Kansas Hospital Association

June 9, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

On behalf of our 123 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the Medicare Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Long-Term Care Hospitals (LTCH) for fiscal year (FY) 2024.

KHA is a non-profit membership organization. Our membership includes 82 Critical Access Hospitals, 24 Rural Sole Community and Medicare Dependent Hospitals, and 17 Urban and Specialty Hospitals

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals.

Treatment of Hospitals Reclassified as Rural Under § 412.103 for the Rural Wage Index and Rural Floor Calculation

Pursuant to several courts' interpretations of § 1886(d)(8)(E) of the Social Security Act, which allows urban hospitals to reclassify as rural, CMS is proposing to include reclassified hospitals in states' rural wage index calculation. **KHA supports CMS' proposal as it does not negatively impact rural hospitals' wage index adjustments.** Based on the wage index tables put forth by CMS, we believe that this will likely boost Kansas' rural wage index.

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Proposed Changes to the Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

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 updated as the percentage of uninsured individual's changes and is distributed based on the proportion of total uncompensated care (UCC) each Medicare DSH hospital provides.

For FY 2024, CMS estimates the empirically justified DSH payments to be $3.41 billion. It estimates the 75% pool to be approximately $10.22 billion. After adjusting this pool for the percent of individuals without insurance, CMS estimates that it will total approximately $6.71 billion. This results in a decrease in DSH and uncompensated care payments of $115 million, largely due to an estimated decrease in the uninsured. In order to distribute the 75% pool, the agency proposes to continue to use cost report data on uncompensated care. Specifically, it would use a three-year average of the three most recent fiscal years for which audited cost report data are available. Last year, CMS used S-10 data from FY 2018 and 2019 cost reports to determine the distribution of DSH uncompensated care payments for FY 2023. In calculating the uncompensated care payment, CMS uses projections on the percent of uninsured individuals nationwide from the Office of the Actuary (OACT). OACT projects that for calendar year (CY) 2024 the rate of uninsured individuals will be 9.2%. This projection was 9.3% for CY 2023.

KHA disagrees with this percentage and urges CMS to consider any new data that becomes available before the final rule is released. Accurate projections of uninsured and Medicaid enrollment is important for accurate DSH and UCC payments to hospitals.

Due to the expiration of the Medicaid continuous enrollment requirement, we anticipate that the uninsured rate will be higher than 9.3% for CY 2024. The continuous enrollment requirement was in place until April 1, 2023, meaning that no Medicaid enrollees could lose coverage for the first three months of the year. Additionally, most states are not beginning to terminate coverage until June 2023, or halfway through this year.[1] However, by 2024 all states will have started their termination process and are required to have finished redeterminations before the end of that year. By the end of the redetermination process for all states in 2024, the uninsured rate will likely be higher than 9.3% and more than 0.1% higher compared to CY 2023 (9.2%).

[1] Center for Children and Families, Georgetown University, 50-State Unwinding Tracker (Apr. 1, 2023), https://ccf.georgetown.edu/2023/04/01/state-unwinding-tracker/.

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Proposed Changes to the Inpatient PPS Payment Update

KHA thanks CMS for the 2.8% increase in payments to IPPS hospitals.

However, this update is inadequate given inflation, workforce shortages, and labor and supply cost pressures that hospitals continue to face. During 2021 and 2022, Kansas Hospital's experienced operating expense increases between 6% - 15% while revenue increased 0% - 8% relatively. Losing a hospital is devastating to a community as beneficiaries lose a local point of access to care.

The projections that CMS uses for updating payment rates have recently been lower than actual inflation because historical data is used. Using historical inflation data leads to inadequate payment updates. The 9 – 10% inflation rates that the full economy saw last summer are also affecting hospitals.

KHA recommends CMS consider how it can use its regulatory authority to boost payments to hospitals. Given the historical discrepancies between the projected and actual market basket indexes, hospitals need an adjustment to account for past inadequate payments. Section 1886(d)(5)(I)(i) of the Social Security Act gives the Secretary the authority to make any additional exceptions or adjustments to payments under subsection (d) as deemed necessary.[2] This would include the IPPS standardized payment amounts. **KHA urges CMS to consider updating the final payment rate to reflect the difference between prior years' actual and forecasted market basket increases through its exceptions and adjustments authority.**

Congress granted the Secretary broad authority through this provision and KHA maintains that the current financial pressures that hospitals are experiencing warrant use of this provision. Swift legislative and regulatory action are needed to protect hospitals and mitigate more hospital closings. **KHA urges CMS to contemplate use of its exceptions and adjustment authority to improve reimbursement for hospitals.**

Proposed Changes to Graduate Medical Education (GME)

Training in New Rural Emergency Hospital Facility Type

KHA thanks CMS for including rural emergency hospitals (REH) as graduate medical education (GME) eligible facilities. **We support CMS' proposal to treat REHs similarly to critical access hospitals (CAHs)** for GME purposes and allow facilities to choose whether to be treated a non-provider site or incur the costs of training residents and receive payment based upon 100% of reasonable costs.

KHA asks that CMS adopt cost-based reimbursement of 101% for REHs that choose to incur the costs of resident training in the final rule. CAHs currently receive 101% of reasonable costs for training

[2] 42 U.S.C. § 1395ww(d)(5)(I)(i) ("The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate").

residents and CMS should maintain consistency for those that convert to REH status. Hospitals that choose to convert to an REH do not make the decision lightly and are more likely to be independent CAHs, have a three-year negative operating margin, and have a relatively low average daily census.[3] Hospitals that convert and decide to train residents are doing so while in a precarious financial position and thus should receive higher reimbursement. Moreover, aligning this policy with CAHs is consistent with CMS' approach in other areas of law for REHs, such as mirroring many CAH conditions of participation for REHs.

Proposed Changes to Quality Data Reporting Requirements.

Hospital Value-based Purchasing (HVBP) Program

Beginning with the FY 2026 program year, CMS proposes to adopt a health equity adjustment (HEA) that would add bonus points to a hospital's VBP Total Performance Score. KHA appreciates CMS's acknowledgement of hospitals high quality performance while caring for disproportionately larger underserved patient populations. While the HEA would be the product of two factors — a "measure performance scaler" and "an underserved multiplier", with the measure performance scaler assigning hospitals points based on whether they score in the top, middle or bottom third of performance on each HVBP measure domain, and the underserved multiplier based on the proportion of a hospital's inpatient stays that are for patients that are dually eligible for Medicare and Medicaid. KHA supports the adoption of a HEA, however, we believe that the methodology, especially the use of dual eligible as a proxy for vulnerability should be monitored to ensure that it appropriately reflects the vulnerability of the population served.

One of several proposed changes to the HVBP is to add a new measure — severe sepsis and septic shock management bundle — beginning with the FY 2026 HVBP program. Significant concerns have been raised that is measure could lead to antibiotic overutilization. **KHA recommends further study of this measure is warranted before CMS finalizes this change.**

Hospital Inpatient Quality Reporting Program (IQR)

KHA appreciates CMS' commitment to improving outcomes for older Americans, as Kansas' population that is over 60 is growing while the proportion that is under 60 is shrinking. The U.S. Census Bureau estimates that nearly 25 percent of Kansas' population will be over age 60 by the year 2030, and this trend will likely continue as the overall U.S. population rapidly ages.[4] Additionally, the rural communities continue to see an increasing age in their population. As such, KHA agrees that focusing on optimizing care for older adults is an important goal for hospitals. **KHA agrees that hospitals should focus on protecting and ensuring**

[3] George Pink, et al., *Characteristics of Rural Hospitals Eligible for Conversion to Rural Emergency Hospitals and Three Rural Hospitals Considering Conversion*, NC RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, December 2022.
[4] Jonathan Vespa, *The Graying of America: More Older Adults Than Kids by 2035*, U.S. CENSUS BUREAU (Mar. 13, 2018) https://www.census.gov/library/stories/2018/03/graying-america.html.

good health outcomes for older adults. In particular, older Kansans' are more likely to have complex care needs, more social risk factors, and multiple chronic conditions that require high-quality care. This means that rural states such as Kansas may see higher resource utilization when caring for older adults.

However, KHA maintains that the benefits to patients and the hospital must outweigh the administrative burden associated with new reporting requirements. All hospitals are critically understaffed and would face more challenges to consistently document and report.[5] While attestation based measures are usually less onerous than others, the main burden for staff would be assessing whether the hospital is doing each of the activities listed in the measures. KHA does not see a strong patient or provider benefit to reporting on the measures as they stand.

Potential Establishment of a Publicly Reported Hospital Designation to Capture the Quality and Safety of Patient-Centered Geriatric Care.

KHA's support for establishing a geriatric hospital designation depends upon the benefit compared to the administrative burden and resources needed to achieve such designation. In general, KHA may support a designation if CMS can also incentivize hospitals to seek the designation. **Additionally, KHA cautions CMS against reporting measures and hospital designations that can inadvertently exclude rural hospitals from the benefits of such designations.** Various factors such as staff shortages, may prevent a rural hospital from positively attesting to the reporting measures and subsequently receiving the hospital designation. **KHA also warns CMS against implementing any penalties against hospitals that cannot achieve a designation.** Achieving a designation should be optional and only impact the hospitals that receive it.

Providing technical assistance to hospitals could increase rural participation in a future geriatric hospital designation. As mentioned above, a designation should be an optional achievement as many hospitals are not in a position to take on any, elective reporting requirements. Payment incentives associated with a hospital designation may increase participation. On its own, the designation would not provide direct financial incentives to hospitals. In fact, hospitals are likely dis-incentivized from pursuing a designation because of the costs associated and limited financial resources. Financial Assistance (such as a grant) to help meet any requirements or payment boosts for hospitals that have the designation may encourage geriatric designation.

Other Proposed Changes

Rural Emergency Hospitals (REHs)

[5] National Quality Forum, Measure Applications Partnership (MAP) Hospital Workgroup: Preliminary Analyses, December 1, 2022, at 43, https://mmshub.cms.gov/sites/default/files/2022-preliminary-analysis-hospital-workgroup.pdf.

KHA thanks CMS for codifying guidance on documentation for hospitals' REH applications and enrollment. More detailed information on action plans for conversion provides clarity and consistency for rural hospitals that seek the new designation.

Safety Net Hospitals – Request for Information.

KHA appreciates CMS' interest in further supporting safety net hospitals. Attempting to comprehensively define and identify safety net hospitals is a daunting task, but **KHA firmly believes that the core of any definition must be the hospital's essential ability to service patients that would otherwise not have local access to care.** In addition to local access, KHA urges CMS to consider patient and community demographics as the primary facet of safety net hospitals in its pursuit of a definition.

- How should safety-net hospitals be identified or defined?

One tenet of safety net hospitals should be their role in sustaining access in an area or community that would otherwise not have health care access. To an extent, as discussed below, certain CMS designations capture this. For example, CAHs generally must be thirty-five miles from the nearest hospital to qualify for the designation. Sole community hospitals also must meet similar distance criteria. However, KHA asks that a future safety net definition use more precise indicators than mileage alone. In general, **safety net hospitals should provide critical services in an underserved area.**

- What factors should not be considered when identifying or defining a safety-net hospital and why?

CMS should not use volume-based metrics. Generally, rural hospitals have a much lower patient volume and average daily census than other hospitals. The number of patients served by a hospital should not be included in any definition.

- What are particular challenges facing rural safety-net hospitals?

KHA members consistently express that their biggest challenges are financial, including inadequate Medicare and Medicaid reimbursement. Non-PPS hospitals, like CAHs, receive 101% of reasonable costs, however, the true reimbursement levels are below that due to sequestration and other adjustments. Similarly, due to sequestration, CAHs are paid below costs (99%) and actually lose money providing services to Medicare beneficiaries. Payment adjustments and add-ons, like DSH or SCH payments, partially make up for costs where public payers fail to reimburse for the full costs of care. As rural hospital closures begin to tick up again, defining and protecting safety net hospitals is crucial.

- Are there social determinants data collected by hospitals that could be used to inform an approach to identify safety net hospitals? Are there HHS or CMS policies that could support that data collection?

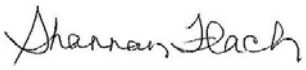
Increased use of Z codes has the potential to assist providers and CMS by providing insight into the social risk factors that most impact their patient populations. However, there are limitations to the data and variations in this data depending on who is capturing and submitting the data, and how the information is input or integrated in a hospitals electronic health record. Further, there are important questions

related to how and what information is collected and who has access to this data that should be addressed. Lack of training, adequate infrastructure, resources, administrative personnel, and trust of providers by patients make implementing Z coding difficult, especially for rural hospitals. However, technical assistance, including financial assistance, would hospitals in beginning to use or increasing their utilization of Z codes.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We urge CMS to consider the changes outlined above in the FY 2024 proposed rule in order to serve our Medicare patients to our best ability.

If you would like additional information, please contact Shannan Flach at sflach@kha-net.org.

Sincerely,



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