Illinois Health and Hospital Association

June 6, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

**Re: FY 2024 Inpatient Prospective Payment System Proposed Rule (CMS-XXXX-P)**

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed rule.

Overall, we appreciate the Centers for Medicare & Medicaid Services' (CMS) streamlined approach to the FY 2024 IPPS proposed rule. However, CMS' proposed rate increase, at 2.8%, continues to be too low to adequately support our nation's hospitals. Further, the proposed rate update for Long-Term Care Hospitals (LTCHs) is a net negative 0.9%. LTCHs have borne unique challenges over the last three years of the COVID-19 public health emergency (PHE), often treating patients experiencing prolonged COVID-related complications in addition to their normal patient census. **Consistent with our comments on the FY 2023 IPPS proposed rule, we strongly urge CMS to reexamine the policies and methodologies utilized in updating hospital Medicare payment rates.** For the past several years, the current approach has resulted in rate updates that are inadequate and inconsistent with the economic reality hospitals face.

**Rate Increase**

The proposed 2.8% rate increase is inadequate and will result in an overall payment reduction for hospitals because it fails to account for extraordinarily high inflation, and high labor and drug costs. CMS' market basket methodology has been inadequate for several years. In fact, in FY 2022 CMS finalized a market basket payment update of 2.7% based on data that did not anticipate or incorporate the record high inflation and significant increases in the costs of labor, drugs and equipment. The actual market basket update for FY 2022 was 5.7%.

CMS relies on historical data in the FY 2024 proposal 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, but in reality, hospitals and health systems financial pressures have resulted in productivity declines, not gains.

The low proposed FY 2024 increase would severely exacerbate these problems and does not properly recognize the significant financial challenges hospitals are navigating. IHA urges CMS to consider using its special exceptions and adjustments authority to revise the proposed payment rate in the final IPPS rule and make a retrospective adjustment for FY 2022 based on the actual market basket.

**DSH Payments: Calculating Factor 2**

IHA appreciates CMS' methodology for determining Disproportionate Share Hospital (DSH) payment changes and the calculation of Factor 2. We understand that current data suggest uninsured rates of 9.3 percent and 9.2 percent for calendar years (CYs) 2023 and 2024, respectively. However, we are very concerned that these figures may under-represent the national uninsured rate as states work through Medicaid redeterminations.

Therefore, **we urge CMS to continue monitoring and revising its uninsured rate estimates with updated data.** We agree that the impact of the expiration of the Families First Coronavirus Response Act's continuous Medicaid enrollment provision may result in higher uninsured rates over the next several months. Additionally, it may take time for newly uninsured individuals to take advantage of the Internal Revenue Services' amended regulations expanding eligibility for Marketplace subsidies or the Inflation Reduction Act's extension of enhanced Marketplace premium tax credits. Further, we ask CMS to be mindful of the uninsured rate once the enhanced Marketplace premium tax credits expire. Monitoring this space is paramount to providing hospitals with the resources necessary to provide high quality healthcare, particularly for high DSH hospitals that are at the forefront of addressing health disparities.

**Reasonable Cost Payment for Nursing and Allied Health Education Program**

IHA appreciates CMS' commitment to addressing past underpayments to nursing and allied health education programs as required by the Consolidated Appropriations Act, 2023 (CAA, 2023). We are concerned, however, with the proposed rules indication that Medicare Administrative Contractors (MACs) will only recalculate eligible hospital's nursing and allied health Medicare Advantage payment for portions of cost reporting periods that are still within the 3-year reopening period.

Section 4143 of CAA, 2023 did not stipulate that repayments should only be made for cost reporting periods within the 3-year reopening period. Rather, it eliminated the cap on total payments for all years between 2010 and 2019. It was clearly Congress' intent that nursing and allied health programs be made whole for past underpayments so long as they were still

functioning at the time CAA, 2023 was passed. **CMS should revise this policy in the FY 2024 IPPS final rule, instructing MACs to make repayments as appropriate for all cost reporting periods between 2010 and 2019.**

**Homelessness Diagnosis Codes**
IHA commends CMS for the proposed changes to the severity level designation for diagnosis codes related to homelessness. Changing Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness) from NonCC to CC for FY 2024 better reflects the resources necessary to treat acute and long-term issues affecting homeless patients. IHA also encourages CMS to continue analyzing the effect of social determinants of health (SDOH) on patient outcomes and provider resource utilization to better assist hospitals in providing higher quality care.

IHA and its members ask that CMS produce additional guidance on how hospitals should operationalize the use of these diagnosis codes. Considering the number of diagnosis codes available, it would be helpful if CMS might instruct hospitals on how to prioritize the use of SDOH-related codes. Further, guidance or standards that will standardize the way electronic medical records and claims processing systems treat SDOH-related diagnosis codes will not only assist providers that may work across various systems, but also CMS' efforts to collect more SDOH data as it will increase the likelihood that providers and hospitals ask for and record SDOH data.

**Rural Emergency Hospital Training**
IHA appreciates CMS recognizing the importance of allowing Rural Emergency Hospitals (REHs) to qualify for Graduate Medical Education payments. Rural hospitals are of critical importance to their regions and qualifying for the additional funding assists in their continued success. While Illinois does not currently have any REHs, there are several organizations in our membership that are considering this provider type in the future. Allowing REHs to attract, educate, and be reimbursed for training additional healthcare workforce will help sustain these critical healthcare access points across rural Illinois.

**Hospital Value-Based Purchasing (VBP) Health Equity Adjustment**
IHA appreciates CMS adding a Health Equity Adjustment (HEA) to the VBP program, which will reward hospitals with high quality performance that care for large numbers of dually eligible patients by adding up to ten bonus points to a hospital's VBP Total Performance Score. IHA, and its members, are committed to advancing health equity and recognize this proposal supports that goal.

However, we seek clarity on the proposed methodology for the HEA. We would appreciate additional details on how VBP payments will be redistributed once we account for the HEA. Such feedback will allow us to better analyze the potential impact of this change and provide more substantive comments.

**Request for Information: Safety Net Hospitals**

We applaud CMS making health equity the first pillar in its strategic plan and agree Safety Net Hospitals play a crucial role in the advancement of health equity. Illinois is actively focused on improving health equity and how the healthcare delivery system, including Safety Net Hospitals, can improve access to quality healthcare for individuals in all communities.

We can only make progress by acknowledging hard to accept facts. Residents in one Chicago neighborhood have a documented 30-year lower life expectancy than those in a neighborhood just eight miles away. In several Illinois counties outside of Chicago this disparity in life expectancy persists as Black residents have a five to eight year shorter life expectancy than white residents. Health disparities also exist in rural areas of Illinois where individuals have higher incidences of chronic conditions, including diabetes, some cancers and obesity. People and communities of color have faced health inequities driven by systemic racism for generations—a wrong that the COVID-19 pandemic laid bare, not only in Illinois, but nationwide.

And while the COVID-19 pandemic highlighted the weaknesses in our healthcare delivery system, the pressures on providers, particularly Safety Net Hospitals, had been growing for years before the pandemic. As CMS notes, the term "Safety Net" Hospital can take many forms. Our experience in Illinois is that our most financially challenged hospitals are those serving the most vulnerable urban and rural communities. IHA has a longstanding principle of advocating for added consideration to be provided to Safety Net Hospitals and Critical Access Hospitals to help assure access to quality care for the communities served by those institutions.

The pressures on all hospitals are amplified on Safety Net Hospitals and include: serving an increasing number of Medicare, Medicaid and uninsured patients; public payers that reimburse hospitals at much lower rates than private payers; a loss of population in many communities placing increased financial pressure to retain needed services; shifts in the service delivery location from inpatient to outpatient; the impact of changing from a fee-for-service centric model to one requiring providers to contract with managed care organizations; and an enhanced focus on integrated care delivery through a more holistic approach.

The Illinois environment is particularly challenging, as the state Medicaid program reimburses hospitals about 80% of what it costs to provide care, while the Medicare program covers about 90% of costs. Medicaid and Medicare account for 2/3 of hospital inpatient stays and over half of all hospital outpatient services. Today, the Illinois Medicaid program is the largest single insurer in the state, insuring 3.6 million or 3 in 10 Illinoisans, compared to 1 in 10 Illinoisans in 1995. Illinois ranks 48 out of the 50 states and Washington DC in Medicaid spending per enrollee.

While all hospitals are struggling in this environment, CMS must recognize that this pressure is more intense on Safety Net Hospitals that are serving predominately low-income and uninsured patients with very limited resources. The healthcare needs of this population are complicated

by the social factors that influence their health, such as housing and food insecurity. This means Safety Net Hospitals face extensive challenges in quickly adapting to the transforming landscape, and therefore, experience greater financial challenges compared to other hospitals. Safety Net Hospitals are on the front lines of providing access to essential healthcare services on a shoe string budget and are in need of additional funding from the government payers they depend on, since they have relatively fewer commercial patients. As such, it is vital that hospitals, patients and payers have a clear understanding of how CMS envisions moving forward with its goal of advancing health equity and providing targeted support to Safety Net Hospitals.

The request for information included two options for identifying a Safety Net Hospital, using the Safety Net Index and using area-level indices. Without greater detail on these two options and just how each might impact which hospitals receive additional consideration, it is difficult to provide substantive feedback. We suggest that CMS consider the following principles as it considers options for providing additional support to Safety Net Hospitals.

- **Provide new funding.** Any attempt to define and fund Safety Net Hospitals must use new funding allocated by Congress. IHA does not necessarily see where CMS has existing authority to define and fund Safety Net Hospitals. However, if the agency did have that authority, it would be a budget neutral effort, redistributing funds from some hospitals to fund others. Given the current state of underfunding, redistributing scarce Medicare resources would amount to "robbing Peter to pay Paul."
- **Avoid hard cutoffs and year-to-year funding swings.** As CMS explores defining and funding Safety Net Hospitals, the agency should avoid definitions that have hard cutoffs/thresholds. Instead, the agency should look to scale funding to all hospitals in proportion to the factor (or factors) that may ultimately be used to define and fund Safety Net Hospitals. Specific to year-to-year funding swings, CMS should consider using a multi-year data approach in order to increase the stability of any factor(s) used to define and fund Safety Net Hospitals.
- **Ensure data transparency, availability and time to analyze any Safety Net Hospital proposal.** As CMS further explores this topic, it must ensure data and information is public for the hospital field to analyze and understand agency proposals and objectives. For example, one major issue with MedPAC's Medicare Safety Net Index recommendation is that all of the data necessary to fully explore the recommendation is unavailable. As a result, those exploring the recommendation are required to use inexact data and make extensive assumptions that may or may not ultimately align with the commission's intent or outcome. Data availability and transparency is essential for appropriate analysis and consideration of any new definition that will potentially define and fund Safety Net Hospitals.
- **Evaluate potential impacts on other payment streams.** We also suggest that CMS thoroughly analyze how new Safety Net Hospital funding might impact affected hospitals' eligibility for other federal programs, such as the 340B drug pricing program.

Additionally, CMS should explore the implications of adjusting Medicare payment for both inpatient and outpatient services as part of any new Safety Net funding opportunity.

We commend CMS for its intentional direction and encourage a more robust dissemination of the concepts under consideration to provide additional support to Safety Net Hospitals and their potential application. Better understanding the ultimate and intermediate goals would help interested parties identify areas for comment and engagement.

IHA looks forward to working with CMS as it advances health equity and provides Safety Net Hospitals with the resources required to deliver critical, high quality healthcare services to all patients.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association