Washington State
Hospital Association

June 10, 2024

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

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:

On behalf of the Washington State Hospital Association and our more than 100 member organizations, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed inpatient prospective payment system (PPS) proposed rule issued April 10.

Market Basket Increase

We have significant concerns over the proposed payment update for IPPS hospitals for FY 2025. To ensure that Medicare payments for acute care services more accurately reflect the actual cost of providing hospital care, we urge CMS to consider and implement the specific changes below.

For FY 2025, CMS proposes a market basket update of 3.0 percent, less a productivity reduction of 0.4 percentage points resulting in an update of 2.6 percent. Unfortunately, this update lags far behind actual increases in the cost of providing care experienced by hospitals in the current inflationary environment. We urge CMS to consider the changing health care system dynamics and their effects on hospitals as it determines these figures.

The current inflationary economy combined with the lingering effects of the COVID-19 crisis continues to put unprecedented pressure on hospitals. They continue to struggle with persistently higher costs and additional downstream challenges that have emerged because of the lasting and durable impacts of high inflation, workforce shortages, and the pandemic.

Specifically, historic inflation has continued and heightened the severe economic instability that the pandemic has wrought on hospitals. This includes increased drug costs and dramatic

increases in the cost of attracting and retaining nurses and other hospital staff. Because this high rate of inflation is not projected to abate in the near term, and inflationary pressures continue to work their way into wage expectations, it is critical to account for these challenges when considering hospital and health system financial stability in FY 2025 and beyond. Market basket updates based on time periods where inflation was less of an issue, are resulting in woefully inadequate reimbursements for our hospitals. We ask CMS to use its exceptions and adjustments authority to implement a marketbasket increase for FY 2025 that is more reflective of the actual increases to the cost of providing care that hospitals are experiencing.

Productivity Adjustment

Additionally, we ask that CMS reduce or eliminate the productivity cut for FY 2025. The adjustment assumes hospitals can mirror productivity gains occurring in other industries. Productivity adjustments penalize hospitals and patients when costs that are largely outside of their control increase more suddenly and rapidly than efficiency and productivity gains can occur. These assumed gains do not consider the impact of additional regulation and requirements have on productivity. Productivity gains assume and require a degree of stability which has not occurred in the last few years due to the impacts of the Covid emergency. Therefore, we have strong concerns about the magnitude of the proposed productivity cut given the extreme and uncertain circumstances in which our hospitals are currently operating

TEAM Model

Our member hospitals support the health care system moving toward the provision of more accountable, coordinated care. As such, our members are in the process of redesigning delivery systems to increase value and better serve patients. However, we are deeply concerned about the proposed TEAM as it includes problematic design elements and assumptions that would make it difficult for hospitals to participate without subjecting themselves and their communities to significant financial risk. Specifically, we strongly recommend that CMS delay implementation until these issues can be resolved, and at a minimum make TEAM voluntary, lower the 3% discount factor and make needed changes to problematic design elements. We would refer you to comments from the American Hospital Association for a more detailed explanation of our concerns. The concerns include:

- **High cost to implement the program**, particularly for smaller hospitals and inclusion of low-volume episodes. At a minimum, hospitals should be able to select among the five types of episodes to participate in.

- **Availability of post acute resources**. The TEAM assumes uniform and adequate and uniform access to various types and venues for post-surgical rehabilitation. Because of many issues, the availability of home health, skilled nursing, and swing bed services vary among hospitals even within broader geographic regions. The model as proposed

would penalize hospitals for arranging what may be the most clinically appropriate care, and in some cases the only care available to the patient. The model needs greater flexibility to accommodate these circumstances.

- **Proposed discount factor.** The proposed rule includes a 3% discount factor, which is unrealistically high. This means that CMS will take 3% in cost savings right off the top, regardless of whether the episode achieves cost savings. CMS must provide hospitals with a fair opportunity to achieve enough savings to garner a reconciliation payment, otherwise it may jeopardize the hospital's ability to provide care for that episode category. We recommend that a discount factor of no more than 1% be applied.

- **Glidepath to two-sided risk needed.** CMS' proposed one year of upside-only risk for all hospitals is insufficient given the infrastructure investment required and the risk involved, particularly for safety-net hospitals, rural hospitals and special designation hospitals. Other APMs have provided much longer glidepaths to two-sided risk. For example, in the Medicare Shared Savings Program, organizations inexperienced with performance-based risk can access upside-only risk for the first five years of participation. Considering CMS is proposing to oversample from markets with low previous exposure to bundles, we recommend extending the upside-only glidepath to a minimum of two years.

The changes we recommend above would help facilitate our and other hospitals' success in providing quality care to Medicare beneficiaries, achieving savings for the Medicare program and having an opportunity for reward that is commensurate with the risk they are assuming. We appreciate your consideration of these comments.

Proposal for Drug Buffer Stock

We appreciate CMS' proposal to provide additional payment to certain small prospective payment hospitals to offset some of the additional storage and other costs related to maintaining a buffer stock of certain essential medicines. In talking to our member hospitals that would be eligible, the additional payment would do little to solve the underlying supply chain issues that put such hospitals in a disadvantageous and vulnerable position. We encourage CMS to consider ways to require drug manufacturers to provide more equitable distribution and sale of drugs to smaller entities that lack the purchasing clout of larger organizations.

Changes to Conditions of Participation for Obstetrical Services

We are very concerned about the proposal to baseline health and safety standards through changes to hospital Conditions of Participation for obstetrical (OB) services. In Washington State, some hospitals have needed to close their labor and delivery departments due to the

unsustainably high cost of maintaining 24/7 access for those services, coupled with relatively low volume. We are concerned that adding new CoP requirements, unless accompanied with payment increases and additional resources, will have the opposite of the intended outcome and exacerbate closures, reducing access for obstetrical services.

Proposal to Review Medicare OB Payment

We support CMS' proposal to review the adequacy and appropriateness of Medicare MS-DRG payment. Because few Medicare patients receive obstetrical services, it does not seem that Medicare weight and classifications would be a statistically reliable basis for payment, particularly as adopted by commercial health plans. We are concerned about the degree that commercial plans have adopted the Medicare DRG methodology and weights for obstetrical services, though the methodology and weights poorly reflect the costs and range of complexity for obstetrical services for the commercial population. We believe this has resulted in commercial underpayment and exacerbated the difficulties hospitals face in sustaining labor and delivery services

Thank you for your consideration of our comments. If you have questions regarding our comments, please contact Andrew Busz, at andrewb@wsha.org.

Sincerely,

Jacqueline Barton True
VP, Rural and Federal Programs
Washington State Hospital Association

Andrew Busz
Policy Director, Finance
Washington State Hospital Association