between FY 2013 and FY 2023. However, section 7(b)(2) remains unchanged in stating that any of the adjustments made for documentation and coding shall not be included in the determination of the standardized amounts for discharges occurring in a subsequent year.

In addition, section 7(B)(4) of the TMA indicates that “nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.” Again, the statute requires that CMS not continue the adjustments made under paragraph 7(b)(1)(B) into IPPS rates after FY 2023. Just as CMS fully restored prior recoupment adjustments made in FY 2012 for

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<sup>21</sup> 87 Fed. Reg. 48800 (August 10, 2022).

FY 2013<sup>22</sup>, CMS must fully restore the prior recoupment adjustments made since FY 2013. **Therefore, as required by paragraphs 7(b)(2) and 7(b)(4) of the TMA, we ask that CMS fully restore the current 0.9412 percentage point shortfall in updating the FY 2024 standardized amounts. At the very least, CMS should fully restore the 0.9412 percentage point shortfall using its special exceptions and adjustments authority.**<sup>23</sup>

## **MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75% 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**

**The AHA 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, we urge 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.<sup>24</sup> In this table, the agency includes an “Other” column that it says

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<sup>22</sup> 77 FR 53266 (August 31, 2012)

<sup>23</sup> See 42 U.S.C. § 1395ww(d)(5)(I); *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 699 (D.C. Cir. 2014) (explaining that the secretary had authority under 42 U.S.C. § 1395ww(d)(5)(I) to adjust the hospital-specific rate for payments).

<sup>24</sup> 88 Fed. Reg. 26991 (May 1, 2023).

“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 AHA’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% add-on, differences between total inpatient hospital discharges and IPPS discharges, or some other adjustment that contribute to Medicare DSH estimates. Without CMS’ methodology detailing how each of the input 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 in Medicare Advantage plans.”<sup>25</sup> With half of all eligible Medicare beneficiaries enrolled in MA nationally,<sup>26</sup> 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. **The AHA 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, the AHA welcomes the opportunity to work with CMS in examining the impacts of MA enrollment on FFS inpatient hospital payments.

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<sup>25</sup> 88 Fed. Reg. 26991 (May 1, 2023).

<sup>26</sup> 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/>

## 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%. In this rule, CMS proposes to maintain this uninsured rate at 9.2% for FY 2024. **We strongly disagree 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.<sup>27</sup> **We, as well as 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 coverage in the 14 months following the end of the COVID-19 PHE.<sup>28</sup> 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% by 2033.<sup>29</sup> 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

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<sup>27</sup> Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2021-2030. <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>

<sup>28</sup> 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>

<sup>29</sup> Congressional Budget Office (May 2023). CBO Publishes New Health Insurance Coverage Projections for 2023 to 2033. <https://www.cbo.gov/publication/59132>

disenrollment from Medicaid, roughly two-thirds of people had a period of uninsurance.<sup>30</sup> 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.<sup>31</sup> 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% in FY 2024.<sup>32</sup>

For the NHEA to project that there would be modest growth in Medicaid enrollment for 2024 begs belief and is in contrast to HHS's 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 AHA's ability to comment sufficiently on this issue, we urge 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. We urge the agency to do so.**

### Section 1115 Waiver Days

**The AHA opposes CMS' proposal to limit the inclusion of patient days for patients who are regarded as eligible for Medicaid benefits under a Section 1115 demonstration project in the Medicare DSH calculation.** Please refer to our [comments](#) on the proposed rule published in the Federal Register on Feb. 28, 2023. This proposal could have a devastating impact on access to care for lower-income populations by curtailing much needed resources used to finance health care in historically marginalized communities. Specifically, CMS' proposal is fatally flawed because it fails to consider the impact of its policy on low-income patients and the hospitals that care for them. The agency also has not indicated how this proposal would affect its estimation of Medicaid enrollees, and subsequently its determination of Factor 1 in the calculation of DSH. This is in addition to its failure to determine the impact of its proposal on the Medicaid fraction of the Medicare DSH patient percentage. **Therefore, we continue to urge CMS to withdraw this proposal and associated proposed rule.**

### Use of Worksheet S-10 Data

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<sup>30</sup> 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/>

<sup>31</sup> 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](https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf)

<sup>32</sup> 88 Fed. Reg. 26991 (May 1, 2023).

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.

**The AHA has a longstanding position supporting 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, we appreciate and support 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.

### **Interim Uncompensated Care Payments**

In making DSH payments, CMS calculates an interim amount per discharge for each DSH hospital, based on the hospital's estimated DSH total uncompensated care payment (UCP) divided by the hospital's most recently available three-year average number of discharges. For FY 2024, CMS is proposing to exclude FY 2020 data and instead use FYs 2019, 2021 and 2022 data to calculate a three-year average. **We support this proposal.**

### **We also support the following DSH proposals:**

- Newly Merged Hospitals. CMS proposes to continue its policy to treat hospitals that merge after the development of the final rule similar to new hospitals. Specifically, the newly merged hospital's (i.e., the surviving hospital's) current fiscal year cost report would be used to determine the hospital's DSH payment. CMS also proposes to continue its policy that interim uncompensated care payments for the newly merged hospital would be based only on the data for the surviving hospital's CMS Certification Number (CCN) available at the time of the development of the final rule. CMS would then determine the final DSH payment for the newly merged hospital during FY 2024 cost report settlement.
- "New Hospitals." CMS proposes to continue its policy for "new hospitals." Specifically, for newly established hospitals, the hospital's Medicare Administrative Contractor (MAC) would make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement.



## **GRADUATE MEDICAL EDUCATION (GME)**

Medicare direct GME and indirect medical education (IME) funding is critical to educating the physician workforce and sustaining access to care. Yet, the currently insufficient funding levels and limitations on the number of residents for which each teaching hospital is eligible to receive GME reimbursement are a major barrier to reducing the nation's significant physician shortage. CMS proposes several modifications that would affect Medicare direct GME payments to teaching hospitals.

### **Rural Emergency Hospital**

Hospitals may count residents training in “non-provider” sites for direct GME and IME payment. Beginning on Oct. 1, 2019, CMS stated that this includes critical access hospitals (CAHs). Specifically, hospitals may include FTE residents training in a CAH in their direct GME and IME FTE counts as long as the CAH meets the non-provider setting requirements. CMS acknowledges that the term “non-provider” is not explicitly defined in statute; therefore, the agency is using its same logic that defines a CAH as “non-provider” to allow it 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. **We support this proposal that will allow either the hospital or the REH to receive payment from Medicare for incurring the cost of training occurring at an REH.**

### **Nursing Allied Health (NAH) Education Payments**

Medicare pays providers for Medicare's share of the costs that providers incur in connection with approved education activities, including NAH programs. The costs of these programs are not included in the calculation of payment rates for hospitals paid under the IPPS; instead, they are separately paid on a reasonable cost basis. Hospitals that operate approved NAH programs and receive Medicare reasonable cost reimbursement also receive additional payments from Medicare Advantage (MA) organizations. The total spending for these programs is capped at \$60 million for any calendar year (CY). However, during CYs 2010 through 2019, CMS inadvertently did not apply the \$60 million cap; as such, it began seeking recoupment of the overpayments that resulted from its error.

Section 4143 of the Consolidated Appropriations Act (CAA) 2023 provided relief for hospitals subject to this recoupment by lifting the \$60 million cap during these years. This only applies to hospitals that as of enactment of the CAA 2023 continue to operate schools of nursing or allied health. This proposed rule provides the details for implementation of Section 4143. Specifically, the MACs would recalculate a hospital's total NAH MA payment and reconcile them with prior amounts already paid or recouped. Amounts previously recouped would be returned to hospitals and recoupments that would have occurred would no longer occur. **We support this proposal and urge CMS to direct MACs to**

**expeditiously recalculate and reconcile NAH payments before the final rule goes into effect on Oct. 1, 2023.**

## **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% 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% cap on any decrease in a hospital's final wage index due to its adoption of updates from Office of Management and Budget (OMB) bulletin 18-04. In last year's rule, CMS permanently adopted the 5% 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. **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. While we support this policy that would increase the predictability of IPPS payments, we continue 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 25th percentile, the agency increased the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. CMS had indicated that it would adopt this policy for at least four years 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. **The AHA 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, the AHA 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, MedPAC estimates that hospitals' aggregate Medicare margins will be *negative* 10% in 2023. Aggregate Medicare margins in 2021 were a *negative* 8.2%

excluding federal relief funds (-6.2% including relief funds). Unfortunately, these figures are a continuance of a longstanding trend of substantially negative Medicare margins.<sup>33</sup> Taken together, these observations strongly suggest that there is a need to *add* funds into the system, such as by implementing this policy in a non-budget-neutral manner.

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

**Finally, we ask that CMS provide clarification on its plans for this policy moving forward.** Specifically, we urge it to specify how many years of data it expects to need in order to evaluate whether the policy has increased wages for low-wage hospitals. Additionally, we urge it to describe how it will account for the dramatic shifts in wage costs during the COVID-19 PHE. **Doing so will help provide clarity and predictability to the field, especially during the current financial climate in which hospitals are operating.**

### **Imputed Rural Floor Calculation**

As required by law, CMS proposes to continue the minimum area wage index for hospitals in all-urban states, known as an “imputed rural floor,” for FY 2024. This policy applies to states that have no rural hospitals or no rural areas to set a rural floor wage index for those states. Also as required by law, CMS proposes to apply this policy in a non-budget-neutral manner. **We support this proposal.**

## **RURAL HOSPITAL PROVISIONS**

### **Low-volume Adjustment and Medicare Dependent Hospital (MDH) Program**

The Consolidated Appropriations Act 2023 extended both the low-volume adjustment and Medicare Dependent Hospital programs through FY 2024. Thus, CMS is proposing to make conforming changes, including continuing the past process for hospitals to apply for low-volume hospital status. In addition, in anticipation of the MDH program expiring, CMS previously revised the SCH program to allow MDHs to apply for SCH status. CMS is unaware of any hospitals that cancelled MDH status to become an SCH and asked any hospitals uncertain of their status to contact their MACs for verification. **We support the agency’s proposals and appreciate its support of hospitals that serve rural communities. Additionally, we urge CMS to expeditiously process claims and provide instructions to MACs during program extensions, especially in instances**

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<sup>33</sup> 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/2023/03/Ch3\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf)

**when extensions are made retroactively. Seamless transition of programmatic support are crucial life lines for rural providers. We look forward to working with CMS and Congress to make these programs permanent.**

### **Sole Community Hospitals**

CMS is proposing that when a SCH approval is dependent on a merger, the SCH classification and payment adjustment would be effective as of the effective date of the approved merger. CMS recognized that in some situations, the time difference between the effective date of the merger, which may be retroactive, and the effective date of the SCH status may be problematic because these hospitals cannot benefit from the special payment protections during this time period. In addition, different merger requirements across states may create an uneven playing field for providers seeking SCH status. **We support this proposal and applaud CMS for instating policies that help hospitals care for patients in rural communities.** Additionally, we ask that CMS also apply this proposal for those SCHs who were seeking their status during the COVID-19 pandemic and were impacted by this time difference. These rural hospitals were at the front lines of fighting the pandemic in their communities and policies that help support these hospitals are critical in maintaining access to care for their patients. We also ask that in finalizing the proposal, the agency clarifies its current policy of “complete” applications in accordance to the regulation for cases contingent on a merger.

### **Rural Emergency Hospitals**

CMS is proposing to update certain definitions and codify information requirements from in its Jan. 26, 2023, guidance related to the REH enrollment and conversion process. This includes updating definitions in the survey and certification regulations to specify that REHs are included in the definition of “Provider of services or provider.” In addition, CMS is proposing to add conforming language to include the action plan that REHs must submit as part of its application process. **We support these proposals. Additionally, we urge CMS to work with Congress and the Health Resources and Services Administration (HRSA) to allow REHs to be eligible for and continue receiving support from the Small Hospital Improvement Program (SHIP)/Medicare Rural Hospital Flexibility (FLEX) Program, which allow small rural hospitals to receive invaluable technical assistance and support for quality improvement.**

### **Hospitals Applying for Rural Referral Center (RRC) Status**

One way in which a hospital can qualify for RRC status is based on a combination of discharge volume and case-mix criteria, in comparison to other providers in the hospital's region. CMS proposes to use FY 2022 data to calculate case-mix criteria and FY 2021 cost report data to calculate discharge volume. **We support this proposal.**

## PHYSICIAN-OWNED HOSPITALS PROPOSALS

We applaud CMS' efforts to further implement portions of section 6001 of the Affordable Care Act. For decades, the Stark Law has protected federal health care programs, beneficiaries, and communities from the inherent conflict of interest created when physicians self-refer their patients to facilities and services in which they have a financial stake. Recent data from Dobson and DaVanzo<sup>34</sup> reinforces the existing robust body of work from HHS, the Office of Inspector General, Government Accountability Office and MedPAC which have shown that physician-owned hospitals (POHs) cherry-pick patients by avoiding Medicaid and uninsured patients, treat fewer medically complex patients and provide fewer emergency services, instead relying on publicly funded 911 services for emergent care. **As such, we strongly support CMS' proposals to reinstate program integrity restrictions and reinforce processes for requesting an exception from the prohibition on POH expansion.**

### Physician Self-referral Law: Physician-owned Hospitals

CMS states that it has the discretion to approve or deny requests for expansion exceptions for POHs. The AHA agrees and has previously commented<sup>35</sup> that through Section 1877(i)(3) of the Social Security Act, the Secretary was granted statutory "discretion to consider" requests for facility expansion. **We appreciate and support CMS' clarification that it has authority to both approve AND deny requests for expansion.**

### Process for Requesting an Exception from the Prohibition on Expansion of Facility Capacity

For 2024, CMS proposes to consider only expansion exception requests from eligible hospitals, require community input for eligibility and approval/denial determinations, standardize certain data sources (require use of Healthcare Cost Report Information System or HCRIS data for expansion requests), and identify the process/factors for expansion exception requests. It also clarifies the data and information that must be included in expansion exception requests. **We support the agency's proposals.** That said, the proposed rule would require community input on requests submitted for both eligibility and whether requests should be approved or denied, but limits community input to geographies served by the hospital or counties impacted by requests for expansion. **We agree that input should be collected for both eligibility and approval/denial determinations. However, we request that input be more broadly solicited and accepted — not limited to certain geographies.** This broader stakeholder feedback is appropriate given the potential program integrity risks posed by expansion of POHs.

### Program Integrity Restrictions on Approved Facility Expansion

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<sup>34</sup> <https://www.aha.org/fact-sheets/2023-03-28-select-financial-operating-and-patient-characteristics-pohs-compared-non-pohs-fact-sheet>

<sup>35</sup> [aha-fah-urge-cms-to-deny-exception-to-physician-self-referral-prohibition-letter-3-11-22.pdf](#)

The proposed rule would also reinstate program integrity restrictions for POHs approved as “high Medicaid facilities” (which were previously removed in the CY 2021 OPPS final rule). **We support this proposal, which would reinstate restrictions to expansion that would result in a hospital’s facility capacity exceeding 200% of its baseline facility capacity, restrictions to requests for expansion exceptions up to once every two years, and restrictions on the location where expansion of facility expansion could occur to only the hospital’s main campus.** We agree with CMS’ position that the removal of these restrictions in 2021 has posed program integrity risks and that “...protecting the Medicare program and its beneficiaries, as well as Medicaid beneficiaries, uninsured patients, and other underserved populations, from harms such as overutilization, patient steering, cherry-picking, and lemon-dropping outweighs any perceived burden on high Medicaid facilities.” Reinstatement of program integrity restrictions would also ensure consistency in parameters between both applicable hospitals and high-Medicaid facilities.

### **Other Issues on Physician Self-referral and Physician-owned Hospitals: Reporting of Physician Ownership Information**

In addition to the proposals discussed above, we encourage CMS to take action regarding reporting of POH ownership information. Section 6001 of the Affordable Care Act required the reporting of physician ownership information on an annual basis. As a result, in 2011, CMS added an attachment to the CMS-855A enrollment form to capture POH ownership and investment information. However, this attachment was removed in 2013 under the pretense the agency would create a separate CMS-855POH form. Although this form was approved by the Office of Management and Budget in 2013, CMS announced in 2015 that reporting using the form would be suspended until further notice citing concerns about data accuracy. **Now, in 2023, a full eight years later, the agency still has no mechanism to collect physician ownership information on an annual basis and is out of compliance with Section 6001 requirements.** Indeed, earlier this year CMS proposed to collect even less information on POHs by proposing to remove question 2A3 from the CMS-855A, which captures whether an organization is a POH. We provided comment opposing this change.<sup>36</sup> We now reiterate our strong opposition to the elimination of this question, as it is the only way to identify POHs. **In addition, we again urge CMS to come into compliance with Section 6001 as soon as possible.**

### **CHANGES TO MS-DRG CLASSIFICATIONS**

**Broadly, the AHA supports CMS’ proposed changes contained within the MS-DRG classifications. We agree with several proposals given the data, the ICD-10-CM/PCS codes, and information provided. However, we urge CMS to consider the exceptions that are detailed below.**

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<sup>36</sup> [aha-comments-on-the-cms-information-collection-request-re-revision-of-medicare-enrollment-application-for-institutional-providers-cms-855a-letter-2-13-23.pdf](https://www.aha.org/~/media/2023/06/2023-06-09-aha-comments-on-the-cms-information-collection-request-re-revision-of-medicare-enrollment-application-for-institutional-providers-cms-855a-letter-2-13-23.pdf)

## **FY 2024 MS-DRG Updates**

CMS uses the criteria established in FY 2008 (72 FR 47169) to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG is warranted. In the FY 2021 IPPS and long-term care hospital (LTCH) PPS final rule (85 FR 58448), CMS finalized the proposal to expand existing criteria to create a new CC or MCC subgroup within a base MS-DRG. Specifically, CMS finalized the expansion of the criteria to include the NonCC subgroup for a three-way severity level split. CMS believed that this would better reflect resource stratification and promote stability in the relative weights by avoiding low volume counts for the NonCC level MS-DRGs.

CMS' analysis applying the NonCC subgroup criteria to all FY 2021 MS-DRGs split into three severity levels found that, for FY 2022, it would have deleted 96 MS-DRGs (32 MS-DRGs x 3 severity levels = 96) and created 58 new MS-DRGs.

For the FY 2023 IPPS/LTCH PPS proposed rule, CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2021 update of the FY 2021 MedPAR file, which contained hospital bills received from Oct. 1, 2020, through Sept. 30, 2021, for discharges occurring through Sept. 30, 2021. CMS' analysis of applying the NonCC subgroup criteria to the FY 2023 MS-DRGs split into three severity levels would have deleted 123 MS-DRGs and created 75 new MS-DRGs.

CMS' MS-DRG analysis for this FY 2024 IPPS/LTCH PPS proposed rule was based on ICD-10 claims data from the September 2022 update of the FY 2022 MedPAR file. CMS utilized additional claims data available from the December 2022 update of the FY 2022 MedPAR file for purposes of assessing the application of the NonCC subgroup criteria to these existing MS-DRGs as well as to determine whether a proposed new base MS-DRG satisfies the criteria to create subgroups. Findings from this analysis indicate that approximately 45 base MS-DRGs would be subject to change based on the three-way severity level split criterion finalized in FY 2021. Specifically, CMS found that applying the NonCC subgroup criteria to all MS-DRGs currently split into three severity levels would result in the potential deletion of 135 MS-DRGs (45 Base MS-DRGs x 3 severity levels = 135) and the potential creation of 86 new MS-DRGs. There was potential for an additional 12 obstetric MS-DRGs (4 base MS-DRGs x 3 severity levels = 12) that would be subject to change based on the application of the three-way severity according to CMS' internal analysis. However, based on prior public comments and CMS' discussion in prior rulemaking, CMS proposes to exclude the additional 12 obstetric MS-DRGs from application of the NonCC subgroup criteria.

CMS conducted analysis of the MS-DRG classification requests for FY 2024 that were received by Oct. 20, 2022, and included additional analyses in connection with those classification requests. Additionally, while CMS' initial MS-DRG analysis for FY 2024 was

generally based on ICD-10 claims data from the September 2022 update of the FY 2022 MedPAR file, the additional claims data available in the December 2022 update of the FY 2022 MedPAR file was used to assess the case counts and other criteria for determining whether a proposed new base MS-DRG would satisfy the criteria to create subgroups.

Within this proposed rule, and in response to prior public comments received, CMS made available several files reflecting application of the NonCC subgroup criteria in connection with the FY 2024 MS-DRG changes. Notably, one of these files is table 6P.10f which includes alternative cost weights analysis with the NonCC subgroup criteria and provides the calculated weights with application of the NonCC subgroup criteria using alternative GROUPER software V41.A.<sup>37</sup>

**We thank CMS for making these files public along with the GROUPER V41.A so that stakeholders can better analyze and understand the impact of proposals if the NonCC subgroup criteria were applied to existing MS-DRGs with a three-way severity level split.** CMS noted that after delaying application of the NonCC subgroup criteria for two years, and in response to prior public comments, these additional analyses were made available for the public to review and to provide opportunity for public comment that will help inform CMS' application of the NonCC subgroup criteria for FY 2025 rulemaking.

**We again appreciate CMS' recognition and the acknowledgement of the concerns around the impact of implementing this volume of MS-DRG changes. In the previous two years, we strongly agreed with CMS' proposal to delay the application of the NonCC subgroup criteria to existing MS-DRGs in FY 2022 and FY 2023. Again, we strongly agree with CMS' proposal to delay the full implementation and application of the NonCC subgroup in FY 2024.** Specifically, we agree with CMS' proposal to maintain the current structure of the 135 MS-DRGs (45 Base MS-DRGs x 3 severity levels = 135) MS-DRGs that currently have a three-way severity level split that would otherwise be subject to these criteria for FY 2024, and we agree with CMS' proposal to exclude obstetric MS-DRGs from application of the NonCC subgroup criteria.

**In reviewing the FY 2021, 2022 and 2023 rules, while the expansion of the criteria to include the NonCC subgroup was finalized in 2021 as acknowledged, the application of the criteria was intentionally delayed to existing MS-DRGs in 2022 and 2023. While CMS' proposed to delay the full implementation and application of the NonCC subgroup criteria for FY 2024, we respectfully request CMS' insight and rationale as to the reasoning that the NonCC subgroup criteria has been applied to the proposed MS-DRG changes for FY 2024. If the intent is to delay the application of the NonCC subgroup criteria for future or FY 2025 rulemaking consideration, we would like to**

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<sup>37</sup> In addition to table 6P.10f, CMS provides other files such as Table 5 - Alternate List of Medicare Severity Diagnosis Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay, an alternate Length of Stay (LOS) Statistics file, an alternate Case Mix Index (CMI) file, and an alternate After Outliers Removed and Before Outliers Removed (AOR\_BOR) file.



**better understand why the NonCC subgroup criteria was applied to the current MS-DRG proposals.** CMS states, “In our analysis of the MS-DRG classification requests for FY 2024 that we received by October 20, 2022, as well as any additional analyses that were conducted in connection with those requests, we applied these criteria (NonCC subgroup) to each of the MCC, CC, and NonCC subgroups.” As such, this criterion has been applied with the proposed new MS-DRGs for FY 2024 based on CMS’ data analysis completed for these proposals, i.e., MS-DRGs 173, 212, 275, 276, 277, 278, 279, 321, 322, 323, 324, 325, 397, 398 and 399. Within this comment letter under MDC 04 and 05, we provide comments in response to MS-DRG change proposals in instances where notable impacts result from the application of the NonCC subgroup criteria.

**In conjunction with the above request for rationale related to the application of the NonCC subgroup criteria for FY 2024 MS-DRG change proposals, we continue to urge CMS to delay the implementation of this change due to the need for additional data transparency and operational considerations listed below.**

**Data Transparency Issues.** We respectfully recommend CMS consider the following.

- We appreciate CMS making available the additional files for review and analysis with this FY 2024 proposed rule, and we acknowledge that this is the first time this type of in-depth analysis has been made available for public review and comment. **Therefore, we request that CMS consider allowing additional time for hospitals to review this information and perform detailed internal analyses that will afford hospital organizations the opportunity to better forecast individual organizational impact.**
- **We request that CMS provide streamlined data analysis by hospital type in FY 2025 rulemaking.** Providing this streamlined data and additional time for hospital organizations to review would allow for better comment submission in response to the CMS requests for comments outlined in the FY 2024 proposed rule related to experiences of large urban hospitals, rural hospitals, and other hospital types.
- We again appreciate the additional files and historical information that CMS has provided regarding the NonCC subgroup criteria to assist with preparation of comment consideration for future rulemaking on this topic. In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58448), CMS finalized the proposal to expand existing criteria to create a new CC or MCC subgroup within a base MS-DRG. Not transparent within the narrative or files from the proposed rules for FY 2021 through FY 2024, **we would appreciate CMS’ insight regarding the rationale for the dynamic nature of the MS-DRG change applying the NonCC subgroup criteria.** For example:
  - **For the FY 2022 IPPS/LTCH PPS proposed rule,** the March 2020 update of the FY 2019 MedPAR file and the September 2020 update of the FY 2020 MedPAR file was utilized in the analysis of the application of the NonCC subgroup criteria to all MS-DRGs split into

three severity levels beginning in FY 2022. **Based on CMS' analysis at that time, the proposal was to delete 96 MS-DRGs and create 58 new MS-DRGs.**

- **For the FY 2023 IPPS/LTCH PPS proposed rule**, the September 2021 update of the FY 2021 MedPAR file was utilized in the analysis of the application of the NonCC subgroup criteria to all MS-DRGs split into three severity levels beginning in FY 2023. **Based on CMS' analysis at that time, the proposal was to delete 123 MS-DRGs and create 75 new MS-DRGs.**
- **For this FY 2024 IPPS/LTCH PPS proposed rule**, the September 2022 update of the FY 2022 MedPAR and the December 2022 update of the FY 2022 MedPAR was utilized in the analysis of the application of the NonCC subgroup criteria to all MS-DRGs currently split into three severity levels. **Based on current CMS analysis, the proposal for FY 2024 includes the deletion of 135 MS-DRGs and the creation of 86 new MS-DRGs.**
- To further illustrate the point about the dynamic nature, a few examples of differences in the MS-DRGs considered for change since the new NonCC subgroup criteria was first introduced with FY 2021 rulemaking are noted below. These examples highlight some of the MS-DRGs that were proposed for deletion in FY 2023 (Table 6P.1b) that are not proposed for deletion in FY 2024 (6P.10b).
  - MS-DRGs 196, 197 and 198 (Interstitial Lung Disease, with MCC, with CC, without CC/MCC respectively)
  - MS-DRGs 597, 598 and 599 (Malignant Breast Disorders of the Breast with MCC, with CC and without CC/MCC respectively)
  - MS-DRGs 673, 674 and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC and without CC/MCC respectively)
  - MS-DRGs 802, 803 and 804 (Other O.R. Procedures of the Blood and Blood Forming Organs with MCC, with CC and without CC/MCC respectively)

**As noted, we would like the opportunity to better understand the rationale for the dynamic nature of these proposals and would greatly appreciate CMS' insight on this matter. As illustrated, not only have the MS-DRG change proposals fluctuated in volume in the FY 2022-FY 2024 proposals, the changes among which MS-DRG proposals proposed for deletion and creation have also fluctuated.**

Additionally, we want to bring to CMS' attention that the proposed NonCC subgroup methodology, intentionally or unintentionally, eliminates many of the "with CC/MCC" MS-DRGs. For example, as illustrated in Table 6P.10f with this proposed rule for existing MS-DRGs to which the NonCC criteria has been applied, none of the illustrated changes in this

table result in a two-way split with and without MCC/CC. All the MS-DRG two-way splits in this table are with and without MCC only. This is also demonstrated with all proposed new MS-DRGs for FY 2024. The direction that this implies is that complication/comorbid conditions increasingly need to be a MCC to impact the complexity and severity of a case. **We are concerned that the impact of CCs is fading without an explicit transparency of CMS' intent.** We look forward to CMS' response to this stated concern.

**Operational and Financial Impact Considerations.** As mentioned in our [comments](#) in response to the FY 2023 IPPS/LTCH PPS proposed rule, we wish to reiterate again that the impact of MS-DRG change proposals on community hospitals could be significant as their case mix may be more significantly affected since they do not perform as many complex surgeries. For such hospitals, significant changes in the MS-DRG structure could result in large financial losses if the MS-DRG redistribution is across all MS-DRGs rather than within related MS-DRG clusters. **As stated previously in our comments, we urge CMS to perform additional analysis for the explanatory power of predicting resource use by hospital types**, i.e., large urban, rural and other hospital types.

As an additional unintended consequence consideration, commercial payers and Medicare Advantage programs may rely on the MS-DRG groupings to calculate payment or negotiate annual contracts. Without the ability to perform a more accurate, thorough and detailed financial analysis, hospitals will be unable, or at a disadvantage, when renegotiating such MS-DRG based managed care contracts.

**Again, we thank CMS for providing more meaningful data analysis in this FY 2024 proposed rule. However, as noted, additional streamlined data by hospital type is needed and hospitals need additional time to have the opportunity to analyze the operational and monetary impact of this type of proposed change closely and thoroughly.**

#### **MDC 04 - Diseases and Disorders of the Respiratory System — Ultrasound Accelerated Thrombolysis for Pulmonary Embolism**

For the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes to create a new base MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis with Principal Diagnosis Pulmonary Embolism). CMS' internal review and claims data analysis included cases in MS-DRGs 163, 164 and 165, (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) and MS-DRGs 166, 167 and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) that involved cases reporting conventional catheter-directed thrombolysis (CDT) or ultrasound-assisted thrombolysis (USAT) with or without thrombolytic(s) and a principal diagnosis of pulmonary embolism (PE). CMS' analysis indicated that while this subset of cases for patients undergoing a thrombolysis (CDT or USAT) procedure for PE does not clinically align with patients undergoing surgery for malignancy or treatment for infection and does not involve the same level of complexity, monitoring or support as cases grouping to MS-DRGs 163,

164 and 165, the differences in resource consumption warrant proposed reassignment of these cases.

**We support CMS’ proposal to reassign these cases from the current MS-DRGs 166, 167 and 168 that have a principal diagnosis of pulmonary embolism with ultrasound accelerated and other thrombolysis. However, we do not support the creation of a single MS-DRG to capture these cases.** CMS’ internal analysis supported that it was unclear if the device or the reporting of secondary codes or the combination of both were impacting the average costs. Based on this analysis, we believe that the creation of a single level MS-DRG does not acknowledge the secondary diagnosis impact.

**We further believe that this example demonstrates that the NonCC subgroup may not be suitable for application with some MS-DRGs.** As illustrated in the proposed rule, there were a total of 1,534 patients reporting procedure codes describing an USAT or CDT procedure with a principal diagnosis of PE. NonCC subgroup criteria requires a minimum of 500 cases per tier. With this disease process, it is unlikely that there would ever be an equal split due to the volume being so close to the minimum number. The table provided in the proposed rule further illustrated the breakdown of cases by tiers and that the distribution of cases within these tiers did not meet the criteria of 500 cases in each of the tiers.

<b>MS-DRG</b>	<b>Number of Cases</b>	<b>Average Length of Stay</b>	<b>Average Costs</b>
With MCC	1,058	5.31	\$28,618
With CC	393	3.85	\$23,164
Without CC/MCC	83	2.88	\$20,886

Since the criteria for a three-way split failed, the next step illustrated within the analysis determined that a two-way split of this base MS-DRG also failed to meet the criterion that there be at least 500 cases in the without MCC (CC+NonCC) subgroup.

<b>MS-DRG</b>	<b>Number of Cases</b>	<b>Average Length of Stay</b>	<b>Average Costs</b>
With MCC	1,058	5.31	\$28,618
Without MCC	476	3.7	\$22,767

Since the criteria for the two-way split of the base MS-DRG failed, the next step illustrated within the analysis applied a two-way split for the “with CC/MCC and without CC/MCC” subgroups additionally failed to meet the criterion that there be 500 cases in the without CC/MCC (NonCC) subgroup.

MS-DRG	Number of Cases	Average Length of Stay	Average Costs
With CC/MCC	1,451	4.9	\$27,141
Without CC/MCC	83	2.88	\$20,886

CMS’ analysis illustrated that the criterion for both two-way splits failed, therefore, a split (or CC subgroup) is not warranted for the proposed new base MS-DRG. As a result, for FY 2024, the following table reflects a simulation of the proposed new base MS-DRG.

MS-DRG	Number of Cases	Average Length of Stay	Average Costs
Proposed MS-DRG 173	1,534	4.8	\$26,802

As illustrated, the average costs have a continuous decline with a three-tier and two-tier distribution. For cases with MCC the average costs are \$28,618. This decreases slightly to \$27,141 when using the MCC/CC criterion and the single tier falls further to \$26,802. Unfortunately, this results in a single tier MS-DRG with a weight that has been significantly lowered from **the prior multiple tiers** that does not appear to recognize the resource consumption relative to the diagnosis, evaluation and treatment provided.

#### **MDC 04 - Diseases and Disorders of the Respiratory System — Respiratory Infections and Inflammations Logic**

For the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes to correct the logic for case assignment to MS-DRG 177 by excluding the 16 diagnosis codes from the first logic list “Principal Diagnosis with Secondary Diagnosis” from acting as an MCC when any one of the listed codes is reported as a secondary diagnosis with a diagnosis code from the second logic list “or Principal Diagnosis” reported as the principal diagnosis.

The logic for case assignment to MS-DRGs 177, 178 and 179 (Respiratory Infections and Inflammations with MCC, with CC, and without CC/MCC, respectively) is comprised of two logic lists.

- First logic list “Principal Diagnosis with Secondary Diagnosis”: Defined by a list of five ICD-10-CM diagnosis codes describing influenza due to other or unidentified influenza virus with pneumonia in combination with a separate list of 11 diagnosis codes describing the specific pneumonia infection.

When any one of the five listed diagnosis codes from the “Principal Diagnosis” logic list is reported as a principal diagnosis in combination with any one of the 11 listed diagnosis codes from the “with Secondary Diagnosis” logic list as a secondary

diagnosis, the case results in assignment to MS-DRG 177, 178 or 179 depending on the presence of any additional MCC or CC secondary diagnoses.

- Second logic list “or Principal Diagnosis”: Defined by a list of 57 diagnosis codes describing various pulmonary infections. When any one of the 57 diagnosis codes from this list is reported as a principal diagnosis, the case results in assignment to MS-DRG 177, 178 or 179 depending on the on the presence of any additional MCC or CC secondary diagnoses.

Although specific examples and logic explanation would have been a helpful addition to the proposed rule narrative to better understand CMS’ intent, we acknowledge that CMS proposes to correct the logic for case assignment to MS-DRG 177 making it similar to existing logic for other MS-DRGs. Based on the understanding of intent, **we respectfully request that CMS reconsider excluding all the influenza ICD-10-CM codes in the first logic list, J10.00; J10.01; J10.08; J11.00 and J11.08 acting as a MCC/CC when assigned as a secondary diagnosis in conjunction with any of principal diagnosis listed under the second Principal diagnosis logic list.** Many of the Principal diagnoses listed on the second Principal diagnosis list for MS-DRGs 177-179 are not excluded as MCCs from each other because they are not inherently related to each other, and, in combination, they have potential to be more complicated and resource intensive to treat than any of the diagnoses occurring alone.

### **MDC 05 - Diseases and Disorders of the Circulatory System — Surgical Ablation**

For the FY 2024 IPPS/LTCH PPS proposed rule, CMS noted consideration that it clinically requires greater resources to perform an aortic/mitral valve repair/replacement with another concomitant procedure.

Based on this consideration and CMS’ internal analysis, CMS proposes to create a new base MS-DRG for cases reporting an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure in MDC 05 - MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures).

We agree with CMS’ proposal to create a new base MS-DRG for cases reporting an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure in MDC 05 - MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures). **However, please consider the below to ensure consistency in the proposed logic intent for new MS-DRG 212.**

- In table 6P.4a and the draft version of the MS-DRG V41.0 Definitions Manual, the procedure codes are categorized by type. There are valve procedures that are listed under the “other concomitant procedure” list. Not all valve repair procedures would have the root operation of repair or replacement. Those procedures that are supplement for the specific aortic and mitral valve should be re-considered to be

moved under their respective valve repair category. “Supplement” is the root operation utilized for valve replacements. Additionally, there could be other open valve procedures to consider that may have a root operation of restriction or release that could apply to the open valve procedures.

Based on the understanding of how the logic for MS-DRG 212 is applied, a procedure on the aortic valve and the mitral valve must be performed before a concomitant procedure can be considered for the MS-DRG 212 assignment logic. For example, the more specific aortic and mitral valve ICD-10-PCS repair code would be assigned, such as repair with an annuloplasty ring that is coded to supplement aortic or mitral valve with synthetic substitute. However, the content in the proposed rule pertaining to this topic, the MS-DRG logic in the current v41 MS-DRG Definitions Manual and the current MS-DRG description for MS-DRG 212 doesn’t seem clear or consistent in terms of the logic intent.

- Given the clinical and data analysis made available within the FY 2024 IPPS proposed rule content, it is not readily clear if there is specific enough analysis to support if the logic intent is to have both a mitral and aortic valve procedure with a concomitant procedure of the logic intent is to have a mitral OR aortic valve procedure with a concomitant procedure to assign a case to this new MS-DRG 212. **We request that CMS clarify the logic intent and provide additional clinical and/or data analysis to support the logic intent as applicable.**
- We request that language in the v41.0 Definitions Manual be clarified to ensure that the intent of the logic is clear. Please consider the title change in the Definitions Manual to state as such, like other MS-DRGs. For example, proposed new MS-DRGs 321 (Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and MS-DRG 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC).
- We also request that consideration be given to add Coronary Artery Bypass Graft (CABG) to the MS-DRG title since the concomitant procedure could involve surgical ablation or CABG.

## **MDC 05 - Diseases and Disorders of the Circulatory System — External Heart Assist Device**

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 44820 through 44831), CMS received a request to reassign certain cases reporting procedure codes describing the insertion of a percutaneous short-term external heart assist device from MS-DRG 215 (Other Heart Assist System Implant) to MS-DRGs 216, 217 and 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively). Based on CMS’ analysis, CMS finalized the proposal to assign ICD-10-PCS codes 02HA0RJ, 02HA3RJ or 02HA4RJ that describe the intraoperative insertion of a short-term external heart assist device to MS-DRGs 216, 217, 218, 219, 220 and 221 beginning in FY 2022.

For this FY 2024 IPPS/LTCH PPS proposed rule, CMS received a request to reassign certain cases reporting procedure codes describing the insertion of a short-term external heart assist device using an axillary artery conduit from MS-DRG 215 to MS-DRGs 001 and 002 (Heart Transplant or Implant of Heart Assist System with MCC and without MCC, respectively) and MS-DRG 003 (ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures).

In conjunction with the MS-DRG reassignment request, we acknowledge that a request for a new ICD-10-PCS procedure code to describe the Impella® 5.5 with SmartAssist® System was also presented at the March 7-8, 2023, ICD-10 Coordination and Maintenance Committee meeting. Therefore, diagnosis and procedure code proposals that were presented at the March 7-8, 2023, ICD-10-CM Coordination and Maintenance Committee meeting for an October 1 implementation (upcoming FY) were not finalized in time to include in Table 6A. – New Diagnosis Codes and Table 6B. – New Procedure Codes in association with this FY 2024 IPPS/LTCH PPS proposed rule.

Consistent with what CMS has noted in prior rulemaking (86 FR 44805), CMS uses the established process to examine the MS-DRG assignment for the predecessor codes to determine the most appropriate MS-DRG assignment. Specifically, CMS reviews the predecessor code and MS-DRG assignment most closely associated with the new procedure code, and in the absence of claims data, CMS considers other factors that may be relevant to the MS-DRG assignment, including the severity of illness, treatment difficulty, complexity of service and the resources utilized in the diagnosis and/or treatment of the condition. CMS restated in this FY 2024 proposed rule that this process does not automatically result in the new procedure code being assigned to the same MS-DRG or to have the same designation (O.R. versus Non-O.R.) as the predecessor code.

Under this established process, the MS-DRG assignment for any new procedure codes describing the Impella® 5.5 with SmartAssist® System, if finalized, will be reflected in Table 6B. – New Procedure Codes associated with the final rule for FY 2024.

**We support CMS’ proposal to reassign the current ICD-10-PCS code 02HA0RZ (describing the open insertion of a short-term external heart assist device, i.e., Impella® 5.5 with SmartAssist® System) when reported as a standalone procedure from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRGs 001 and 002. However, we acknowledge the pending request for a new ICD-10-PCS code and the fact that the MS-DRG to which a new code will be assigned, if approved, will not be known until the FY 2024 final rule is published. As a result, we urge CMS to maintain steps that are consistent with the process under the “predecessor” code MS-DRG assignment to ensure that the FY 2024 proposal to reassign this procedure to MS-DRGs 001 and 002 is maintained.**

**MDC 05 - Diseases and Disorders of the Circulatory System — Coronary Intravascular Lithotripsy**



For the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes to make the following changes in MDC 05 for cases involving Coronary Intravascular Lithotripsy (IVL).

CMS proposes to delete the following MS-DRGs:

- MS-DRGs 246 and 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents and without MCC, respectively)
- MS-DRG 248 ((Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents) and
- 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent without MCC).

With these deletions, CMS proposes to create five new MS-DRGs.

CMS proposes to create a new base MS-DRG with a two-way severity level split for cases describing *percutaneous cardiovascular procedures with intraluminal device in MDC 05*.

These new proposed MS-DRGs include:

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

Additionally, CMS proposes to create two new MS-DRGs with a two-way severity level split for cases describing *coronary intravascular lithotripsy involving the insertion of an intraluminal device in MDC 05*. CMS is also proposing to create a new MS-DRG for cases describing coronary intravascular lithotripsy without an intraluminal device. These proposed new MS-DRGs include:

- MS-DRG 323 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC)
- MS-DRG 324 (Coronary Intravascular Lithotripsy with Intraluminal Device without MCC) and
- MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device).

CMS also proposes to add the procedure codes from the current MS-DRGs 246, 247, 248 and 249 to the proposed new MS-DRGs 321 and 322. CMS also proposes to revise the titles for MS-DRGs 250 and 251 from “Percutaneous Cardiovascular Procedures without Intraluminal Device with MCC, and without MCC, respectively” to better reflect the ICD-10-PCS terminology of “intraluminal devices” versus “stents” as used in the procedure code titles within the classification. **We agree with the MS-DRG title revisions.**

We acknowledge and agree with CMS’ data analysis for MS-DRGs 246-251 in that the data clearly shows that cases reporting percutaneous coronary IVL, with or without involving the insertion of intraluminal device, have higher average costs and generally longer LOS compared to all the cases in the assigned MS-DRGs in this category.

**However, we strongly disagree with the application of the NonCC subgroup criteria to determine the proposed new MS-DRGs for this complex group of cardiac cases.** We completed an internal review and analysis utilizing CMS’ data for this group of MS-DRGs, i.e., the case volume information included in FY 2024 Table NPRM AOR-BOR V40 and V41, and weights from Table 5 FY 2023 for current MS-DRGs and proposed Table 5 for proposed FY 2024 new MS-DRGs. The table below demonstrates that this new group of MS-DRGs will have a significant impact that does not seem to capture the resource utilization for this group of cases. While we clearly support that this group of cases warrant revisions within the MS-DRG grouping, we strongly recommend that CMS revisit this proposal to reconsider how resource consumption could be better captured. **Additionally, we request that CMS reconsider the use of the NonCC subgroup logic for this group of MS-DRGs, especially given CMS’ proposal to delay the implementation of the NonCC subgroup logic until future rulemaking.**

FY24 MS-DRGs	New MS-DRG Description FY2024	FY24 MS-DRG Weight	FY23 MS-DRGs	FY23 MS-DRGs Description (Red Font=Deleted MS-DRGs for FY24)	FY23 MS-DRG Weight	MS-DRG Weight FY24 for Existing MS-DRG	CMS FY24 Wt + Chg in Cases	CMS Financial Impact Using Av Blended Rate \$6249.82	CMS V41 Cases (FY2)	CMS V40 Cases (FY2)	CMS Change in Cas
321	Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices	2.8812				New	117567.3660	\$734,774,875.37	40,805	-	40,805
322	Percutaneous Cardiovascular Procedure with Intraluminal Device without MCC	1.8309				New	103775.4120	\$648,577,645.43	56,680	-	56,680
323	Coronary Intravascular Lithotripsy with Intraluminal Device With MCC	4.1576				New	8651.9656	\$54,462,566.10	2,081	-	2,081
324	Coronary Intravascular Lithotripsy with Intraluminal Device without MCC	2.9848				New	6450.1528	\$40,312,293.97	2,161	-	2,161
325	Coronary Intravascular Lithotripsy without Intraluminal Device	2.6810				New	1085.8050	\$6,786,085.81	405	-	405
				246 Percutaneous Cardiovascular Procedures with Drug-eluting Stent with MCC or 4+ Arteries or Stents	2.9954		-128044.3638	-\$800,254,225.76	-	42,747	(42,747)
				247 Percutaneous Cardiovascular Procedures with Drug-eluting Stent without MCC	1.9095		-110097.9510	-\$688,092,376.12	-	57,658	(57,658)
				248 Percutaneous Cardiovascular Procedures with Non-Drug-eluting Stent with MCC or 4+ Arteries or Stents	3.0098		-1733.6448	-\$10,834,967.94	-	576	(576)
				249 Percutaneous Cardiovascular Procedures with Non-Drug-eluting Stent without MCC	1.8167		-1129.9874	-\$7,062,217.85	-	622	(622)
				250 Percutaneous Cardiovascular Procedures without Intraluminal	2.4197	2.3506	-495.9766	-\$3,099,764.47	3452	3,663	(211)
				251 Percutaneous Cardiovascular Procedures without Intraluminal Device without MCC	1.6253	1.5885	-300.2265	-\$1,876,361.58	3176	3,365	(189)
								-\$26,306,447.04			

We agree with CMS’ logic that the presence of a CC and/or MCC and the presence of the intraluminal device impact the LOS and charges for the proposed new MS-DRGs 323, 324 and 325 based on the data analysis provided in the proposed rule. We agree that distinct tiers within these proposed MS-DRGs are necessary to reflect with a device impacted by MCC and with a device not impacted by MCC as demonstrated with MS-DRG 323 and 324 MS-DRG descriptions. **However, we recommend that CMS consider creating an additional MS-DRG to pair with MS-DRG 325 to reflect when a device is utilized with and without the presence of a complicating diagnosis such as MCC or CC.**

## **MDC 05 - Diseases and Disorders of the Circulatory System — Shock**

For the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes to make the following changes in MDC 05 for cases involving cardiac defibrillators with/without cardiac catheterization and with/without acute myocardial infarction (AMI), heart failure (HF) or shock.

CMS proposes to delete the following MS-DRGs:

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

With these deletions, CMS proposes to create three new MS-DRGs. CMS proposes to create a new base MS-DRG for cases reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as an MCC and a new MS-DRG with a two-way severity level split for cases reporting both a cardiac catheterization and a secondary diagnosis designated as an MCC. These new proposed MS-DRGs include:

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

We agree with CMS' analysis that it no longer is necessary to subdivide the MS-DRGs for cases reporting a cardiac defibrillator implant based on the diagnosis code reported.

CMS' analysis indicated that all 3,467 cases analyzed in predecessor MS-DRGs reported a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as a MCC. Therefore, CMS proposes that secondary diagnosis codes with a severity designation of MCC be used in the definition of the logic for assignment to the proposed base MS-DRG for cases reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as an MCC. Given that, CMS did not apply the criteria to create further subgroups in a base MS-DRG for cases reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as an MCC.

CMS' further analysis for cases reporting a cardiac defibrillator implant without additionally reporting both a cardiac catheterization and a secondary diagnosis designated as a MCC along with the application of the criteria to create subgroups in a base MS-DRG are illustrated in the table to follow. As noted, the three-way split of the proposed new MS-DRGs failed the criterion that there be at least 500 cases for each subgroup due to low

volume. Specifically, for the “without CC/MCC” (NonCC) split and also failed the 20% difference in average costs between the CC and NonCC subgroup.

MS-DRG	Number of Cases	Average Length of Stay	Average Costs
With MCC	3,830	8.4	\$53,924
With CC	3,653	4.3	\$42,466
Without CC/MCC	452	3.2	\$39,394

CMS then applied the criteria for a two-way split for the “with MCC” and “without MCC” subgroups for the proposed new MS-DRGs and found that all five criteria were met.

Proposed new MS-DRGs	Number of Cases	Average Length of Stay	Average Costs
With MCC	3,830	8.4	\$53,924
Without MCC	4,105	4.2	\$42,128

**We agree with CMS’ analysis that it no longer is necessary to subdivide the MS-DRGs for cases reporting a cardiac defibrillator implant based on the diagnosis code reported.** We completed an internal review and analysis utilizing CMS’ data for this group of MS-DRGs, i.e., the case volume information included in FY 2024 Table NPRM AOR-BOR V40 and V41, and weights from Table 5 FY 2023 for current MS-DRGs and proposed Table 5 for proposed FY 2024 new MS-DRGs. The table below demonstrates that this new group of MS-DRGs will have an impact that does not seem to capture the resource utilization for this group of cases. We acknowledge that CMS’ analysis of all 3,467 cases analyzed in predecessor MS-DRGs reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis indicated a diagnosis that was designated as a MCC. However, we still believe that a tiered MS-DRG 275 should be considered to include an option that indicates without MCC as it currently is not clear as to where cases that do not have an MCC will be assigned. This scenario also is an example of our previously noted concern that we mentioned about the NonCC subgroup, intentionally or unintentionally, eliminating the option of a “with CC” MS-DRG.

**While we clearly support that this group of cases warrant revisions within the MS-DRG grouping, we strongly recommend that CMS revisit this proposal to reconsider how resource consumption could be better captured. Additionally, we request that CMS reconsider the use of the NonCC subgroup logic for this group of MS-DRGs, especially given CMS’ proposal to delay the implementation of the NonCC subgroup logic until future rulemaking.**

FY2024 MS-DRGs	New MS-DRG Description FY2024	FY24 MS-DRG Weight	FY23 MS-DRGs	FY23 MS-DRGs Description (Red Font=Deleted MS-DRGs for FY24)	FY23 MS-DRG Weight	MS-DRG Weight FY24 for Existing MS-DRGs	CMS FY24 Wt * Chg in Cases	CMS Financial Impact Using Av Blended Rate \$6249.82	CMS V41 Cases (FY2)	CMS V40 Cases (FY2)	CMS Change in Cas
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC	7.1043			New	New	24630.6081	\$153,936,878.99	3,467		3,467
276	Cardiac Defibrillator Implant with MCC	6.2775			New	New	24049.1025	\$150,302,546.16	3,831		3,831
277	Cardiac Defibrillator Implant without MCC	4.8430			New	New	19880.5150	\$125,144,294.91	4,105		4,105
				222 Cardiac Defibrillator Implant with Cardiac Catheterization with AMI, HF or Shock, with MCC	7.6566		-12242.9034	-\$76,515,942.53	-	1,599	(1,599)
				223 Cardiac Defibrillator Implant with Cardiac Catheterization with AMI, HF or Shock, without MCC	5.2187		-1508.2043	-\$9,426,005.40	-	289	(289)
				224 Cardiac Defibrillator Implant with Cardiac Catheterization without AMI, HF or Shock with MCC	7.0892		-12321.0296	-\$77,004,217.21	-	1,738	(1,738)
				225 Cardiac Defibrillator Implant with Cardiac Catheterization without AMI, HF or Shock without MCC	5.0577		-6327.1827	-\$39,543,752.98	-	1,251	(1,251)
				226 Cardiac Defibrillator Implant without Cardiac Catheterization with MCC	6.4009		-24521.8479	-\$153,257,135.44	-	3,831	(3,831)
				227 Cardiac Defibrillator Implant without Cardiac Catheterization without MCC	5.0207		-13525.7658	-\$84,533,601.61	-	2,694	(2,694)
								<b>-\$10,896,935.11</b>			

### Operating Room and Non-O.R. Issues

In the FY 2020 IPPS/LTCH PPS proposed rule, CMS announced that given the long period of time that has elapsed since the original O.R. (extensive and non-extensive) and non-O.R. designations were established, incremental changes that have occurred to these O.R. and Non-O.R. procedure code lists, and changes in the way inpatient care is delivered, CMS planned to conduct a comprehensive, systematic review of the ICD-10-PCS procedure codes. CMS noted that this will be a multi-year project during which the process for determining when a procedure is considered an O.R. procedure will also be reviewed.

Since the FY 2021 IPPS/LTCH PPS proposed and final rule publications, and with this FY 2024 IPPS/LTCH PPS proposed rule, we acknowledge CMS' continued decision to allow additional time before developing the process and methodology for conducting a comprehensive, systematic review to determine O.R. and Non-O.R. designation.

**We agree with CMS on the decision to allow for additional time before developing the process and methodology for conducting a comprehensive, systematic review to determine O.R. and Non-O.R. designation. We look forward to CMS providing more detail on this analysis and the advanced notice for comment in future rulemaking regarding the proposed methodology for conducting this review.**

### Proposed Changes to Severity Levels

We appreciate CMS taking into consideration the public comments in response to the FY 2023 IPPS/LTCH PPS proposed rule related to severity level changes to consider for FY 2024 rule making related to ICD-10-CM diagnosis codes that represent social

determinants of health (SDOH) codes. We agree with CMS' proposal to designate the three ICD-10-CM diagnosis codes below as CCs for FY 2024.

- Z59.00 (Homelessness unspecified) — Non-CC to CC for FY 2024
- Z59.01 (Sheltered homelessness) — Non-CC to CC for FY 2024
- Z59.02 (Unsheltered homelessness) — Non-CC to CC for FY 2024

**As expressed by our concerns related to the NonCC subgroup criteria topic, the elimination of “with MCC/CC” tier with the proposed new MS-DRGs along with the MS-DRG changes associated with Table 6P.10f which CMS is proposing to delay, may have significant impact to homelessness as a CC. With this intentional or unintentional elimination of the “with MCC/CC” tier there is potential for fewer MS-DRGs to be impacted by the presence of homelessness as a CC.**

In the FY 2024 IPPS/LTCH PPS proposed rule, we acknowledge that CMS continues to solicit feedback regarding the guiding principles and other ways to incorporate meaningful indicators of clinical severity. Additionally, we acknowledge that CMS continues to encourage feedback on ways to foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to reflect each health care encounter more accurately in effort to improve the reliability and validity of the coded data including that support efforts that advance health equity.

Recognizing that there is a separate date for additional feedback on this topic of Oct. 20, 2023, as outlined in the FY 2024 proposed rule, we will continue to review and consider additional comments that may be warranted for this separate comment period.

### **Proposed Changes to the Medicare Code Editor (MCE) — Sex Conflict Edit**

We appreciate CMS' commitment to look holistically at the concerns raised by the commenters across all settings of care regarding the original design of the sex conflict edit and consideration of claims processing of transgender individuals. We support that this edit continues to be applicable in all settings of care to ensure accurate claims processing. We look forward to collaborating with CMS as indicated to address concerns related to transgender claims processing and condition code considerations where applicable.

**Additionally, we support all CMS' proposals within the FY 2024 proposed rule related to the Medicare Code Editor.**

### **Proposed Changes to Surgical Hierarchies**

For the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes to modify the existing surgical hierarchy for several MS-DRGs for FY 2024. **We agree with the surgical hierarchy proposals apart from the below MS-DRG requests for CMS to consider regarding placement.**

- Request to consider switching MS-DRGs 270, 271 and 272 and MS-DRG 319 and 320 in hierarchy so that MS-DRGs 270, 271 and 272 are placed before MS-DRGs 319 and 320.
- Request to consider switching MS-DRG 245 with MS-DRGs 266 and 267 so that MS-DRG is placed above MS-DRGs 266 and 267.
- Request to consider switching MS-DRGs 323, 324 and 325 to be placed after MS-DRGs 319 and 320 after it switches places with MS-DRG 270, 271 and 272. (i.e., placement 270, 271, 272 then 319 and 320 then 323, 324 and 325).

### **New COVID-19 Treatments Add-On Payment (NCTAP)**

CMS proposed that discharges involving eligible products would continue to be eligible for the NCTAP through Sept. 30, 2023. **Given the end of the eligibility for products considered for NCTAP, we request that CMS continue to monitor the impacts of this change for consideration in the creation of new MS-DRGs specific to COVID-19 in future rulemaking.**

### **PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS**

#### **Reporting Period**

In prior rulemaking, CMS established the following reporting periods for hospitals to demonstrate they are meaningful users of EHRs:

- For the CY 2023 reporting/FY 2025 payment years, any continuous 90-day period during CY 2023, and
- For the CY 2024/FY 2026 payment years, any continuous 180-day period during CY 2024.

CMS proposes to continue a 180-day reporting period for the CY 2025 reporting/FY 2027 payment year. In addition, CMS solicits feedback on further increasing the length of the EHR reporting period in future years.

**The AHA remains concerned with a 180-day reporting period for the Promoting Interoperability Program, and we would object to any further lengthening of the reporting period at this time. In fact, we urge CMS to carefully monitor the CY 2024 reporting period and consider additional flexibilities if hospitals are unable to meet the continuous 180-day reporting requirement.**

CMS previously established a reporting period of any continuous 90 days in recognition that EHRs are far from static tools. EHRs are continually undergoing software upgrades, system downtime, expansions to other sites with a system, and a variety of other improvement and maintenance activities. When CMS makes changes to the requirements of the Promoting Interoperability Program, these changes affect *all* of the thousands of

hospitals required to participate in the program. Yet, to make the changes and upgrades needed to comply with Promoting Interoperability Program requirements, hospitals are drawing on the same EHR vendors simultaneously, and the capacity of those vendors is finite. That is why hospitals have frequently chosen reporting periods later in the year. In some cases, their vendors are simply not available to perform the needed work because they are working with multiple other facilities. Hospitals also need sufficient time for testing and implementation, which is necessary to identify and resolve problems with the software and provide essential training to end users. Ultimately, these activities are crucial to ensuring EHRs do not inadvertently compromise the safe delivery of care.

In addition, the COVID-19 pandemic has left hospitals facing profound financial, workforce and operational challenges, all of which have implications for the resources they are able to dedicate to meeting new Promoting Interoperability requirements. Many critical health IT projects were appropriately delayed at the height of the pandemic in order to free up resources to meet other vital needs in helping hospitals respond to the pandemic. Health IT departments remain integral to the mandatory reporting of COVID-19-related data to the federal government. Those departments also had to adapt and implement system supports when hospitals temporarily expanded to other sites of care, and greatly expanded their telehealth presence in order to maintain access to care. **As the health care field continues its recovery from a once-in-a-century pandemic, we urge CMS to use a measured approach to considering and adding any new program requirements.**

### **SAFER Guidelines**

In the FY 2022 inpatient PPS final rule, CMS added the SAFER Guide measure to the Protect Patient Health Information objective of the Promoting Interoperability Program. Developed by the Office of the National Coordinator for Health Information Technology (ONC), the SAFER assessment includes nine guides that ask hospitals to assess the safety and effectiveness of their EHR implementation, proactively identify potential vulnerabilities and adopt a “culture of safety” with respect to the use of EHRs in their organizations. Beginning with CY 2022, hospitals have been required to attest “yes/no” to whether they conducted an annual assessment using all nine SAFER guides. However, given CMS’ stated interest in EHR safety, CMS proposes that beginning with CY 2024 reporting/FY 2026 payment, hospitals would be required to conduct the annual SAFER Guides self-assessments and attest a “yes” response accounting for a completion of the self-assessment for all nine guides.

**The AHA urges CMS not to finalize its proposal to require hospitals to attest “yes” to completing the SAFER Guides annually.** We remain concerned that the SAFER guidelines have not undergone a comprehensive review and update since 2016. The health IT landscape has shifted dramatically since then, calling into question whether the contents of the SAFER guide remain relevant to hospitals and effective in ensuring the safe implementation of EHRs. Furthermore, we note the considerable length of each of the



nine guides, and the level of administrative effort required to complete them, especially for CAHs and other hospitals with fewer resources.

The AHA also believes the concept of requiring hospitals to attest “yes” on this or any other Promoting Interoperability measure is a fundamental misuse of the program’s design. When CMS adopted a performance-based scoring approach for the program, the agency’s goal was to provide differential rewards based on how hospitals perform in order to incentivize the adoption of a particular practice. Performance-based scoring was never intended to create an across-the-board requirement for all participants in the program; yet, this is precisely what CMS’ proposal would do.

At the same time, we appreciate CMS’ focus on ensuring the safety of the implementation and use of EHR technology. We believe these efforts can most effectively advance through the dissemination of more modernized approaches and guidelines to EHR safety, and not necessarily using a measure in a promoting interoperability program. That said, if CMS is intent on adopting a measure, we encourage the agency to consider a more focused approach that addresses more specific gap areas in EHR safety, rather than a broad-based assessment like the SAFER guides. If CMS is intent on mandating the use of the SAFER guides, then we urge the agency to work with ONC on an update of the guides, informed by stakeholder input, and undertake an education and awareness campaign to disseminate information to the field, including information tailored to small- and medium-sized health care organizations.

### **Clinical Quality Measurement**

CMS proposes changes to the Promoting Interoperability Program’s electronic clinical quality measures (eCQMs) measure set and reporting requirements that are aligned to changes proposed in the Hospital Inpatient Quality Reporting (IQR) Program. See the IQR section of this letter for the AHA comments on these proposed changes.

### **HOSPITAL VALUE-BASED PURCHASING**

The ACA mandated that CMS implement the HVBP program, which ties a portion of hospital payment to selected measures of the quality, safety and cost of hospital care. CMS funds the program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance.

CMS proposes several significant changes to the HVBP program for FYs 2024 and beyond.

### **Addition of Severe Sepsis and Septic Shock Management Bundle (SEP-1)**

Beginning with the FY 2026 HVBP program, CMS proposes to add the SEP-1 measure used in the IQR program to the HVBP's safety domain. In the proposed rule, CMS suggests that adopting SEP-1 would be consistent with its renewed focus on patient safety and would accelerate hospital progress on delivering better care for sepsis patients.

The AHA agrees that sepsis is an important patient safety issue worthy of attention in national quality measurement programs, and we share CMS' goal of reducing preventable sepsis mortality. However, we are concerned that the risks of using this well-intentioned but flawed measure in the HVBP program outweigh its benefits, especially in the context of a pay-for-performance program that would create a strong incentive for hospitals to adhere to the measure. **For this reason, we urge CMS not to finalize its proposal to adopt the SEP-1 measure for the HVBP program.**

Researchers, clinicians and hospital staff have been working tirelessly for decades to improve care and prevent sepsis and septic shock. We are heartened to see this work reflected in the rapidly evolving sepsis management landscape. However, this accelerated learning has also meant that the underlying evidence around which interventions are most effective and appropriate for reducing sepsis mortality for given types of patients have changed continually. These shifts matter greatly for a process of care measure like SEP-1 that prescribes the use of specific time-based steps in sepsis care management that are supposed to be derived from evidence.

Unfortunately, the SEP-1 measure has struggled to keep up with shifting evidence, and emerging studies suggests the implementation of the measure carries potential significant negative unintended consequences. For several years, multiple specialty societies (including the American College of Emergency Physicians, Infections Diseases Society of America, the Society for Healthcare Epidemiology in America, and the Association for Professionals in Infection Control and Epidemiology) have correctly highlighted peer-reviewed research showing no meaningful association between implementation of the SEP-1 measure and improved sepsis outcomes.<sup>38</sup> Furthermore, SEP-1's focus on immediate administration of antibiotics has the high potential to lead to excessive use of antibiotics.<sup>39</sup> The overuse of antibiotics is an especially important risk to consider given that the CDC has repeatedly [highlighted](#) antimicrobial resistance as a global public health

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<sup>38</sup> See Barbash IJ et al, Treatment Patterns and Clinical Outcomes after the Introduction of the Medicare Sepsis Performance Measure (Sep-1). *Ann Intern Med.* 2021. Rhee et al, Association between Implementation of the Severe Sepsis and Septic Shock Early Management Bundle Performance Measure and Outcomes in Patients with Suspected Sepsis in Us Hospitals. *JAMA Netw Open.* 2021;4(12):e2138596; and Anderson DJ et al. The Impact of Centers for Medicare & Medicaid Services Sep-1 Core Measure Implementation on Antibacterial Utilization: A Retrospective Multicenter Longitudinal Cohort Study with Interrupted Time-Series Analysis. *Clin Infect Dis.* 2022;75(3):503-511.

<sup>39</sup> See Weinberger J et al. A Critical Analysis of the Literature on Time-to-Antibiotics in Suspected Sepsis. *J Infect Dis.* 2020;222(Suppl 2):S110-S118; Im Y et al. Time-to-Antibiotics and Clinical Outcomes in Patients with Sepsis and Septic Shock: A Prospective Nationwide Multicenter Cohort Study. *Crit Care.* 2022;26(1):19; and Alam N et al. Prehospital Antibiotics in the Ambulance for Sepsis: A Multicentre, Open Label, Randomised Trial. *Lancet Respir Med.* 2018;6(1):40-50.

threat. We also note that hospitals have continually expressed frustration about continual shifts in and a lack of clarity in the measure specifications. We are concerned this has led to inconsistent interpretations and implementation of the measure across facilities.

In the proposed rule, CMS indicates that it is working on a sepsis outcome measure in collaboration with the CDC that could ultimately replace the SEP-1 process of care measure. The AHA believes the use of a well-designed sepsis outcome measure would be a far more effective way of encouraging improvement in sepsis outcomes than a process of care measure on which there are important concerns about unintended consequences and implementation complexity. We encourage CMS and CDC to continue their work to bring the sepsis outcome measure from concept to reality rapidly and look forward to considering its use in future HVBP program. In the meantime, the AHA cannot support the use of the SEP-1 bundle measure in the HVBP.

### **Revisions to Existing HVBP Measures**

CMS proposes substantive updates to two HVBP measures:

Medicare Spending per Beneficiary (MSPB). **The AHA does not support CMS' proposed update to the MSPB measure.** We are especially concerned by CMS' proposal to permit readmissions to trigger new episodes that could count in calculating a hospital's MSPB performance. We believe this approach could lead to the same costs being attributed to hospitals twice, thereby providing a misleading portrayal of hospital performance. Furthermore, the measure's NQF endorsement review suggested the measure's reliability and validity were quite low. The AHA believes far more work is needed to this measure to ensure it is assessing hospital performance fairly.

Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Complications. **The AHA supports CMS' proposed updates to the THA/TKA Complication measure used in the VBP.** Starting with the FY 2030 HVBP program, CMS proposes to use an updated version of the THA/TKA measure. The measure cohort would be expanded to include index admission diagnoses and in-hospital comorbidity data from Medicare part A claims. This change would enable the inclusion of 26 additional mechanical complication ICD-10-CM codes.

Health Equity Adjustment (HEA). In the proposed rule, CMS indicates that it wants to ensure its VBP programs help advance health equity by "reduc[ing] avoidable differences in health outcomes experienced by people who are disadvantaged or underserved." The agency acknowledges research showing the relationship between health outcomes and social risk factors (e.g., income, housing, transportation and nutrition), as well as various methodological approaches for accounting for social risk factors in assessing provider performance. CMS indicates that being dually eligible for Medicare and Medicaid (which the agency calls dual-eligible status, or DES) is a strong predictor of having greater social needs, health risks and negative health outcomes.

In order to reward high quality performance for hospitals caring for larger populations of underserved patients, CMS proposes a HVBP health equity adjustment (HEA) that would add up to 10 bonus points to a hospital's VBP Total Performance Score (TPS). The equity adjustment will be the product of two CMS-calculated factors — a “measure performance scaler” and “an underserved multiplier.” The measure performance scaler would assign hospitals points for each HVBP measure domain based on whether they score in the top, middle or bottom third of performance on the measure. The measure performance scaler would be multiplied by the underserved multiplier, which reflects the logarithmic function of the proportion of a hospital's inpatient stays that include Medicare FFS and Medicare Advantage patients with DES.

**The AHA supports CMS' proposed health equity adjustment, and thanks CMS for recognizing the complex interplay between quality measures and health-related social needs.** We share the agency's goal of ensuring that all hospitals are incentivized to deliver high quality, equitable care to all patients and communities. CMS has proposed a methodological approach that both acknowledges the factors beyond hospitals control that may impact their performance in the HVBP, while continuing to encourage high levels of hospital performance. We also appreciate that CMS has proposed the HEA in the form of bonus points rather than adding the HEA to the base TPS. The design of the HEA also ensures that bonus points would be potentially available to all hospitals participating in the HVBP, ensuring that all hospitals share an incentive to deliver higher quality care to patients and communities facing sustained structural challenges. While the AHA believes CMS should continue explore a full range of approaches to accounting for social drivers of health in quality measurement — including direct risk adjustment where appropriate — we believe the proposed HEA is an important step forward.

In the proposed rule, CMS also asks for feedback on potential future changes to its HEA methodology. For example, CMS is considering the incorporation of other variables in the HEA's underserved multiplier, including area deprivation index (ADI), and receiving the Medicare Part D Low-Income Subsidy (LIS). CMS uses both the ADI and LIS in calculating a HEA in the Medicare Shared Savings Program (MSSP).

**The AHA believes both ADI and LIS have merit as variables in the HEA's underserved multiplier and encourages CMS to consider incorporating them.** Conceptually, the underserved multiplier is designed to use one or more “proxies” to reflect the extent to which hospitals are caring for underserved populations. No single proxy is perfect, and each carries potential strengths and drawbacks. For example, DES has the significant benefit of being consistently recorded in Medicare administrative data, and relatively easy to tie back to individual hospitals. There also is a body of research showing the link between DES and other measures of social drivers, such as income. At the same time, DES tends to reflect those patients who face the most significant social needs. Furthermore, Medicaid eligibility criteria can vary across states, which means it may be a

more comprehensive reflection of underserved populations for some hospitals than for others.

Similarly, the main strength of the ADI is that it attempts to create a multi-dimensional picture of the social drivers of health in a community. It draws on multiple data sources — including Medicare administrative data and census data — and uses 17 indicators of social risk to develop a single score for a geographic region. At the same time, because ADI is calculated at a census-block level, it has the potential to obscure differences within a particular census block. For example, the ADI for a community could look average, but parts of the community may face enormous structural barriers to accessing health care and other supportive resources that lead to better outcomes.

We recognize that combining more than one proxy for underserved status — as CMS does in the MSSP program — also adds potential administrative complexity. However, we believe this concern likely is outweighed by the potential to draw in multiple sources of information on the patients and communities that hospitals serve and create multiple ways to recognize the structural challenges that patients and hospitals may face in achieving better outcomes.

### **HCAHPS Administration Changes**

**The AHA supports CMS' proposed changes to the administration and submission requirements for the HCAHPS survey that would take effect beginning with the FY 2027 HVBP program year.** We refer CMS to the IQR section of this letter for additional comments.

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

The HAC Reduction Program imposes a 1% reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates. In this rule, CMS proposes updates to the HAC Reduction Program's validation requirements and solicits feedback on ways to advance patient safety through the HAC Reduction Program.

#### **Validation Changes**

**The AHA supports CMS' proposal to establish a validation reconsideration process for the HAC Reduction Program.** The five healthcare-associated infection (HAI) measures used in the HAC Reduction program are subject to validation by CMS. Hospitals that fail validation automatically receive the worst possible scores for the validated measures. Given this significant consequence, we are pleased that CMS would establish a process to allow hospitals to provide CMS with additional information to substantiate their compliance that, if sufficient, CMS could use to reverse a finding of non-compliance.

#### **Request for Information on Advancing Patient Safety**

In the proposed rule, CMS indicates that advancing patient safety is among its top priorities, and that the agency is considering updates to the measure set and scoring methodology used in the HAC Reduction Program to more effectively incentivize improvements in safety.

As a general matter, the AHA is not confident the HAC Reduction Program is a particularly effective mechanism for promoting advances in patient safety. In fact, the AHA has long opposed the statutory design of the HAC Reduction Program, which imposes penalties on up to 25 percent of hospitals each year, regardless of whether hospitals have improved performance, and regardless of whether performance across the field is consistently good. Peer-reviewed research has [shown](#) that the program's design unfairly penalizes teaching hospitals, large hospitals, small hospitals and hospitals caring for structurally marginalized communities. Additional research has also demonstrated that the performance of hospitals receiving the penalty often is [statistically indistinguishable](#) from those who are not, suggesting that the use of a penalty threshold is arbitrary.

Nevertheless, the AHA appreciates CMS seeking to work within statutory constraints to make improvements to the program and offer two suggestions. **First, the AHA urges CMS to sunset the patient safety indicator measure (PSI 90) from the HAC Reduction Program.** As the AHA has repeatedly noted, PSI measures have long had questionable levels of reliability<sup>40</sup> and profound disconnects between performance captured in billing data and clinical reality.<sup>41</sup> Furthermore, as noted above, the inclusion of the PSI measure in the HAC Reduction Program likely biases the program against large hospitals and teaching hospitals that care for more complex patients. We suspect that part of the reason the PSI measure remains in the HAC Reduction Program is because it purports to capture a breadth of patient safety events and enables the inclusion of a larger number of hospitals who may not have sufficient volumes to report on the healthcare-associated infection (HAI) measures used in the program. Yet the measure's reliability is so poor — and its utility in improving care is so low — that we believe it is time for CMS to transition to more modern and accurate measures of patient safety.

**Second, we encourage CMS to prioritize the development and implementation of patient safety measures based on clinical data that are drawn from electronic sources.** In making this suggestion, we acknowledge this would entail a significant multi-year effort for both the agency and for hospitals and health systems. At the same time, hospitals would welcome the opportunity to engage with CMS to identify the best measurement topics to include in such measures, and facilitate the development of meaningful measures to drive patient safety forward. Given that any measure used in the HAC Reduction Program has significant payment implications for hospitals, any electronic

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<sup>40</sup> See [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP\\_Measure\\_Reliability-.pdf](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf)

<sup>41</sup> Among other studies, see Ramanathan R et al. Validity of Agency for Healthcare Research and Quality Patient Safety Indicators at an academic medical center. *The American Surgeon*. 2013 Jun; 79(6):578-82.

measure must be reliable, accurate and field tested before being used in the HAC Reduction Program. The measure must also work consistently regardless of the EHR platform a hospital uses. Lastly, we urge CMS to implement new HAC Reduction Program measures in the IQR program for at least one year before moving them into the HAC Reduction Program.

In the proposed rule, CMS notes it is considering the use of eCQMs derived from EHRs, including the three eCQMs proposed for the IQR. As described in the IQR section of this letter, we are not yet sure those measures are ready for widespread implementation in hospitals, let alone use in a pay-for-performance program. However, we appreciate CMS beginning to take steps to make greater use of EHR-based patient safety measures. When designed appropriately, these measures can result in more timely and accurate data for hospitals, patients and CMS.

## **HOSPITAL IQR PROGRAM**

The IQR program is CMS' pay-for-reporting program in which hospitals must submit measures and meet other administrative requirements in order to avoid a payment reduction equal to one quarter of the annual market basket update. The IQR program also includes a requirement to report on selected EHR-derived eCQMs using CMS-mandated reporting standards. The IQR eCQM reporting requirements align with the eCQM reporting requirements in the Promoting Interoperability Program.

Among other changes, CMS proposes to add three new eCQMs to the IQR program beginning with the CY 2025 reporting/FY 2027 payment year while removing three existing IQR measures. CMS also proposes to update the definitions of its health care personnel (HCP) COVID-19 vaccination measure to reflect "up to date" vaccination status and to revise the administration and data collection requirements of the HCAHPS survey.

### **New IQR eCQMs**

Beginning with the CY 2025 reporting/FY 2027 payment year, CMS proposes to add three new measures to the menu of eCQMs from which hospitals can choose to fulfill the IQR's eCQM reporting requirements.

**Hospital Harm — Pressure Injury eCQM. The AHA supports adding this proposed measure to the menu of available eCQMs in the IQR and Promoting Interoperability Program.** This measure assesses the proportion of inpatient hospitalizations for patients 18 years and older that develop a new stage 2, stage 3, stage 4, deep tissue or unstageable pressure injury, and is not risk-adjusted. CMS uses a nearly identical version of this measure in several post-acute care quality reporting programs, where pressure injuries are under constant surveillance due to the nature of patients receiving long-term care.

We appreciate that CMS has taken steps to improve this measure from its initial development by more effectively excluding pressure injuries that are unlikely to be attributable to the hospital. For example, the measure now excludes pressure injuries that are present on admission or that develop in a time window where the cause is unlikely to be tied to quality of care at the admitting hospital. In addition, we believe using EHRs as the basis to capture pressure injury data likely is appropriate as more clinical documentation of pressure injuries becomes electronic.

Given the potential for pressure injuries to lead to significant complications, we certainly understand CMS' interest in implementing this measure in the IQR. At the same time, as CMS considers whether to require its reporting of all hospitals in future years, we urge it to carefully assess the performance gap on this measure to determine whether it remains a priority. When this measure was presented to the Measure Applications Partnership (MAP) as part of CMS' pre-rulemaking process, the measure developer included an analysis showing that the incidence of new stage 2-4, unstageable or deep tissue pressure injury in 2020 was 0-2% with an average of 1.06%. While hospitals are eager to prevent as many pressure injuries as they can, it also is possible there is a smaller performance gap to close with this measure than with other patient safety issues. Given CMS' continued focus on implementing a streamlined, focused set of "meaningful measures" for its programs, CMS should weigh the performance gap of this measure against its other existing and potential new measures of patient safety to ensure it merits use in its programs.

**Hospital Harm — Acute Kidney Injury eCQM. The AHA does not support the adoption of this measure for the IQR or Promoting Interoperability Program currently.** While we appreciate the concept of using an EHR-based measure to identify a precursor to a potentially serious safety event, there are significant questions about whether the definitions and focus of this measure are appropriate. At a minimum, we urge CMS not to adopt the measure unless and until it has been endorsed by a consensus-based entity.

This measure assesses the proportion of inpatient hospitalizations for patients 18 years and older who have an AKI (stage 2 or greater) that occurred during the encounter. An AKI stage 2 or greater is defined as a substantial increase in serum creatinine value, or by the initiation of kidney dialysis (continuous renal replacement therapy (CRRT), hemodialysis or peritoneal dialysis). We appreciate that CMS' goal in proposing the measure is to prevent moderate-to-severe AKI, as there is no specific treatment to reverse it.

However, the MAP pre-rulemaking review process highlighted several significant concerns with the design of the measure. Clinical experts have noted that AKIs are multifactorial, often unpredictable, and not always clinically significant. In fact, sometimes elevations in serum creatinine are linked to the underlying disease that brought a patient to the hospital rather than being a reflection of the safety of care provided in the hospital. CMS has attempted to focus on hospital related AKIs by excluding creatinine elevations within the first 48 hours of admission. However, commenters noted this may not be sufficient



because diseases can progress at different paces, particularly complex diseases. Comments from the American Society of Nephrology also noted that modest increases in serum creatinine “may be expected and appropriate, potentially representing an indicator of high-quality care rather than of harm,” citing an association between increased serum creatinine levels and decongestion for patients with congestive heart failure.

We believe a CBE endorsement process can help CMS assess whether the measure truly reflects a precursor of harm, whether the definitions in the measure are appropriate and whether the measure is feasible to collect from EHRs.

**Excessive Radiation eCQM. While the AHA does not object to adding this proposed measure to the menu of available eQMs for the IQR and Promoting Interoperability Program, we strongly urge CMS to not mandate its reporting until hospitals gain further implementation experience.**

CMS characterizes this proposed measure as a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses while preserving image quality. It is expressed as a percentage of eligible CT scans that are “out-of-range” based on having either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. While we appreciate the goal of this measure, some inpatient facilities may not perform many CT scans depending on their case mix, limiting the measure’s relevance for some providers.

Furthermore, the AHA is concerned by the sheer complexity of the measure. In part, the measure relies on free software that would be used to calculate the data elements in the measure from hospital sources. However, hospitals and imaging centers will need to integrate this software as well as processes to aggregate multiple data components into their workflow, and it is not clear from the testing information provided whether this has been proven feasible on a wide scale. It is also not entirely clear how hospitals will use the aggregate results they receive from the measure to prioritize efforts to optimize radiation dosing in CT scans. In part, this will depend on whether the software needed to calculate the measure produces granular enough data to be actionable.

**Updated COVID-19 Vaccination Coverage among Health Care Personnel (HCP) Measure.** Beginning with the FY 2025 IQR CMS would adopt a modified version of the COVID-19 Vaccination Coverage among HCP currently used in the IQR. While the current measure assesses the number of HCP “who have received a complete vaccination course against COVID-19,” CMS would replace this term with “who are up to date” with their vaccination as recommended by the Centers for Disease Control and Prevention (CDC) at the time of the reporting period.

The AHA strongly supports the vaccination of health care personnel and communities against COVID-19. We also agree with CMS’ rationale underlying the proposal to adopt

this modified measure that measures in use in its quality reporting programs should reflect the current science. However, the evidence around the optimal cadence for booster doses of COVID-19 vaccination, as well as the seasonality of the virus itself, is evolving rapidly. Over the past several months, CDC and FDA have indicated they are seriously considering the adoption of a once-yearly regimen for COVID-19 vaccinations comparable to the well-established approach used for influenza vaccination. In addition, the AHA is concerned that the administrative complexity of collecting CDC's current definition of "up to date" status may outweigh its benefit. For these reasons, **we recommend CMS continue to collect up to date vaccination status on a voluntary basis and implement required reporting of up to date status after FDA and CDC have completed their recommendations on an updated vaccination schedule.**

We encourage CMS to learn from the experience of implementing the previous version of this measure and take into account the foreseeable logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs. As CMS notes in the proposed rule, health care facilities are collecting and reporting data on "up to date" COVID-19 vaccination status, though the "up to date" data field cannot be used for public reporting unless CMS finalizes the proposed measure specification change. However, facilities have reported that this collection process is administratively burdensome under CDC's current "up to date" definition. This is because the collection protocol uses a reference time period for determining up to date status that changes every quarter. Practically speaking, this means that an HCP who counted as "up to date" in a given quarter may no longer be up to date in the next quarter.

Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCPs may need an additional booster. In fact, collecting accurate data on HCP's underlying risk factors likely would require hospitals to both obtain permission to have such data and a mechanism to keep the data fully secure. The AHA is concerned that the resource intensiveness of collecting data under CDC's current definitions may outweigh its value.

The AHA believes that the adoption of a once-yearly vaccination regime would alleviate much of the administrative complexity of collecting up to date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as fall 2023. By delaying the required reporting of "up to date" vaccination status, CMS could align its reporting requirements around this more efficient approach. In practical terms, we believe the soonest facilities could report up to date status based on a once-yearly vaccination regimen is the second quarter of CY 2024, but we recognize that more time may be needed.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we continue to urge that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS' stated goals of encouraging vaccination).

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among healthcare personnel. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of healthcare personnel who are up to date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects. Similarly, the measure under consideration is inconsistent with CMS's recently sunset Condition of Participation (CoP) requiring vaccination among health care personnel in terms of its exceptions for sincerely held religious beliefs. To maintain continuity with the CoP and align with HHS Office of Civil Rights guidance, we recommend that CMS develop an additional exclusion for this measure to account for sincerely-held religious beliefs.

**Updated Hybrid Hospital-wide Readmission and Mortality Measures. The AHA supports the concept of CMS' proposal to include Medicare Advantage patients in the calculation of its two hybrid readmission and mortality measures. However, we encourage CMS to have this update reviewed and endorsed by a consensus-based entity before adopting it.**

These two measures are "hybrid" measures that combine CMS claims data with EHR-derived data that hospitals collect and submit to CMS. CMS adopted these measures in prior rulemaking as an attempt to leverage the use of EHR data to calculate readmission and mortality rates. CMS indicates that its data sources now permit the inclusion of Medicare Advantage patients, and that their inclusion is appropriate given the rapid growth in Medicare Advantage participation.

The AHA appreciates the concept of ensuring CMS' measures reflect the breadth of the Medicare patient population. At the same time, the inclusion of Medicare Advantage patients could affect hospital measure performance, as well as the measure's reliability and accuracy. While we suspect the inclusion of Medicare Advantage patients would improve the measure, a review by a consensus-based entity would ensure an in-depth, multi-stakeholder assessment of the change.

**Proposed Measure Removals. The AHA supports CMS' proposals to remove three measures from the IQR.** We agree it is appropriate to remove the THA/TKA complications and MSPB measures from the IQR because they are proposed for the HVBP, making their inclusion in the IQR redundant. We also agree with CMS' assessment that its elective delivery prior to 39 weeks gestation (PC-01) has topped out. Given that the IQR now includes three other maternal health-related measures that may be redundant, it is appropriate to sunset the PC-01 measure.

**HCAHPS Changes. The AHA supports CMS' proposed changes to the HCAHPS survey data collection and administration processes and believes CMS' proposals would both modernize the HCAHPS and advance health equity.** The AHA especially applauds CMS' proposal to the use of web-based surveys as a part of a mixed-mode survey administration process. For several years, the AHA and other stakeholders have urged CMS to permit the use of web-based surveys for the HCAHPS in order to align with the growing patient preference to receive surveys electronically. We believe using web-based surveys in combination with other follow up modes (phone and/or mail) could help improve HCAHPS survey response rates.

The AHA also appreciates CMS' proposal to require hospitals to administer the official Spanish translation of the HCAHPS to patients that indicate they would prefer it. Hospitals are working steadfastly to advance health equity and are working to ensure that language does not hinder the quality or experience of care. Given that many hospitals serve significant numbers of Spanish speakers, the administration of the CAHPS in Spanish would help enable the capture of their insights into their care.

**Potential Future Structural Measures on Care for Geriatric Patients.** For future IQR programs, CMS is considering the adoption of two structural measures reflecting the extent to which hospitals adopt certain practices related to geriatric care. One of the measures, "Geriatric Hospital Care," includes eight domains and 14 individual practices that CMS believes would comprise a "comprehensive framework for the optimal care of older patients." The second measure, "Geriatric Surgical Care," includes seven domains and 11 individual practices reflecting practices thought optimize pre-and-post surgical care and outcomes. CMS also is considering a future designation for geriatric care that would be reflected on its Care Compare website that could include these measures or other measures focused on the care of older adults.

The AHA strongly supports efforts to make health care better for older adults. In fact, the AHA leads the Age-Friendly Health Systems initiative in partnership with the John A. Hartford Foundation and the Institute for Healthcare Improvement. The goal is to rapidly spread a specific framework that ensures that every older adult's care is guided by an essential set of evidence-based practices and is consistent with what matters to the older adult and their family. More than 2,800 health care organizations in the US are now part of this movement.

While some of the items addressed in the two measures CMS is considering relate to and even align with AHA's work, many other items are of unclear value. For example, several of the questions ask hospital to confirm whether they "have protocols" for establishing certain processes. These attestations are not clear and specific enough to glean meaningful information about quality of care or patient experience.

Furthermore, when this measure was presented to the MAP during the pre-rulemaking process, there was little evidence demonstrating that use of the measure actually leads to improvement. In fact, the data presented to the MAP's Hospital Workgroup suggests the measure may already be extremely close to being "topped out." On average, hospitals fully attest to six out of the seven domains on the Geriatric Surgical Care measure, and the median score was five out of seven. This suggests there is little room for improvement, another indication that this measure is unlikely to result in improved patient outcomes.

The AHA acknowledges the lack of measures that focus on geriatric surgical care, and would be pleased to engage with CMS to develop further ideas for outcome-based measures that help us identify gaps in care for older adults. However, implementing attestation-based measures with apparently small performance gaps and unclear attestations is unlikely to lead to improvement in care for the geriatric population.

## **DISCLOSURES OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION**

CMS currently requires disclosure of certain ownership, managerial and other information regarding Medicare skilled-nursing facilities and Medicaid nursing facilities. In a Federal Register [notice](#) published Feb. 15, 2023, CMS proposed definitions of "private equity company" (PEC) and "real estate investment trust" (REIT) for purposes of ownership disclosure in the CMS 855A Medicare enrollment form. Previously, CMS had issued a Paperwork Reduction Act [submission](#) to require all owning and managing entities listed on any provider's or supplier's Form CMS 855A submission to disclose whether they are a PEC or REIT. In this rule, CMS is proposing that all providers and supplies that enroll in Medicare using CMS 855A enrollment disclose PEC and REIT information; it also seeks feedback on whether CMS should consider collecting any other types of private ownership besides PECs and REITs as part of the enrollment process.

The agency states that it is concerned "about the quality of care furnished by PEC-owned and REIT-owned SNFs and the consequent need for transparency regarding such owners," and that "these concerns about PEC and REIT are not limited to SNFs but extend to other provider and supplier types."<sup>42</sup> Therefore, the agency believes that it is important to "collect this information from all providers and suppliers that complete the Form CMS-855A so as to: (1) determine whether a similar connection exists with respect to non-SNF

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<sup>42</sup> 88 Fed. Reg. 27190 (May 1, 2023).

providers and suppliers; and (2) help us take measures to improve beneficiary quality of care to the extent such connections exist.”

**The AHA is concerned by this unnecessary and burdensome requirement. With little actual basis in fact, CMS appears to impugn the integrity of private equity owners based on loose analogies and suppositions. Private equity ownerships, including for-profit hospital arrangements, do not inherently indicate lower quality care or lesser care than any other ownership type. The agency should *not* finalize this requirement. At the very least, it should explain (1) how it will determine if a connection exists between quality and ownership type for non-SNF providers and suppliers; and (2) how quality is impacted if the requested data shows that such a connection exists.**

## **REQUEST FOR PUBLIC COMMENTS: SAFETY-NET PROVIDERS**

Safety-net hospitals serve as a critical access point for primary care and specialized health care services. Yet, despite their vital roles and the complex needs of the patients they serve, many face significant financial challenges. The AHA has been examining this critical issue of how better to support urban hospitals that provide critical care and social services to patients who are low-income and often experience challenges in accessing care. **We thank CMS for its interest in exploring ways to support safety-net hospitals and look forward to engaging with the agency and Congress to work on AHA’s alternative payment [proposal](#) — the Metropolitan Anchor Hospital (MAH) — to bolster these providers so they can continue to provide crucial services and act as access points for many communities in need.**

We consider urban hospitals that care for patients in low-income or historically marginalized communities to be MAHs because of the anchor role they play in their communities. In addition to being a key access point for many kinds of care, they also serve as de facto public health entities. They are often trusted community partners, working closely with area schools, civic and religious organizations, and community leaders to reach historically marginalized populations and improve community health. During the COVID-19 pandemic, many took on an expanded public health role, standing up COVID-19 testing operations, vaccination clinics and organizing public health awareness campaigns that benefit the entire community. Additionally, to address the urgent unmet needs of their patients, they often develop and lead social support programs such as transportation services, on-site childcare, nutrition services, charity programs and public health awareness campaigns that benefit the broader community. **For these reasons and others, we believe Congress should establish a MAH designation in statute for hospitals that meet criteria we have developed, which include geographic and uncompensated care costs, among others.**

According to our analysis, hospitals that meet our MAH criteria are more likely to provide essential services, such as burn care, neonatal intensive care, trauma care and HIV/AIDS

support. They are more likely to provide care for patients who face health inequities, structural and financial barriers, and other challenges in accessing timely, culturally competent and high-quality care. They serve a patient population disproportionately covered by Medicare or Medicaid, which reimburse less than the cost of care. The patients served often have more complex health needs or need more care than other populations. These hospitals also provide significant care for the uninsured, including in outpatient settings. This is a critical role because, despite coverage gains, about 27.5 million people were uninsured in 2021 according to a KFF analysis.<sup>43</sup> The uninsured rate remains at nearly 9% nationally. Other coverage gaps also persist, including in states that have expanded Medicaid. More information about our MAH criteria, what types of patients they serve, and what clinical and non-clinical services they provide can be found in NORC's research paper, "[Exploring Metropolitan Anchor Hospitals and the Communities They Serve](#)."

### **MedPAC Safety-net Index Proposal**

MedPAC has also examined this issue and put forth a proposal to create a Medicare Safety-Net Index (MSNI) payment. We thank the commission for recognizing that more can and should be done to support the sustainability of these critical hospitals and health systems. We have communicated extensively with the commission about the proposal, including in [December 2021](#), [November 2022](#), [January 2023](#) letters. Below, we highlight some of the continued concerns we have with the MSNI.

In its discussion of its MSNI proposal, MedPAC engaged in a conversation around the purpose of Medicare, whether Medicare funding should only be spent on Medicare beneficiaries, and whether the commission was applying this philosophy consistently across its policy discussions. It concluded that Medicare should not be cross-subsidizing other programs. **We disagree with this approach.**

**First, we are concerned that MedPAC's proposal defines safety net too narrowly.** America's safety net should cover all Americans, regardless of their insurance coverage or status. MedPAC's proposal focuses exclusively on low-income Medicare beneficiaries, excluding, for example, Medicaid-covered and uninsured individuals, in part because MedPAC is limited by its authorizing statute. The challenges that safety-net providers address, whether related to a specific individual's health status or to a community's health needs and infrastructure, are broader than just Medicare-covered individuals. We should consider policy solutions that address everyone's needs, rather than solutions that would further fragment safety-net care.

**We also disagree with MedPAC's use of the MSNI to redistribute existing DSH and uncompensated care payments to eliminate cross-subsidization.** This design element was based on the commission's concerns that Medicare DSH payments were indirectly

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<sup>43</sup> KFF. (December 2022). Key Facts about the Uninsured Population. Available at <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

subsidizing hospitals for providing care to Medicaid and uninsured patients, and the misguided belief that state governments would fill in (via Medicaid) any gaps in safety-net funding inadvertently created by this proposal. Medicare DSH creates incentive for hospitals and health systems to provide care for patients regardless of what type of coverage they carry or their ability to pay. Indeed, the adjustment's congressional intent was to ensure ongoing access to care for low-income Medicare beneficiaries and *for all beneficiaries who reside in areas with substantial low-income population*.<sup>44</sup> Medicare DSH payments reimburse hospitals for providing care to patients who lack access to care, have difficulty affording health care and other needs, have complex health needs, or face unmet health and social needs. Many of these patients face health disparities and other inequities. Redefining safety net to mean hospitals that serve a large share of only low-income Medicare beneficiaries could create new incentives for hospital to focus exclusively on certain patients. This could further exacerbate inequities that many of these hospitals are working hard to eliminate.

**In contrast, rather than redistributing existing Medicare DSH and uncompensated care funds as MedPAC has recommended, we urge that any proposal use *new funds to support safety-net providers*.** Medicare DSH and uncompensated care payments are intended to bridge the gap between the cost of providing care to certain patients and low Medicare payment rates. As documented above, inflation and costs skyrocketed in 2022, making this one of the most financially challenging times for hospitals. A redistributive path would reduce revenue to hospitals that score low on the safety-net index, resulting in significant negative implications for Medicare beneficiaries and other patients at these hospitals. In fact, MedPAC finds that government hospitals would see their fee-for-service Medicare revenue *decline* by 1.5% even when another \$1 billion is added into the system. Furthermore, we find that government hospitals would see their safety-net payments reduced by \$700 million and urban hospitals reduced by \$113 million even when another \$2 billion is added into the system as MedPAC proposes for FY 2024.<sup>45</sup> This would be extremely detrimental for those very hospitals the proposal aims to protect.

**Furthermore, we disagree with a focus on only financial margins and hospital closures as the primary metrics by which to evaluate the merits of the proposal.** MedPAC examines FFS Medicare and all-payer total revenue as metrics under which hospitals would gain or lose under a shift from the current DSH and uncompensated care model to a new MSNI model. It also cites that “hospitals that disproportionately treat Medicare beneficiaries face increased risk of financial pressure or closure.”<sup>46</sup> These are important measures, but this policy may have other implications for hospitals and Medicare beneficiaries. For example, it is important to consider what implications this proposal may have for service line closures, hospitals' investments in new technology or upgrades to

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<sup>44</sup> Congressional Budget Office (May 1990). Medicare's Disproportionate Share Adjustment for Hospitals.

<sup>45</sup> AHA's analysis of MedPAC's Medicare safety-net index proposal.

<sup>46</sup> 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/2023/03/Ch3\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf)



facilities, and hospitals' ability to access capital. By reducing payments to hospitals with low safety-net index scores, this proposal could inadvertently create or exacerbate financial pressures for hospitals and health systems who provide care for Medicare beneficiaries and other patients. Indeed, a group of hospitals who currently receive DSH and uncompensated care payments would receive *no* safety-net payments and another group of hospitals that score extremely high on the safety-net index, and thus treat a high disproportionate number of low-income patients, would lose significant payments compared to their current DSH and uncompensated care funds because the MedPAC proposal places a cap in the distribution of safety-net payments. Revenue reductions to these hospitals would have significantly negative implications for Medicare beneficiaries and other patients served by these already financially fragile hospitals.

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

June 2023

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

### **1. Overview**

The Centers for Medicare & Medicaid Services (“CMS”) determines its annual updates to Inpatient Prospective Payment System (“IPPS”) rates using the IPPS hospital market basket.<sup>47</sup> The IPPS hospital market basket is designed to measure the change in prices of goods and services hospitals purchase to provide inpatient care.<sup>48</sup>

Because Medicare pays for a large share of the patients who visit hospitals annually and since other payers often set their hospital payments based on Medicare reimbursement, updates to the IPPS rates can have a substantial impact on hospital margins – and mismeasurement of changes in hospital costs has the potential to push hospitals into significant financial distress. For example, in 2019, Medicare patients accounted for 49% of a typical hospital’s volume.<sup>49</sup> At the same time, cumulative hospital expense grew by more than double the cumulative increase in Medicare IPPS reimbursement from 2019 to 2022, contributing to over half of hospitals in 2022 operating at a financial loss.<sup>50</sup> During this period, CMS’s IPPS Final Rule rate updates fell below the realized increase in the IPPS hospital market basket. However, even if the IPPS Final Rule had matched the IPPS hospital market basket, it would have failed to keep up with actual changes in hospital costs.

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<sup>47</sup> Department of Health and Human Services, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program,” Federal Register 86(88), pp. 25070–25790 (“Federal Register 86(88)”) at p. 25070.

<sup>48</sup> Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, “FAQ – Market Basket Definitions and General Information,” May 2022, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/info.pdf> (“CMS (2022)”) (“Although “market basket” technically describes the mix of goods and services used in providing health care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket.... [I]t measures the change in price, over time, of the same mix of goods and services purchased in the base period.”).

<sup>49</sup> American Hospital Association (2021). Fact Sheet: Hospital Costs Explained.

<https://www.aha.org/system/files/media/file/2020/09/fact-sheet-billing-explained-0820.pdf>

<sup>50</sup> American Hospital Association (2023). Cost of Caring. <https://www.aha.org/costsofcaring>

While there may be a number of reasons for CMS’s Final Rule rate increases to have fallen below rates of hospital cost increases, one prominent reason appears to be the way the IPPS hospital market basket measures the cost of hospital labor inputs that are needed to provide inpatient care (which include nursing and other highly-skilled professional labor hours). The single largest input that is included in the construction of the 2018-based IPPS hospital market basket (the last time the IPPS market basket was rebased and revised), with a weight of 53 percent, is compensation for hospital workers.<sup>51</sup>

Given the high share of labor inputs in the IPPS hospital market basket, it is important for CMS to use a proxy for labor costs that closely matches hospitals’ actual labor costs. Since 2020, this does not appear to have been the case. CMS relies on the Employment Cost Index (“ECI”) for the hospital industry, prepared by the Bureau of Labor Statistics (“BLS”), as the price proxy for this category of input costs. While the ECI has some advantages,<sup>52</sup> it has not incorporated several significant shifts in hospitals’ labor force – particularly the greater use of contract labor – because it lacks timeliness: it only periodically updates the frequency with which a particular job is expected to occur. For example, while the hospital field has increasingly used high-cost contract labor in recent years, the ECI has not updated with this growth in contract labor. As a result, we find that the ECI has likely underestimated the hospital labor cost growth since the COVID-19 pandemic, leading to insufficient updates to Medicare rates.

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

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<sup>51</sup> The Federal Register includes the current set of weights in the IPPS hospital market basket. See Table IV-05 in Department of Health and Human Services, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program,” Federal Register 86(88), pp. 25070–25790, (“*Federal Register* 86(88)”) at p. 25425, Table IV-05. available at <https://www.govinfo.gov/content/pkg/FR-2021-05-10/pdf/2021-08888.pdf>. The ECI is limited to civilian workers.

<sup>52</sup> “We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers.” *Federal Register* 86(88) at p. 25401.

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

Key takeaways:

- In the wake of the COVID-19 pandemic, the ECI has recorded substantially less growth in hospital labor costs than a closely-related measure—the Employer Costs of Employee Compensation (“ECEC”). Between 2019 Q4 and 2022 Q4, the ECI for hospital industry wages grew by 13 percent, seven percentage points below the 20 percent increase over the same period in the ECEC for hospital industry wages. The growth in total compensation shows a similar pattern to the growth in wages, with the ECI<sup>53</sup> and the ECEC recording growth of 12 percent and 17 percent, respectively, a four percentage point gap.<sup>54</sup>
- The gap between the ECI and the ECEC may in part be explained by the shift to increased reliance on contract labor over this time period—a labor segment with high and quickly-growing pay rates. The ECEC incorporates both increases in compensation and changes in the mix of labor inputs on a timelier basis than the ECI. When the ECEC grows faster than the ECI, this suggests that the mix of labor inputs is moving towards greater utilization of high-cost-level or fast-cost-growth categories of labor. This is exactly what occurred in the hospital field between 2019 and 2022, and is expected to continue.
- The ECI will not quickly, or potentially ever, catch up with the overall level of actual hospital labor cost increases. Since underestimates in one direction compound over time, it could take several years of overshooting the true growth rate for the ECI to catch up with costs. Thus, without compensatory

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<sup>53</sup> BLS only publishes a wages and salaries ECI and a total compensation ECI for the hospital industry. As noted in section 3, CMS uses the hospital industry total compensation ECI as its price proxy for employee benefits.

<sup>54</sup> Percent growth and percentage point gap values do not sum due to rounding.

changes CMS updates to hospital prices are likely to remain substantially below the trend of hospital costs.

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

The hospital industry has been buffeted by extreme disruptions in staffing for medical professionals, particularly since the onset of the COVID-19 pandemic. Hospitals experienced greater turnover in their nursing staff, leading to increases in training costs, along with a substantial decline in the number of nurses.<sup>55</sup> At the same time, hospitals experiencing a surge of patients needed to rapidly increase their staffing, leading them to make greater use of short-term contract labor, such as traveling nurses.<sup>56</sup>

The shift towards contract labor has not subsided even as the strain of the pandemic has eased.<sup>57</sup> One factor in this shift, nursing shortages, may have been exacerbated by the pandemic but has continued past it,<sup>58</sup> forcing hospitals to continue to rely more on contract labor.<sup>59</sup> Hospital staff in salaried positions have also been incentivized to move into contract positions, given the greater flexibility and increasingly higher wages that contract positions offer.

Over the 2019 to 2022 period, the usage of and pay rates for contract labor saw dramatic increases. A recent edition of *Hospital Vitals: Financial and Operational Trends* documents these substantial increases.<sup>60</sup> Full-time equivalent staffing hours

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<sup>55</sup> Auerbach et. al. (2022), "A Worrisome Drop In The Number Of Young Nurses", *Health Affairs*, April 13, 2022, available at <https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses>

<sup>56</sup> See, e.g., Karen Roush (2022), "Staffing Crisis Fueled by COVID-19 Creates Boom for Travel Nurse Industry," *AJN, American Journal of Nursing* 122(5), May 2022, p. 12, available at [https://journals.lww.com/ajnonline/fulltext/2022/05000/staffing\\_crisis\\_fueled\\_by\\_covid\\_19\\_creates\\_boom.5.aspx](https://journals.lww.com/ajnonline/fulltext/2022/05000/staffing_crisis_fueled_by_covid_19_creates_boom.5.aspx).

<sup>57</sup> KaufmanHall (2022), "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report," May 2022, pp. 1–14 at pp. 7–10, available at <https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf> ("KaufmanHall (2022), 'National Hospital Flash Report'").

<sup>58</sup> Brendan Martin, Nicole Kaminski-Ozturk, Charlie O'Hara, Richard Smiley (2023), "Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses," *J Nurs Regul* 14(1), April 2023, pp. 4–12, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/pdf/main.pdf> ("Martin, Kaminski-Ozturk, O'Hara, and Smiley (2023)").

<sup>59</sup> KaufmanHall (2022), "National Hospital Flash Report."

<sup>60</sup> Syntellis and the American Hospital Association (2023), "Hospital Vitals: Financial and Operational Trends: Workforce Pressures Take Their Toll in 2022," February 2023, pp. 1–9 at pp. 2–5, available at

for contract labor increased 138.5% over this period. As a share of total worked hours, contract labor increased by 133.1%. At the same time, wages for contract labor increased from already high levels. For example, Kaufman Hall reports that hourly wages for contract nurses more than doubled, increasing from \$64 in 2019 to \$132 in 2022 Q1, a 106% increase. By contrast, in-house nursing staff wages rose only 12% over the same period, from \$35 to \$39.<sup>61</sup>

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

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

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

- The wages and salaries component, with a weight of 41 percent in the 2018-based hospital market basket, uses the ECI for wages and salaries;
- The employee benefits component, with a weight of 12 percent in the 2018-based hospital market basket, uses the ECI for total compensation.<sup>62</sup>

The ECI is constructed through a multi-step process that is intended to smooth out short-term fluctuations in the composition of the labor pool.<sup>63</sup> Construction begins

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[https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf) (“Syntellis and AHA (2023).”).

<sup>61</sup> KaufmanHall (2022), “National Hospital Flash Report” at p. 11.

<sup>62</sup> *Federal Register* 86(88) at p.25425, Table IV-05.

<sup>63</sup> See Bureau of Labor Statistics, “National Compensation Measures: Calculation”, *Handbook of Methods*, December 15, 2017, available at <https://www.bls.gov/opub/hom/ncs/calculation.htm> (“The ECI is a measure

with a set of hospital “jobs,” which are groups of positions that have similar characteristics. Such characteristics include whether a position is full-time vs. part-time, has union vs. non-union status, has time-based vs. incentive-based pay structure, and has similar work levels.<sup>64</sup> The BLS collects pay rates for each of these jobs from a set of hospitals that have been selected to be part of its employer survey.<sup>65</sup>

A hospital and job will remain in the sample for 3 years once they enter the sample.<sup>66</sup> Each year, new hospitals and jobs are added, while others reach the end of their 3-year window and are dropped, so that the sample updates slowly over time.

The BLS assigns each job in the sample to a specific occupation, which corresponds to one of 9 broad occupation categories.<sup>67</sup> The BLS then calculates the cost growth for each occupation as a weighted average across jobs assigned to the occupation, where the weight for each job corresponds to its size when it first entered the sample. Finally, the BLS calculates the growth rate for the hospital industry using a weighted average across occupations. The weights for this final step are updated infrequently – about once every ten years.<sup>68</sup>

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

- First, the ECI can miss rapid changes in the hospital industry because it only includes a job in the calculation of the within-occupation

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of the change in the cost of labor, independent of the influence of employment shifts among occupations and industry categories.”) (“BLS (2017), ‘Calculation’”).

<sup>64</sup> BLS (2017), “Calculation.” The BLS selects hospitals to be a part of the National Compensation Survey (NCS). See Bureau of Labor Statistics, “National Compensation Measures: Collections and Data Sources,” *Handbook of Methods*, December 15, 2017, available at <https://www.bls.gov/opub/hom/ncs/data.htm> (“BLS (2017), ‘Collections and Data Sources’”) (“The National Compensation Survey (NCS) uses Bureau of Labor Statistics (BLS) field economists to collect compensation data from survey respondents.”).

<sup>65</sup> BLS (2017), “Collections and Data Sources.”

<sup>66</sup> Gwyn R. Ferguson, Joan L. Coleman, and Chester H. Ponikowski (2011), “Update on the Evaluation of Sample Design Issues in the National Compensation Survey,” Bureau of Labor Statistics, August 2011, available at <https://www.bls.gov/osmr/research-papers/2012/pdf/st120280.pdf> (“Ferguson, Coleman, and Ponikowski (2011)”).

<sup>67</sup> BLS (2017), “Calculation.” The BLS performs this calculation for 59 industries, and refers to the combination of an industry and occupation as a “cell.” Because we consider only the hospital industry, the occupations we refer to are also cells.

<sup>68</sup> See U.S. Bureau of Labor Statistics (2023), “Employment Cost Index: Reweighting and Recoding in the ECI,” January 25, 2023, available at <https://www.bls.gov/eci/factsheets/eci-reweighting-and-recoding.htm> (“BLS (2023), ‘Reweighting and Recoding.’”).



average cost growth if it has been in the sample for at least two consecutive quarters.<sup>69</sup> This means that jobs are six months old by the time they enter the calculation. Thus, new contract jobs in the hospital industry will already have been present, and causing higher labor costs, well before they are included.

- Second, when averaging the growth rates of jobs within an occupation, the ECI fixes the sampling weight of a job at its weight when it first entered the sample.<sup>70</sup> Thus, a job first sampled in 2020 retains the 2020 weight even when it is used to calculate cost growth between 2022 Q2 and 2022 Q3. This job would retain the same weight until it exits the sample after 3 years. The fixed sampling weight for a job means that changes in the mix of jobs within an occupation (e.g., due to a shift towards greater use of contract labor) can be delayed several years as the sample of jobs and their associated weights turns over.
- Third, because the ECI calculation holds the mix of occupations fixed between rebasings,<sup>71</sup> rapid changes in the importance of different occupations may take some time to be incorporated.

An alternate measure of labor cost growth, the Employer Cost of Employee Compensation (“ECEC”), presents a useful comparison to the ECI.<sup>72</sup> The ECEC is

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<sup>69</sup> BLS (2017), “Calculation” (“All wage and benefit indexes are computed from the following data: Matched quotes are average hourly wages (or benefit costs) for detailed occupations (six-digit SOC) or groups of occupations, in sample establishments for which data are available for both the current and previous quarters.”).

<sup>70</sup> Michael K. Lettau, Mark A. Loewenstein, and Aaron T. Cushner (1997), “Explaining the Differential Growth Rates of the ECI and the ECEC,” *Compensation and Working Conditions* Summer 1997, pp. 15–23 at pp. 16, 23, available at <https://www.bls.gov/opub/mlr/cwc/explaining-the-differential-growth-rates-of-the-eci-and-ecec.pdf> (“Lettau, Loewenstein, and Cushner (1997)”).

<sup>71</sup> Updates to the weights for aggregating over industry-occupation cells happens about once every 10 years. See BLS U.S. Bureau of Labor Statistics (2023), “Employment Cost Index: Reweighting and Recoding,” in the ECI, July 25, 2023, available at <https://www.bls.gov/eci/factsheets/eci-reweighting-and-recoding.htm> (“U.S. BLS (2023)”).

<sup>72</sup> In addition, the ECEC satisfies the CMS criteria of reliability (BLS reports modest standard errors for ECEC). See Bureau of Labor Statistics, “Employer Costs for Employee Compensation Relative Standard Errors,” March 17, 2023, available at <https://www.bls.gov/web/ecec/ecec-rse.htm> (“BLS (2023), ‘ECEC Standard Errors’”) (for discussion and data on ECEC Relative Standard Errors). ECEC also satisfies the CMS criteria of availability (the relevant ECEC measure is published publicly), and timeliness (ECEC is available quarterly). ECEC publication is slightly delayed relative to the schedule for ECI releases. See U.S. Bureau of Labor Statistics, “Schedule of Releases for the Employer Costs for Employee Compensation,” available at [https://www.bls.gov/schedule/news\\_release/ecec.htm](https://www.bls.gov/schedule/news_release/ecec.htm) (U.S. BLS, “ECEC Release Schedule”) and U.S. Bureau

constructed based on the same data as the ECI, but the sampling weights in the ECEC are based on the current quarter, rather than the quarter the job entered the sample<sup>73</sup>, and occupation weights are also based on the current quarter, rather than a base year. Further, the ECEC includes new jobs immediately, without the requirement that they are in the sample for two consecutive quarters. Thus, the ECEC is affected by both increases in compensation and by changes in the mix of labor inputs on a timelier basis. This means that the ECEC will more rapidly account for changes in the workforce mix and compensation. As explained in more detail in Appendix A, when the ECEC grows faster than the ECI this suggests that the mix of labor inputs is moving towards greater utilization of high-cost-level or fast-cost-growth categories of labor. This is exactly what occurred in the hospital field between 2019 and 2022, and is expected to continue.

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

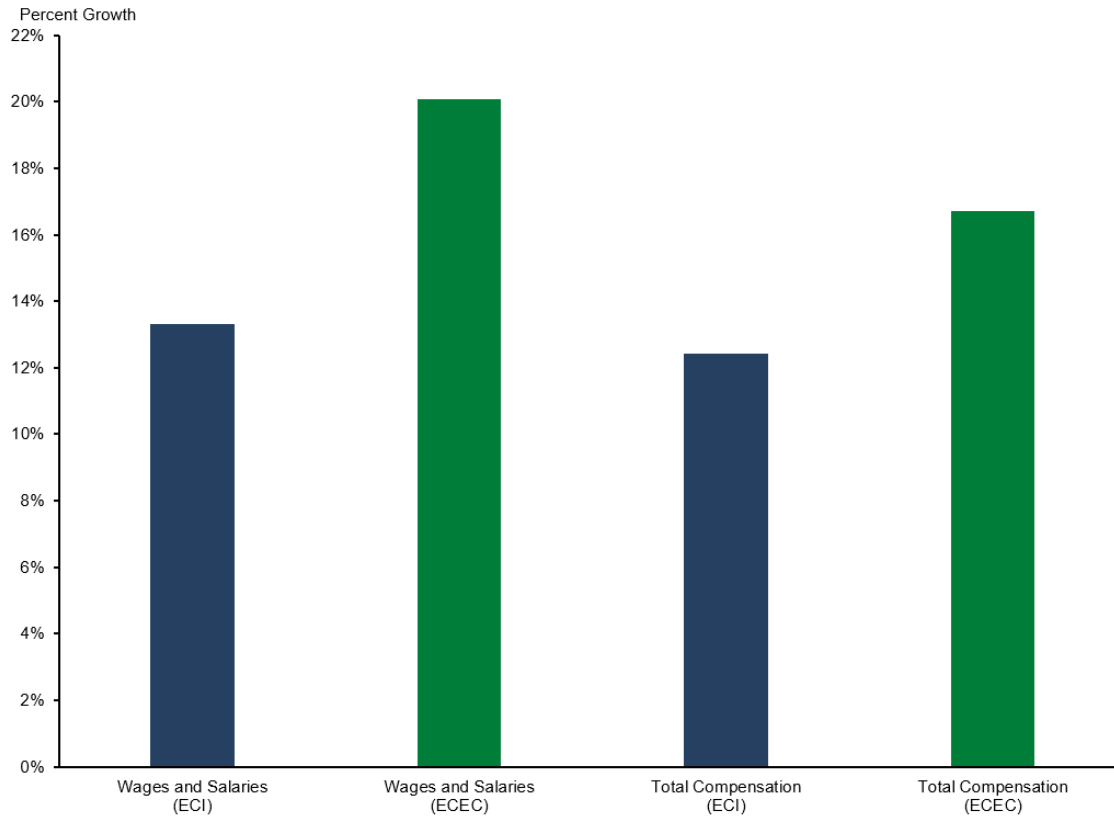
### **Exhibit 1: Hospital Labor Cost Growth: ECI vs. ECEC (2019 Q4 – 2022 Q4)<sup>74</sup>**

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of Labor Statistics, “Schedule of Releases for the Employment Cost Index,” (“BLS (2023), ‘(U.S. BLS, “ECI Release Schedule.”)”) available at [https://www.bls.gov/schedule/news\\_release/eci.htm](https://www.bls.gov/schedule/news_release/eci.htm).

<sup>73</sup> BLS (2017), “Calculation” (“The ECEC uses current employment weights (as opposed to fixed employment weights used in the ECI) to reflect the changing composition of today’s labor force to calculate cost levels.”).

<sup>74</sup> BLS Indices CIU102622000000I, CMU102622000000D, CIU101622000000I, CMU101622000000D, available at <https://data.bls.gov/cgi-bin/srgate>.



Combining the wages and salaries component, and the total compensation component (under current hospital market basket weights), the ECI measures lead to an estimated 13 percent increase in hospital labor costs.<sup>75</sup> In contrast, using the ECEC for the wage and salaries, and total compensation growth over this period would result in a hospital labor cost growth rate of 19 percent, six percentage points higher than generated by the ECI.<sup>76</sup> This difference in measured growth could have had a substantial impact on the IPPS hospital market basket used by CMS.

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

<sup>75</sup>  $(41/(41+12))*13\% + (12/(41+12))*12\% = 13\%$

<sup>76</sup>  $(41/(41+12))*20\% + (12/(41+12))*17\% = 19\%$

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

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

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

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

Notes:

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

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

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

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

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

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

An exact analysis of the divergence between the ECI and the ECEC is not possible with publicly available information. It would require access to underlying data used in the construction of these indices (e.g., detailed survey data and sampling weights) which the BLS does not make publicly available.<sup>77</sup> However, since the ECI adjusts the sampling weights of different jobs slowly, compared to the ECEC, it is likely that the

<sup>77</sup> For an example of such an exact decomposition, including discussion of effects within industry-occupation cells, see Lettau, Loewenstein, and Cushner (1997).

ECI would be slow to incorporate the shift towards greater use of contract labor that has occurred in the hospital industry since the COVID-19 pandemic.<sup>78</sup>

Recent hospital industry reports demonstrate that the increases in pay and utilization of contract labor are reasonably likely to explain the observed gap between the published ECI and ECEC for the hospital industry.<sup>79</sup> These reports include data on the levels and growth of contract labor in hospitals, as well as wages for contract and in-house labor, allowing us to demonstrate, in a simplified form, how a shift towards contract labor can cause the ECI and ECEC to diverge.

Exhibit 2 presents two hypothetical labor cost indices calculated based on data on wages and utilization for in-house staff and contract labor available in recent industry reports.<sup>80</sup> These can be compared to the published BLS ECI and ECEC series as a way to demonstrate how the shift toward contract labor could help explain the difference between the ECI and ECEC.<sup>81</sup> First, we take an approach analogous to the ECI and aggregate growth in wages for in-house and contract labor with the share of labor hours and labor expense fixed at the 2019 level. This index finds overall price growth of 13 percent over the period from 2019 to 2022. Second, we take an approach analogous to the ECEC and account for the shift towards a higher share of labor hours coming from contract labor and a lower share coming from in-house staff.<sup>82</sup> This index finds overall price growth of 17 percent over the period from 2019 to 2022. This comparison of two hypothetical indices (shown as Contract / In-House Mix bars) shows that the shift towards contract labor could have accounted for an extra 4 percentage points of hospital labor cost growth not accounted for in the ECI, over half of the observed 7 percentage point gap between the BLS's ECI and ECEC.

### **Exhibit 2: Hypothetical Wage Growth Aggregating Across Contract and In-House Labor Using Industry Sources, vs. BLS Series<sup>83</sup>**

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<sup>78</sup> ECI is known for holding fixed the mix of employment, but this is only true across industry-occupation categories and between rebasing periods. Within an industry-occupation, ECI allows for composition effects but instead delays incorporating these types of shifts. See Appendix B for more details.

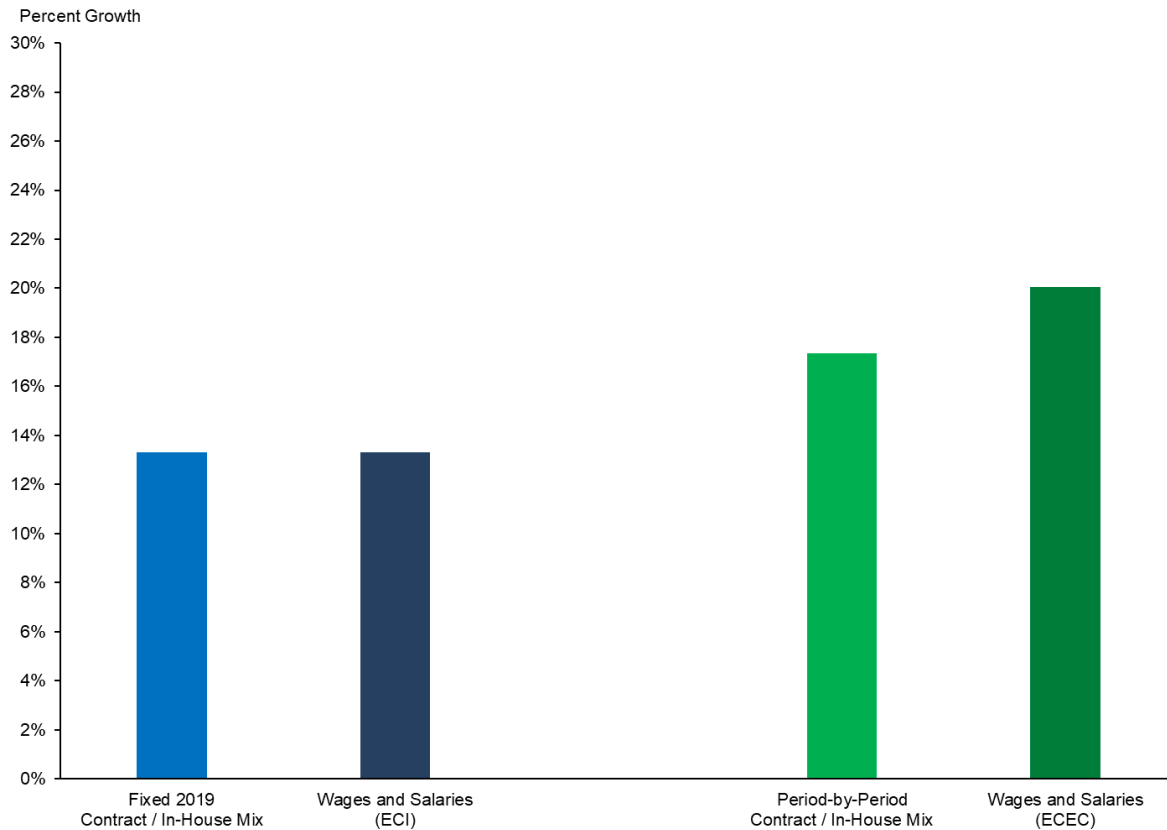
<sup>79</sup> See Syntellis and AHA (2023); KaufmanHall (2022), "National Hospital Flash Report."

<sup>80</sup> See Syntellis and AHA (2023); KaufmanHall (2022), "National Hospital Flash Report."

<sup>81</sup> Details of these estimates are discussed in Appendix B.

<sup>82</sup> For this discussion labor utilization is the share of total hours. Thus growth in one segment's share must be associated with a lower share for the other segment.

<sup>83</sup> BLS Indices CIU1026220000000I and CMU1026220000000D; KaufmanHall (2022), "National Hospital Flash Report" at pp. 7, 9, 11; Syntellis and AHA (2023) at p. 3.



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

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

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

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

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

To see mechanically how these quarter-by-quarter growth rates feed into cumulative growth, it is helpful to compare the ECI and ECEC to another measure of hospital labor costs prepared by the BLS – average weekly earnings as reported in the Current Employment Statistics (“CES”).<sup>84</sup> Exhibits 3 and 4 show growth rates and index levels (cumulative growth) for these three statistics, respectively. The CES average weekly earnings is calculated similarly to the ECEC, but uses data from a different survey, and thus offers additional evidence for the patterns we observe in the ECEC.

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<sup>84</sup> Specifically, we look at average weekly earnings of all employees in the hospital industry (CEU6562200011). CES data are published monthly and have the same industry scope as ECI or ECEC, but however the types of labor costs considered may differ between the two cost measures. See U.S. Bureau of Labor Statistics, “Current Employment Statistics – National: Calculation,” May 4, 2022, available at <https://www.bls.gov/opub/hom/ces/calculation.htm> and BLS (2022). See also, e.g., U.S. Bureau of Labor Statistics, “Current Employment Statistics - CES (National),” May 5, 2023, available at <https://www.bls.gov/web/empsit/ceseeb1a.htm>; cf. U.S. Bureau of Labor Statistics, “BLS Data Viewer: Wages and salaries for All Civilian workers in Hospitals, Index,” May 25, 2023, available at <https://beta.bls.gov/dataViewer/view/timeseries/CIU102622000000I>. (Both indices reference NAICS Code 622, for Civilian Workers in Hospitals.). The analysis here uses the third quarter of each month (March, June, September, December) to compare against ECI and ECEC values. See U.S. Bureau of Labor Statistics, “Current Employment Statistics,” available at <https://www.bls.gov/ces/>.

The sequence of short-run growth rates<sup>85</sup> for each series is shown in Exhibit 3. Comparing the ECEC to the CES, the ECEC grew somewhat slower in 2021 and 2022 until there was a large increase in the ECEC in 2022 Q4. In turn, comparing the ECEC to the ECI, growth rate differences are roughly offsetting over 2019 and 2020, but since 2021 the ECEC has grown either faster or at the same rate as the ECI.

**Exhibit 3: Period-by-Period Hospital Labor Cost Growth (2019 Q1 – 2022 Q4)<sup>86</sup>**



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

<sup>85</sup> The short-run growth rate presented is a four-quarter growth rate: the annualized version of the geometric mean of growth rates for the four previous quarters. We use four-quarter growth rates here to smooth over high-frequency adjustments in the data, such as seasonal variation.

<sup>86</sup> BLS Indices CIU102622000000I and CMU102622000000D; CES Index CEU6562200011, available at <https://data.bls.gov/cgi-bin/srgate>.



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

**Exhibit 4: Cumulative Hospital Cost Growth (2019 Q1 – 2022 Q4)<sup>87</sup>**



**7. Shift to contract labor can reasonably be expected to persist**

Kaufman Hall reports that healthcare facilities are “planning for at least a three-to-four year transition” to a new stable labor market.<sup>88</sup> The wave of workers leaving health care or retiring, together with a limited pipeline of newly trained staff, makes it likely that even if hospitals can successfully move away from current utilization levels for high-cost contract labor, they will not return to the levels seen prior to the

<sup>87</sup> BLS Indices CIU10262200000001 and CMU1026220000000D; CES Index CEU6562200011.

<sup>88</sup> KaufmanHall (2022), “2022 State of Healthcare Performance Improvement: Mounting Pressures Pose New Challenges,” October 2022, available at <https://www.kaufmanhall.com/sites/default/files/2022-10/2022-State-Healthcare-Performance-Improvement.pdf>. (“KaufmanHall (2022B)”).

pandemic.<sup>89</sup> Already, hospitals are moving to build more infrastructure around contract labor including establishing staffing agencies within health systems.<sup>90</sup>

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

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

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

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

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<sup>89</sup> Martin, Kaminski-Ozturk, O'Hara, and Smiley (2023). Brendan Martin, Nicole Kaminski-Ozturk, Charlie O'Hara, Richard Smiley, "Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses," *J Nurs Regul* 14(1), April 2023, pp. 4–12, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/pdf/main.pdf>.

<sup>90</sup> Alan Condon, "Health systems see internal staffing agencies as path to solving labor challenges," *Becker's Hospital CFO Report*, February 20, 2023, available at <https://www.beckershospitalreview.com/finance/health-systems-see-internal-staffing-agencies-as-path-to-solving-labor-challenges.html>.

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

**Exhibit 5: Cumulative Hospital Cost Growth (2019 Q1 – 2022 Q4)<sup>91</sup>**

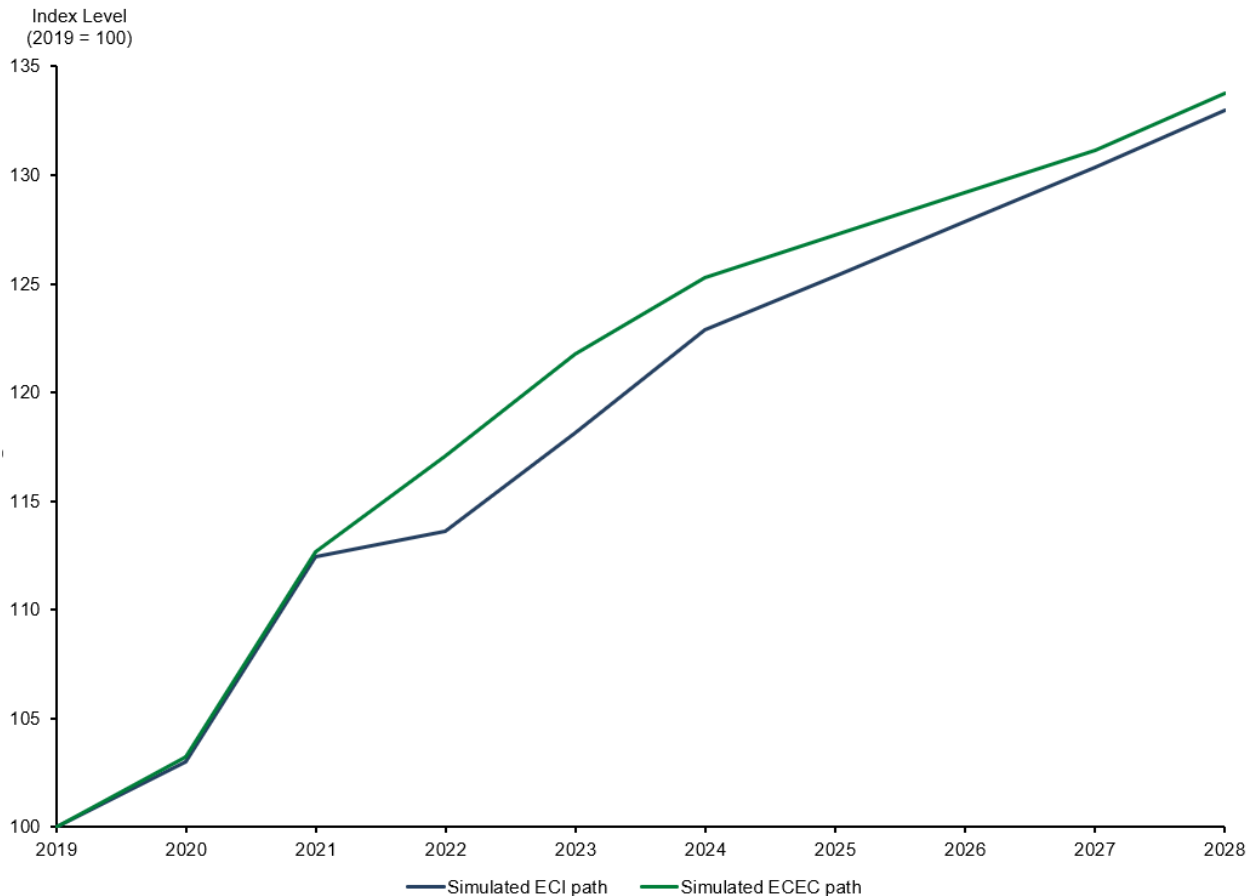


Exhibit 5 reports the path for this simulation exercise, starting in 2019.<sup>92</sup> After 2022, the ECI path catches up somewhat with the ECEC path as the mix reallocates away from expensive contract labor. During this period, the ECI annual growth is higher than the ECEC. However, the depressed base for ECI from its earlier underweighting of the run up in cost of contract labor together with the permanent (albeit smaller) shift towards contract labor means that the ECI never fully catches up in terms of cumulative level of cost increases. In this simulation, the cumulative gap falls from 3 percentage points in 2022 down to 1 percentage point in 2028. Thus, the

<sup>91</sup> KaufmanHall (2022), “National Hospital Flash Report” at p. 7, 11; Syntellis and AHA (2023) at p. 3.

<sup>92</sup> As in the exercise in Exhibit 2, the gap in the simulation between ECEC and ECI is smaller than in the observed data by 2022 because we only account for the effect of the contract labor adjustment.

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

While this section has focused on the issue of increased reliance on contract labor, there are a number of other ongoing shifts in hospital staffing that have raised costs. Staff turnover – which remains elevated – generates costs for hospitals for recruitment. This increases competition for staff, and leads to greater reliance on contract staff and overtime hours while attempts are made to replace lost team members. Signing and retention bonuses have grown in size and popularity.<sup>93</sup> Overall, one industry report finds the average cost of a turnover for a Registered Nurse is \$52,350 in 2022.<sup>94</sup> In light of current and likely future shortages of skilled hospital staff<sup>95</sup> this full suite of pressures on hospital labor costs is unlikely to relent in the foreseeable future. Thus, going forward for a hospital cost measure such as the ECI to be relevant depends significantly on its ability to capture shifts in hospital costs across categories of staff and types of expenses accurately and in a timely manner.

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

This section considers idealized versions of the ECI and ECEC – a pure Laspeyres index and a pure average cost growth series. A Laspeyres index is a method to aggregate price increases for a variety of inputs into a single overall measure of cost growth.<sup>96</sup> Consider a set of labor inputs, each indexed by  $i$ , and an interval of time over which growth is to be measured. The cumulative growth factor in a Laspeyres index from a base period (indexed as time 0) to a future reference period (indexed as time 1) is given by:

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<sup>93</sup> All Zone (2022) “Hospitals Increased Recruitment and Retention Strategies”, available at <https://www.allzonems.com/hospitals-increased-recruitment-and-retention-strategies/>

<sup>94</sup> NSI Nursing Solutions Inc. (2023) “2023 NSI National Health Care Retention & RN Staffing Report”, available at

[https://www.nsinursingsolutions.com/Documents/Library/NSI\\_National\\_Health\\_Care\\_Retention\\_Report.pdf](https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf)

<sup>95</sup> Haines, Julia (2022) “The State of the Nation’s Nursing Shortage” in *U.S. News and World Report* November 1, 2022, available at <https://www.usnews.com/news/health-news/articles/2022-11-01/the-state-of-the-nations-nursing-shortage>

<sup>96</sup> For further discussion of Laspeyres Indices, see IMF (2020), “Consumer Price Index Manual, Concepts and Methods,” pp. 1–509 at Appendix 6, pp. 453–454, available at <https://www.imf.org/-/media/Files/Data/CPI/cpi-manual-concepts-and-methods.ashx> (“IMF (2020)”).

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

where  $p_{it}$  is the price of input  $i$  in periods 1 and 0, respectively,  $s_{it}$  is the share of item  $i$  in total expenditures, and  $\pi_{it}$  is fraction of item  $i$  labor inputs among total labor inputs (measured as hours).<sup>97</sup>

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

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

$$\text{Average Cost}_t = \sum_i p_{it} \pi_{it}$$

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

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

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

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

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

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<sup>97</sup> See IMF (2020) at p. 453, Appendix 6, Expressions A6.1 and A6.7.

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

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

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

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

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

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

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

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

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

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

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

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

**Table 2: Average Cost Growth Calculation<sup>98</sup>**

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

<sup>98</sup> Kaufman Hall (2022), “National Hospital Flash Report” at pp. 7, 9, 11; Syntellis and AHA (2023) at p. 3.