Kentucky Hospital Association

Representing Kentucky Hospitals and Health Systems

June 10. 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Submitted via www.regulations.gov

RE: CMS-1808-P, Medicare and Medicaid Programs and the Children's Health Insurance 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 2025 Rates; Quality Programs Requirements; and Other Policy Changes, (Vol. 89, No. 86), May 2, 2024.

Dear Administrator Brooks-LaSure:

The Kentucky Hospital Association (KHA) represents all hospitals and health systems in the Commonwealth of Kentucky. On behalf of our members, KHA appreciates the opportunity to provide comments relating to the Centers for Medicare and Medicaid Services (CMS) proposed rule for the hospital inpatient prospective payment system (PPS) for fiscal year 2025. We are submitting a separate comment letter on the CMS proposal relating to the Transforming Episode Accountability Model (TEAM).

KHA agrees with recent comments submitted by the American Hospital Association (AHA) on June 5, 2024, and strongly encourages CMS to consider the concerns shared regarding the proposed rule as the final rules are developed. Specifically, we emphasize the following statements from AHA:

> … **we continue to have strong concerns about the proposed payment updates. In particular, we are deeply concerned about the inadequacy of the proposed net payment update of 2.6% given the unrelenting financial challenges faced by hospitals and health systems. As such, we strongly urge CMS to utilize its authority to make a one-time retrospective adjustment to account for what the agency missed in the FY 2022 market basket forecast.** We also are concerned about the agency's lack of transparency in the underlying calculations for disproportionate share hospital (DSH) payments and disagree with the agency's estimates of the number of uninsured for FY 2025. We urge CMS to consider additional data by researchers and policy stakeholders to reach a more

reasonable estimate of the percent of uninsured. Additionally, we are concerned with the agency's graduate medical education (GME) proposals and RFI related to modifications of the "newness" criteria to establish new residency training programs. Finally, we have concerns about several of the agency's quality-related proposals. We urge CMS not to adopt its two proposed new structural measures and not to increase the number of required electronic clinical quality measures. CMS' proposal to use conditions of participation (CoPs) to compel hospitals to share data with the federal government is both needlessly heavy-handed and inconsistent with the intent of CoPs. Rather than jeopardizing hospitals' Medicare participation status, the AHA urges CMS to take a more collaborative approach and to invest in the infrastructure needed to make the voluntary sharing of important data on infectious diseases less burdensome and more meaningful.

Inpatient PPS Payment Update

For FY 2025, CMS proposed a market basket update of 3.0% less a productivity adjustment of 0.4 percentage points, resulting in a net update of 2.6%. Similar to the updates proposed in recent years, the market basket update for FY 2025 remains extremely inadequate and continues to exacerbate Medicare's underpayments to the hospital field. The proposal does not take into account the high levels of input costs and other challenges faced by health care providers, specifically hospitals and health systems. Those challenges include the aftermath of cyberattacks (such as on Change Healthcare and one of our state's hospital systems); economy-wide inflation; rapid and sustained growth in labor costs; record drug costs; and unnecessary administrative costs for large commercial health insurers, including Medicare Advantage and Medicaid managed care plans, including those costs associated with prior authorization requirements, claims denials, and appeals. We join with the AHA in **urging CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing care.**

As stated in our June 2023 comments submission, and also restated by the AHA for the current proposal, we **once again urge CMS to use its "special exceptions and adjustments" authority to implement a retrospective adjustment for FY 2025 to account for the difference between the market basket update that was implemented for FY 2022 and the actual market basket for FY 2022. Specifically, the actual market basket for FY 2022 is 5.7% — a full 3.0 percentage points higher than what hospitals received in 2022. Additionally, we also urge CMS to eliminate the productivity cut for FY 2025.**

There have now been three consecutive years of missed forecasts to hospitals' detriment, beginning in FY 2022. Based on the market basket adjustments alone, this has resulted in underpayments of inpatient PPS of nearly 4.0 percentage points. CMS is strongly urged to use the "special exceptions and adjustments" and address the inadequacy of

payments. We are not starting from a financial ground zero, but more like four levels below.

Low Volume Adjustments

KHA supports the extended low volume adjustment. The Consolidated Appropriations Act of 2024 extended the low-volume hospital qualifying criteria and payment adjustment through December 31, 2024; after that date, these providers would only receive a 25% adjustment if they have less than 200 total discharges (all payer) and are located more than twenty-five miles from another subsection (d) hospital. We encourage CMS to continue using the modified definition of low-volume hospital to provide the adjustment if they have less than 3,800 discharges and are located more than fifteen miles from another subsection (d) hospital.

Area Wage Index and Rural Hospital Provisions

Kentucky is a very rural state and adjustments that benefit our rural hospitals in turn benefit all of Kentucky. Rural hospitals provide and preserve crucial access to care in their communities. Without our rural providers, patients would have to travel hours to receive quality care currently available much closer to home

In Kentucky, the Medicare hospital wage index (AWI) leads to grossly disparate Medicare reimbursement across hospitals and serves to limit access to care in rural and underserved communities. Kentucky's hospitals receive one of the lowest Medicare reimbursement rates in the nation for providing the same care that is delivered in other states, creating greater disparities in access to care for our rural communities. Addressing factors like the area wage index that have a direct impact on healthcare providers, especially in rural states like Kentucky, should be a primary focus for CMS.

As a result of the AWI, hospitals in many states, including Kentucky, are forced to make difficult decisions about future operations and their ability to meet the health care needs of the communities they serve. A recent report issued by the Center of Healthcare Quality and Payment Reform (CHPQR) analyzed the risk of rural hospital closures across the country due to financial strains. In the analysis, eight of the top ten states with the most rural hospitals at risk are rural states where the existing Medicare reimbursement has reached unsustainable levels. For example, of Kentucky's 72 rural hospitals, 30 have been forced to eliminate services, 16 are at risk of closure, with 10 in immediate risk of closure. The flawed AWI is among, if not the top, contributing factor for the severely negative financial pressures that hospitals in Kentucky face.

Our rural communities deserve no less than equity in access to quality healthcare than in other states. Comprehensive reform of the AWI therefore is crucial to preserve the financial viability of hospitals around the country.

Disproportionate Share Hospital (DSH) Payments

KHA has concerns regarding the transparency relating to DSH calculations. As in prior years, we again ask for more clarity on the agency's calculations for DSH payments. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.** States are seeing a large *increase*, rather than a decrease, in the number of uninsured individuals as millions of people lose Medicaid coverage during the unwinding process

Health Equity

KHA commends CMS for their focus on health equity, but we do not support "check the box" type of structural measures for assessing hospital leadership involvement in healthcare equity as it will not be a useful data point and could be misleading to the public by failing to recognize all of the steps hospitals are taking to advance health equity. We are also concerned that the definition of health equity may be too narrowly drawn to focus on race and ethnicity rather than other factors that are more meaningful based on Kentucky demographics. Instead, we suggest that CMS consider regulatory flexibilities that could help providers to effectively act on social determinants of health and gaps in access to care for the populations they serve.

KHA is not opposed to metrics related to health equity, but in fact the diversity in many Kentucky communities is not related to race and ethnicity. For instance, the population of the west end of Louisville is different from the population of Pikeville. If a hospital's population is not racially or ethnically diverse, KHA believes resources would better be spent addressing the diversity and subsequent disparity that may exist in other areas, such as age, gender, and health literacy.

We agree that factors such as rural or urban, and income status are important; however, we are concerned about the data reporting and collection requirements. It will be difficult for hospitals (especially small rural hospitals) to attest to compliance to arbitrary requirements, and it will be difficult to provide evidence without sophisticated electronic health records, which not all of our Kentucky hospitals have. Additionally, as written, hospitals will receive credit if they are doing all required activities, but will not receive any credit for partial compliance. We recommend using a community needs assessment, even though that is labor intensive, and we recommend using measurements that are endorsed by the National Quality Forum. The definition of attestation needs to be broad enough to include the elderly and veterans, for instance, but not too narrowly focused.

Thank you for your consideration of our comments. We urge CMS to implement the changes outlined in our comment letter and in the AHA comment letter in order to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care. Please let us know if you have any questions.

Sincerely,

Nancy Galvagni
President