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Advancing Health in America

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November 30, 2023

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Chernew:

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 Medicare Payment Advisory Commission's (MedPAC) November meeting discussions on Medicare Advantage (MA) prior authorization and network management. As the commission continues its deliberations on the MA program, we would like to share our thoughts, suggestions and concerns related to these issues.

Additionally, as MedPAC begins its discussions on payment adequacy for the Medicare program, we outline concerns about the impact that the shifting labor force and costs have had on hospitals and health systems, including whether the current market basket methodology is adequate to capture these changes.

Therefore, we encourage the commission to:

- Collect and examine additional data points regarding prior authorization denials, appeals and response time, as well as monitor MA plan adherence with the prior authorization policies in the contract year (CY) 2024 MA final rule.
- Examine the adequacy of the current hospital market basket in capturing changing labor dynamics.
- Recommend that a one-time retrospective adjustment be added to the fiscal year (FY) 2025 inpatient, outpatient and long-term care hospital (LTCH) prospective system (PPS) payment updates to help hospitals and health systems remain financially viable.

Our detailed comments on these issues follow.

MEDICARE ADVANTAGE

During the November 2023 meeting, the commissioners discussed the use of prior authorization in Medicare Advantage (MA) and its impact on patient access to care. The AHA appreciates MedPAC's consideration of this important topic. We continue to be concerned about the troubling effects of certain prior authorization practices on timely access to medically necessary care. We outline evidence of concerning prior authorization practices below as highlighted in government reports and information shared from hospitals and health systems across the country.

Accordingly, as the commission continues its deliberations on this topic, **we encourage MedPAC to collect and examine the additional data points discussed below regarding prior authorization denials, appeals and response time, as well as monitor MA plan adherence with the prior authorization policies in the CY 2024 MA final rule.** We believe that additional data collection and reporting on the use of prior authorization in MA is an important step in better understanding practices that may obstruct timely access to care, and would be of great value in advancing much needed oversight of the MA program to improve access to care for Medicare beneficiaries.

Background on the Use of Prior Authorization in MA

Although initially designed to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, many MA plans apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and drive-up costs for the health care system. These problematic practices include inappropriate denial of medically necessary services that would be covered by Traditional Medicare and requirements for unreasonable levels of documentation to demonstrate clinical appropriateness. Of greatest concern, however, is that certain MA plans have an established history of inappropriately utilizing prior authorization to deny medically necessary treatment for patients. Data shows that more than 35 million prior authorization requests were submitted to MA plans on behalf of MA enrollees in the same year.[1] As both MA enrollment and plan usage of prior authorization continue to grow, improper prior authorization programs increasingly impose bureaucratic obstacles to necessary treatment, often jeopardizing patient health in the process.

Inappropriate Patient Care Denials and Appeals

According to a 2022 report by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), MA organizations denied 13% of prior authorization requests that met Medicare coverage rules, thereby denying Medicare beneficiaries of the necessary treatment prescribed by their physician and eligible for coverage under federal regulations.[2] Additionally, a 2018 HHS OIG report found that MA organizations overturned 75% of prior authorization denials that were appealed between 2014 and 2016.[3] This suggests that

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[1] https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/
[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[3] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

inappropriate denial of necessary care is widespread and that MA plan prior authorization practices are routinely leading to improper barriers to care.

In order to address an inappropriate denial, providers are forced to engage in lengthy and resource-intensive appeals processes for MA plans to properly apply applicable criteria, as highlighted by a September 2018 HHS OIG report. Consistent with the OIG report, AHA survey data from 2021-2022 reflects that most prior authorization and claim denials that are appealed are ultimately overturned in the provider and patient's favor, a finding that MedPAC also echoed.[4] Unfortunately this means that necessary care for patients and providers is often delayed while appeals are adjudicated. In fact, **the OIG found that beneficiaries and providers rarely used the appeals process, appealing only 1% of denials during 2014-16. As a result, the system is highly susceptible to abuse if MA organizations are able to deny large volumes of care up front only to routinely overturn them if a provider spends significant time and resources to appeal.** In fact, MedPAC cites to a study that found more than 40% of Traditional Medicare Part B services would have been subject to prior authorization when they were eligible for coverage under federal regulations.[5]

The dire need for timely adjudication of prior authorization is particularly evident in post-acute care (PAC) transfers for MA patients. Institutional PAC providers, including inpatient rehabilitation facilities (IRFs) and units, LTCHs, skilled nursing facilities and home health agencies, play a vital role in patient care. PAC providers work to restore function and allow patients to return to their lives after a serious accident or injury, usually after an acute-care hospitalization. However, prior authorization requests to transfer an MA patient to an appropriate PAC facility are often delayed.[6] For example, an AHA member indicated that a patient with traumatic brain injury was medically ready for discharge but stayed four additional days in the hospital without access to essential PAC because the insurer had not responded to the provider's request to move the patient into a rehabilitation facility.[7] Another AHA member that operates IRFs reports that 11% of their MA referrals take 10 days or longer to resolve.[8] Furthermore, another AHA member reported that, in 2022, over 400 MA patients at its academic medical center had delayed discharges due to insurance issues, the vast majority of which were attributable to prior authorization delays, and the delays amounted to 1,233 avoidable inpatient days.

Patient Care Delays

Prior authorization policies can have a direct, negative impact on patient care and outcomes. Ninety-four percent of physicians report patient care delays associated with prior authorization, and, strikingly, 33% report that prior authorization has led to a serious

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[4] https://www.aha.org/system/files/media/file/2022/10/Addressing-Commercial-Health-Plan-Challenges-to-Ensure-Fair-Coverage-for-Patients-and-Providers.pdf; https://www.medpac.gov/wp-content/uploads/2023/03/MA-access-MedPAC-11.23.pdf

[5] https://www.medpac.gov/wp-content/uploads/2023/03/MA-access-MedPAC-11.23.pdf

[6] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[7] Example provided by AHA member hospital.

[8] Example provided by AHA member hospital.

adverse event for a patient in their care such as hospitalization or death.[9] Additionally, an AHA survey found that 62% of patients report having delayed medical care because of their insurance provider in the last two years, and 43% of those patients say that their health has gotten worse as a result of the delays.[10] For example, an AHA member hospital reported treating a man with a serious skin cancer (metastatic melanoma), requesting imaging scans every three months to assess the progress of ongoing therapies. Unfortunately, the patient's health plan required a new prior authorization for each treatment, a process that frequently delayed the patient's care by weeks at a time, interrupting the timely administration of cancer therapies and disrupting the monitoring of disease progression.[11] **Patients deserve health coverage that does not interrupt potentially life-saving treatments that are inherently time-sensitive, such as cancer treatment regimens.** This type of concerning patient experience with prior authorization underscores the critical need to reform the process to ensure timely access to care.

Lack of Transparency

In addition to inappropriate denials, MA plans frequently utilize their own internal criteria for determining medical necessity, with frequent inconsistencies between the different MAOs. As a result of the significant variability between health plans' prior authorization service lists and approval criteria, providers often are uncertain as to whether a particular recommended treatment requires prior authorization and, if so, which documents the plan requires for approval. Currently, obtaining this information requires significant provider and staff time and hassle spent combing through a myriad of payer websites and policy manuals. A large, national health system spends $15 million per month in administrative costs associated with managing health plan contracts, including two to three full-time staff members who do nothing but monitor plan bulletins for changes to the rules. This lack of transparency, coupled with intense administrative burden and a large volume of services requiring prior authorization, is a frequent reason that claims are delayed or denied. Leaving providers in the dark about what documentation they must provide results in extensive back and forth between providers and plans, which only serves to delay care and unnecessarily burden clinical staff with resource-intensive paperwork.

Varying and Inefficient Submission Methods

One of the most frustrating aspects of prior authorization for providers is the variation in submission processes. Plans vary widely on how to format and submit prior authorization requests and supporting documentation. While some plans accept electronic means, the most common method remains using fax machines and contacting call centers, with regular hold times of 20 to 30 minutes. In addition, plans offering electronic methods of submission most commonly use proprietary plan portals, which require a significant amount of time to log in, extract data from the provider's clinical system and complete idiosyncratic plan requirements, thereby reducing the administrative efficiencies of the process. For each plan, providers and their staff must ensure they are following the correct rules and processes,

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[9] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[10] https://www.aha.org/system/files/media/file/2023/07/New-Consumer-Poll-Finds-Patients-Are-Concerned-about-Commercial-Insurer-Barriers-to-Care.pdf
[11] Example provided by AHA member hospital.

which may change from one request to the next. These inefficiencies can lead to devastating delays spent waiting for authorizations, such as suspected cancer patients anxiously waiting days or even weeks for a diagnostic scan or a psychiatric patient spending extra time in an emergency department while waiting for placement in an appropriate care facility.[12]

Provider Burden

The lack of transparency and inefficient submission methods contribute significantly to provider burden. Importantly, providers continue to report increased burden from complying with resource-intensive prior authorization.[13,14,15] Prior authorization policies burden providers and divert valuable resources from patient care. In response to a recent AHA member survey, 95% of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. And the resource-intensive staff time spent managing health policies adds tremendous cost and burden to the health care system. For example, one 20-hospital system spends $17.5 million annually just complying with health plan prior authorization requirements. And a single 355-bed psychiatric facility needs 24 full-time staff to deal with authorizations. Additionally, physicians report that they and their staff spend about two days per week completing prior authorizations, and 88% of physicians describe the burden associated with prior authorization as high or extremely high. Notably, a May 2022 advisory issued by Surgeon General Vivek Murthy, M.D., states that burdensome documentation and prior authorization requirements are key drivers of health care worker burnout, which exacerbate health care workforce shortages and result in wide-ranging consequences for access to care.[16]

CMS CY 2024 Medicare Advantage Rule

In order to address problematic prior authorization practices that can reduce access to care for MA enrollees, the Centers for Medicare & Medicaid Services (CMS) enacted several reforms in the CY 2024 MA final rule. In the regulation, CMS established that MA plans may not use medical necessity criteria that differs or conflicts with the coverage rules used by Traditional Medicare. Additionally, CMS established clear guardrails about the limited instances in which plans may utilize internal clinical criteria to determine medical necessity for a basic benefit, requiring plans to only use such criteria when a benefit is not "fully established" and where the plan can show that the benefits of such criteria are highly likely to outweigh any downsides, including access to treatment. Furthermore, the rule requires plans to establish Utilization Management (UM) Committees to review medical necessity programs, including prior authorization, to ensure compliance with CMS coverage criteria. **These changes have the potential to enact meaningful change and improvements for**

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[12] Examples provided by AHA member hospitals.
[13] https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf
[14] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[15] https://mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf
[16] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

patients and the providers who care for them; however, we believe additional oversight and enforcement is needed.

Recommendations

Within the 2024 MA rule, CMS repeatedly stressed that a number of the provisions are largely restatements and clarifications of existing CMS requirements for Medicare Advantage Organizations (MAOs). Explaining the need for such rules, CMS notes that it "has received feedback from various stakeholders, including patient groups, consumer advocates, providers and provider trade associations that utilization management in MA, especially prior authorization, can sometimes create a barrier to patients accessing medically necessary care." As a result of such historic MAO noncompliance with CMS rules and regulations among certain plans, **providers are skeptical as to the impact that the 2024 rule will have on their patient care experiences. Accordingly, to ensure that CMS' updates to the MA prior authorization process achieve their intended improvements, the 2024 MA regulations require significant oversight and enforcement.** As a commission responsible for advising lawmakers on the Medicare program and, given the significant and revelatory work the commission has performed thus far, **we believe that MedPAC has an important role in such oversight. We encourage MedPAC to monitor the impact that the recent regulations have on provider and patient experiences.** Specifically, we encourage MedPAC to study the following:

- Prior Authorization Denials. As established in the 2022 OIG report, MA plans routinely deny care that they should have been paid, pursuant to existing requirements, and that would have been covered under Traditional Medicare. A review of MAO denial rates would help establish whether the 2024 MA regulation is fulfilling its intended goal of ensuring beneficiary access to care. To gauge the rule's impact, we recommend tracking and scrutiny of prior authorization denials by MAOs, with particular attention on imaging services, transfers to PAC facilities, and injections, areas that the OIG found a particularly high rate of inappropriate denials.

- Appeals and Overturns. In addition to initial denial rates, we encourage MedPAC to monitor and analyze prior authorization appeal statistics and overturn rates. Overturn rates grouped by service and divided by stage of appeal would help identify areas that require additional attention or oversight. For example, a particular service with a large number of appeals and a significant overturn rate may help identify areas where there may continue to be noncompliance or inconsistent interpretation of CMS rules. Furthermore, these statistics would help measure the impact of the new UM committees, as these committees would be expected to revise or reconsider policies with a high rate of overturn.

- Time Elapsed Between Submission and Decision. Unlike many other provider-insurer interactions, prior authorization requests have a direct and significant impact on patient care. As a result, we encourage MedPAC to monitor prior authorization response times to assess patient's timely access to care.

- Utilization Management Committees. According to the final rule, MA plans must establish a UM committee to review all utilization management policies, including prior authorization, annually, and ensure they are consistent with Medicare Coverage Requirements. Although these committees have the potential to serve as safeguards against inappropriate medical necessity policies and improper denials of prior authorizations, the MA plan is entirely responsible for their creation and management. As a result, many providers fear that these committees will serve as little more than a rubber stamp for plan policies. Therefore, we encourage MedPAC to explore ways of monitoring plan UM committees to ensure that they have been properly composed, conduct legitimate and timely annual reviews of plan policies, and have authority to overturn problematic plan policies.

HOSPITAL PAYMENT UPDATE

An inflationary economy and workforce challenges have put unprecedented pressure on America's hospitals and health systems over the past several years. Health care providers continue to struggle with persistently higher costs as well as downstream challenges that have emerged because of the lasting and durable impacts of high inflation and the pandemic. **As such, the AHA thanks MedPAC for recommending a 2024 update of current law plus 1% for the hospital inpatient and outpatient payment systems.**

Yet, CMS finalized inadequate payment increases for these systems, as well as for LTCHs. Specifically, the agency set a net update of 3.1% for the inpatient and outpatient PPSs and a 0.2% for the LTCH PPS.[17] These updates, especially when taken together with the 2022 payment update of 2.7% for inpatient and outpatient hospitals and 2.6% for LTCHs, continue to be woefully inadequate. They ignore the fact that hospitals and health systems have continued to face unprecedented increases in labor costs and other supply costs. Additionally, they also fail to account for the fact that labor composition and costs have not reverted to normal levels and that, as a result, the hospital field has continued to face sustained financial pressures. **We urge MedPAC to consider the changing health care system dynamics, the unlikelihood of these dynamics returning to normal trends and their effects on hospitals. Specifically, we ask MedPAC to examine the adequacy of the market basket and its labor inputs in the context of these changing labor dynamics.** As we detail below, theses shifts are putting enormous strain on hospitals and health systems, which will continue in FY 2025 and beyond.

Financial Context

Throughout 2022, hospitals battled historic inflation and rising labor and supply costs. These financial pressures continued into 2023 and will not abate soon. According to an analysis, the first quarter of 2023 saw the highest number of bond defaults among hospitals in over a

[17] The agency finalized a LTCH market basket update of 3.5%, reduced by a 0.2% productivity adjustment. However, after adjusting for high-cost outlier cases, overall payments to LTCH in FY 2024 will only increase by 0.2%.

decade.[18] Since February 2023, 72 hospitals have closed departments or ended services at facilities to shore up finances and address staffing shortages.[19] Additionally, days cash on hand has decreased 28% as of June 2023 compared to January 2022.[20]

Workforce shortages continue to create outsized pressures on hospitals and health systems.[21] Labor expenses continue to remain elevated, increasing 20% year-to-date in 2023 compared to 2020.[22] As the demand for 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.[23] Accordingly, hospitals' contract labor expenses increased a staggering 257.9% in 2022 relative to 2019 levels.[24] 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.

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.[25] In 2021, Medicare margins fell to *negative* 8.2% without COVID-19 relief funds, after hitting an all-time low of *negative* 12.3% in 2020.[26] Inadequate payment updates that have not accounted for inflation have caused this underpayment to become even worse since 2021. Specifically, the commission itself has projected that 2023 Medicare margins will fall below *negative* 10%, the *20th straight year* of Medicare paying less than cost.

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[18] Becker's Hospital Review (April 2023). Hospitals See Most 1st-Quarter Defaults Since 2011. https://www.beckershospitalreview.com/finance/hospitals-see-most-1st-quarter-defaults-since-2011.html.
[19] Becker's Hospital Review (November 2023). 72 Hospitals Closing Departments or Ending Services. https://www.beckershospitalreview.com/finance/61-hospitals-closing-departments-or-ending-services.html
[20] Syntellis (November 2023). U.S. Hospitals Face Diminished Reserves, Mounting Reimbursement Challenges. https://www.syntellis.com/resources/report/hospital-vitals-financial-and-operational-trends-23
[21] 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
[22] Kaufman Hall (October 2023). National Hospital Flash Report. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-october-2023
[23] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf
[24] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf
[25] American Hospital Association (February 2022). Underpayment by Medicare and Medicaid Fact Sheet. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf
[26] 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

Market Basket
Generally, to make payment updates to the various fee-for-service Medicare payment systems, CMS uses the market basket to account for price inflation measures that impact the provision of medical services.[27] 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.

In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction does not fully capture the labor dynamics occurring in the health care field. Specifically, CMS uses the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[28] 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 described in detail in our comment letter to CMS, the ECI cannot capture changes in costs driven by shifts between different categories of labor. Yet, as mentioned above, 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% in 2022 compared to 2019 and contract FTEs grew in all clinical departments, ranging from surgical, imaging, emergency to nursing.[29] The largest growth was in nursing where contract FTEs grew 180% from 2019 to 2022.

Indeed, even CMS recognizes that the ECI does not capture these shifts in occupation.[30] The ECI holds the composition of labor fixed between salaried and short-term contract based on a point in time using weights.[31] 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, the price changes in labor compensation were based on the composition of

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[27] CMS. (May 2022). "FAQ – Market Basket Definitions and General Information." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf
[28] 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."
[29] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. https://www.syntellis.com/sites/default/files/2023-03/AHA Q2_Feb 2023.pdf
[30] 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."
[31] U.S. Bureau of Labor Statistics. National Compensation Measures. https://www.bls.gov/opub/hom/ncs/calculation.htm#computing-the-employment-cost-index-eci

salaried and contract labor from 2012, more than a decade ago.[32] 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 was not an accurate reflection of labor cost growth in FY 2022 or FY 2023 when contract labor use and expense shifted dramatically.[33]

When an alternative labor cost index, the Employer Costs for Employee Compensation (ECEC), is examined, it shows how much inaccuracy is created by ECI's lag in updating the labor composition.[34] The ECEC uses current employment weights, as opposed to the fixed employment weights used in the ECI, to reflect the changing composition of today's labor force.[35] 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 health care 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) the cost of contract labor increasing more rapidly than the cost of salaried workers.**

We ask that MedPAC expeditiously examine the labor data and methods used in 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, 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*.[36] Again, we do not believe this is an accurate reflection of labor cost growth going forward.

In addition, these shortcomings are yet another reason that we continue to urge MedPAC to recommend a one-time retrospective adjustment be added to the FY 2025 inpatient, outpatient and LTCH PPS market basket updates to account for the difference between what hospitals should have received and what they did receive in

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[32] 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.
[33] 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.
[34] Refer to AHA's FY 2024 IPPS Comment Letter, Appendix "CMS Misses the Mark in Payment Updates Due to Changes in Labor Composition and Cost Growth." https://www.aha.org/lettercomment/2023-06-09-aha-comment-letter-inpatient-prospective-payment-system-fy-2024-proposed-rule
[35] U.S. Bureau of Labor Statistics. National Compensation Measures. https://www.bls.gov/opub/hom/ncs/calculation.htm#employer-costs-for-employee-compensation-ecec
[36] 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

FY 2022. Specifically, this adjustment would currently be 3.0% for the inpatient and outpatient PPSs and 2.9% for the LTCH PPS.[37,38]

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's senior associate director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners

[37] 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%.
[38] The 2.9 percentage point difference in what was finalized in FY 2022 at 2.6% and what the market basket actually is at 5.5%.