Texas Hospital Association

1108 Lavaca Street, Suite 700
Austin, Texas 78701
512/465-1000
www.tha.org

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1785-P
200 Independence Avenue, SW
Washington, DC 20201
Submitted electronically via https://www.regulations.gov

Re: CMS-1785-P, Medicare Program; 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 Disclosure of Ownership

Dear Administrator Brooks-LaSure:

On behalf of our more than 450 member hospitals and health systems, the Texas Hospital Association (THA) appreciates the opportunity to provide comments on the above-referenced proposed rule for the Hospital Inpatient Prospective Payment Systems. These comments address CMS' proposals regarding the following issues:

A. Proposed changes to prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2024
B. Payment adjustment for Medicare disproportionate share hospitals (DSHs) for FY 2024
C. Proposed changes to the severity level designation for Z Codes describing homelessness
D. Training in new REH Facility Type
E. Proposal to revise the hospital VBP program scoring methodology to add a new adjustment that rewards hospitals based on their performance and the proportion of their patients who are dually eligible for Medicare and Medicaid
F. Refinements to current measures in the Hospital IQR program measure set
G. Proposed updates to the HCAHPS Survey Measure (CBE #0166) beginning with the FY 2027 payment determination
H. Safety net hospitals – Request for information

A. Proposed changes to prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2024

***Recommendation*: THA <u>recommends CMS use its special exception and adjustments authority to update the proposed payment update in the final IPPS rule</u>.**

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***Background*:** Amid the COVID-19 pandemic, hospitals began experiencing skyrocketing costs, mainly attributable to increases in labor, supply, and drug costs. High inflation and labor shortages have persisted, continuing to erode the financial stability of hospitals and their ability to serve their communities.

In the FY2024 proposed rule, CMS relies on historical data that does not predict the impact of the current elevated cost of providing care and the increased growth in expenses due to labor and supply chain costs. Additionally, the productivity update included in the proposed rule assumes hospitals can replicate the general economy's productivity gains. However, the critical financial pressures that hospitals and health systems continue to face have resulted in productivity declines, not gains.

In FY 2022, CMS finalized a market basket payment update of 2.7% based on data that did not anticipate or incorporate record high inflation and significant increases in the costs of labor, drugs, and equipment. For example, inflation, as measured by the consumer price index, hit a high of 9.1% in June 2022. Hospitals' labor expenses, which account for about half of a hospital's expenses, have skyrocketed in recent years. Likewise, drug and purchased service expenses have increased[1]. The agency failed to fully account for these unprecedented cost hikes when it set the payment update for FY 2022.

Given broader economic conditions and evidence that prior market basket updates have failed to accurately track inflation, CMS should utilize its authority to reexamine economic indicators and past payment updates and ensure that the FFY 2024 update will better reflect the costs to hospitals in providing patients quality and timely care.

B. Payment adjustment for Medicare disproportionate share hospitals (DSHs) for FY 2024

Recommendation: THA **recommends CMS revise assumptions related to decreases in uninsured rates**.

In its calculation of Factor 2, CMS projects a nationwide uninsured rate decrease from 9.3% to 9.2%. However, as CMS notes in its proposed calculation of Factor 1, Medicaid enrollment nationwide is projected to decrease 11.1% in FY 2024. The proposed rule does not clarify the additional factors it expects to offset Medicaid coverage losses and drive net coverage gains.

In Texas, the Medicaid continuous coverage provision during the PHE resulted in significant growth in Medicaid enrollment since March 2020, and the state estimates that 2.7 million enrollees are at risk of losing coverage during the redetermination process.

[1] Kaufman, Hall & Associates, LLC (2022). The Financial Impact of COVID-19 on Texas Hospitals. https://www.tha.org/wp-content/uploads/2022/11/Texas-Hospital-Association-Financial-Impact-Report-11.1.22.pdf.

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With the PHE having ended, states have begun disenrollment efforts and early reports show higher percentages than expected being disenrolled. Thus, we urge CMS to reconsider the assumptions it used for calculating projected decreases in the FY 2024 national uninsured rate, as this plainly will not align with the real-world circumstances as Medicaid continuous coverage unwinds. CMS notes that it may consider the use of more recent data that becomes available for estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2024. We ask that CMS update its estimates of the Medicare DSH amount to more accurately reflect both high discharge volumes and health insurance coverage losses likely to occur in FY 2024.

C. Proposed changes to the severity level designation for Z Codes describing homelessness

***Recommendation*:** THA **supports CMS' proposal to change the severity level designation associated with care for unhoused patients**.

***Background*:** THA recognizes the effects that social determinants have on the health of patients and the cost of providing them care. We applaud CMS' efforts to incorporate social determinants of health into its payment structure and look forward to future efforts in this area.

In the specific case of unhoused persons, CMS has rightfully recognized that their medical care incurs additional costs sufficient to designate admissions associated with ICD-10-CM diagnosis codes Z59.00, Z59.01, and Z50.02, collectively homelessness, with a severity level of CC.

D. Training in new REH Facility Type

Recommendation: THA **supports CMS designation of Rural Emergency Hospitals (REHs) as graduate medical education (GME) eligible facilities**.

Background: With Texas having led the nation in rural hospital closures last decade and over a quarter of rural Texas hospitals at risk of closure[2], THA is grateful for CMS' efforts to assist these vital facilities.

THA previously supported the creation of the REH provider type as a means of ensuring continued hospital operations and patient access to care in smaller communities. As CMS notes in the proposed rule, "REHs are intended to provide much needed healthcare services,

[2] Kaufman, Hall & Associates, LLC (2022). The Financial Impact of COVID-19 on Texas Hospitals. https://www.tha.org/wp-content/uploads/2022/11/Texas-Hospital-Association-Financial-Impact-Report-11.1.22.pdf.

often times as the initial and only accessible point of care for individuals in rural underserved areas."

THA believes that designating REHs as GME eligible facilities will support the goal of providing care in rural underserved areas now, through the presence of medical residents providing care, and in the future, through the heightened production of physicians with training and interest in serving rural areas.

THA also appreciates CMS' flexibility for REHs that allows the hospital to determine whether to be a non-provider site or to incur direct GME costs and be paid based on reasonable costs for that training. This flexibility will allow REHs to make the best decision for their facility and contribute to necessary financial stability and continued patient access.

E. Proposal to revise the hospital VBP program scoring methodology to add a new adjustment that rewards hospitals based on their performance and the proportion of their patients who are dually eligible for Medicare and Medicaid

***Recommendation*:** THA **recommends that CMS' review alternate means of defining populations facing health disparities**.

***Background*:** CMS has identified patients with dual eligibility status (DES) as 'one of the most vulnerable populations', a fact with which THA does not disagree. However, Executive Order 13985 of January 20, 2021, on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government identifies not the DES population but a multitude of diverse groups for whom programmatic equity should be a priority. CMS has cited ASPE reports showing some overlap between correlates of the DES population and those included in the Executive Order, but in doing so excludes consideration of several other vulnerable groups, to wit, the LGBTQ community, Asian American and Pacific Islanders and other persons of color, religious minorities, etc.

Rather than relying on a proxy measure that fails to account for the diversity included in the Executive Order, THA believes that CMS should identify other measures that, singularly or in combination, will better capture the breadth of groups negatively impacted by social determinants of health.

What is more, states' Medicaid eligibility policies determine the size of a state's DES population, creating two potential concerns. First, hospitals in states with more generous eligibility policies will appear to have higher numbers of DES patients, resulting in more health equity adjustment (HEA) bonus points. In contrast, hospitals in states with fewer patients covered by Medicaid will necessarily be expected to receive fewer bonus points Second, low-income patients in this second group are likely to have increased health issues due to their lack of access, resulting in greater costs of care. As proposed, the proposed HEA

bonus point structure would penalize hospitals in states with restrictive Medicaid eligibility policies. Once again, THA recommends CMS reconsider alternate methods for identifying and rewarding hospitals treating patients from marginalized populations.

F. Refinements to current measures in the Hospital IQR program measure set

***Recommendation*:** THA **recommends that CMS continue to solicit quality data on Medicare Advantage (MA) enrollees from the MA plans**, rather than requiring hospitals to redundantly report these data.

***Background*:** CMS already requires MA plans to submit data for Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) and Hybrid Hospital-Wide All-Cause Readmission (HWR) but proposes to require hospitals to include MA enrollees in future reporting for these measures. To avoid duplicative efforts and necessary changes to hospital reporting processes and systems, we believe it more efficient to use existing data sources, specifically MA plans, to incorporate MA enrollees into these measures.

G. Proposed updates to the HCAHPS Survey Measure (CBE #0166) beginning with the FY 2027 payment determination

***Recommendation*:** THA **supports CMS' proposals to create greater flexibility for patients in the collection of HCAHPS data**.

***Background*:** Currently, the HCAHPS can only be administered via mail only, via phone only, and using a mail-phone hybrid. CMS' 2021 HCAHPS mode experiment demonstrated notably higher overall response rate when incorporating the internet into these methods. Moreover, CMS found increased representation of younger, Spanish-language-preferring, racial and ethnic minority, and maternity care patients. The CMS proposal to extend the data collection period shows similar gains among disadvantaged groups, and we believe that the allowance of proxies will also increase response rates among certain hard-to-reach groups. THA supports the goal of higher response rates and ensuring that all subpopulations are represented in the HCAHPS survey.

H. Safety net hospitals – Request for information

***Recommendation*:** THA **recommends CMS continue to refine its conceptual approaches for supporting safety net hospitals**, including more in-depth analyses of the potential impacts of the safety-net index (SNI) and other alternative indices, and consider potential additional avenues to advance health equity.

***Background*:** Given the considerable challenges safety net hospitals already face in reaching and providing care for underserved populations, THA is grateful that CMS initiated a request

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for information aimed and supporting these hospitals and that CMS utilized this mechanism prior to proposing a major change to payment structure.

In its Background section, CMS identifies Executive Orders focused on "advancing racial equity and support for underserved communities" and states that "CMS has made advancing health equity the first pillar in its strategic plan", defining health equity in a manner that lists concern for race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes. THA appreciates CMS' goal of advancing health equity and generally supports such efforts.

However, THA has identified some areas of concern in the proposed rules. First, the proposed rule introduces a potential measure, the Medicare Safety Net Index (SNI), that is directly linked to only one of these factors – socioeconomic status. THA believes that CMS has failed to adequately explain how incorporation of the SNI would allow safety-net hospitals to improve their care for these for the diverse groups who face structural barriers to achieving good health. As such, the alternative measures identified by CMS, the area deprivation index and the Social Deprivation index, may have greater utility than the SNI, but their suitability for application to the disadvantaged groups listed in the Executive Order are uncertain and seem too narrow for the outcome CMS hopes to achieve.

In addition to these shortcomings, THA also believes that the SNI, as proposed, could undermine the stated goal of advancing health equity. Specifically, by removing Medicaid fraction patients from the Medicare DSH program, CMS may inadvertently be disincentivizing hospitals and non-expansion states from providing maximum access to care for Medicaid patients. Hospitals, which currently are incented to serve Medicaid patients through their inclusion in Medicare DSH, may have less willingness to do so. Likewise, an adverse knock-on effect to state Medicaid expansion would occur for hospitals in current non-expansion states if uncompensated care volumes go down and Medicaid volumes go up. CMS has a long track record of leveraging safety net care for low-income people, Medicaid enrollees, and the uninsured through its Medicare policy and we encourage CMS to take that perspective here.

THA supports CMS' goal of striving for health equity but believes that overly narrow proxies are unlikely to affect real improvement in the outcomes of disadvantaged populations. Rather than settling for a simple and inadequate arithmetic formula, like the SNI, or existing community-based measures developed for other purposes, THA encourages CMS to consider the identification or creation of measures that directly gauge the extent to which hospitals serve the disadvantaged populations CMS has identified. Such work should include consideration of how existing safety net hospitals and underserved communities will be affected by changes to existing safety-net funding mechanisms. In addition, CMS should take

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this opportunity to examine how low-income Medicare Advantage enrollees ought to be considered in any safety net adjustment.

In whole, CMS should develop more comprehensive proposals with impact analyses, and further solicit comment on these efforts prior to seeking to implement them in rule.

Thank you for your consideration of these comments. We look forward to working with CMS on these issues in the future. Should you have any questions or comments, please contact Matt Turner, Senior Director, Quality & Payment.

Respectfully submitted,

Heather De La Garza
Assistant General Counsel

Anna Stelter
Senior Director, Financial Policy

Matt Turner
Senior Director, Quality & Payment