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Advancing Health in America

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Submitted electronically

Re: Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,000 hospital-based home health (HH) agencies, and our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the calendar year (CY) 2023 HH prospective payment system (PPS) proposed rule.

Our comments address multiple issues, including our concern about CMS's proposed behavioral offset. **The AHA strongly urges the agency to halt this proposed cut, which it states is necessary to ensure budget neutral implementation of the new HH PPS case-mix system.** The offset was calculated using flawed assumptions and, at 7.69 percent, would be of an unprecedented magnitude. In addition, we are concerned about the inadequacy of the proposed market basket given the extraordinary inflationary environment in which we continue to operate. **As such, we urge CMS to discuss further how it will account for these increased costs to ensure that beneficiaries continue to have access to quality HH care.**

HH PPS PAYMENT-RELATED PROPOSALS

Patient-driven Groupings Model (PDGM) Behavioral Offset

The AHA is concerned that CMS's proposed behavioral offset is based on flawed assumptions and, as such, would inappropriately penalize HH providers. Specifically, it fails to account for the drop in average per-episode therapy services under PDGM, which would have substantially reduced payments under the prior case-mix system. The behavioral offset implemented in CY 2020 also was too high due to this shortcoming; it not only reduced payments inappropriately in that year, but also in subsequent years due to the carry-over effect. **As such, we urge CMS not to finalize any budget neutrality adjustment for CY 2023. Instead, we ask the agency to re-evaluate its PDGM budget neutrality methodology to account for the drop in therapy in CY 2020 and subsequent years. Doing so could substantially reduce or negate the need for any behavioral offset, or actually create the need for a future restoration of funds.**

In compliance with the Balanced Budget Act (BBA) of 2018, CMS implemented the PDGM case-mix system together with a 30-day payment episode on Jan. 1, 2020. PDGM primarily bases payments on the clinical characteristics of the patient instead of the patient's therapy volume, which was the prior approach. This law called for a budget neutral implementation that centered on the new 30-day episode of care, not the new case-mix system.

The BBA did not specify a particular methodology for determining budget neutrality. Indeed, CMS's budget neutrality adjustment for CY 2020 was set prospectively based on three assumptions regarding providers' expected behavioral changes. Specifically, CMS assumed that HH agencies would alter their coding of primary as well as secondary diagnoses, both of which are key drivers of the PDGM payment setting process. In addition, the agency's third assumption was that the number of low-volume cases, known as low-utilization payment adjustment (LUPA) cases, would decrease. As discussed in our CY 2022 comment letter, these three behavioral assumptions did not match actual behavior by the field in CY 2020, which raised serious doubts about the accuracy of the original CY 2020 behavioral offset.

This rule proposes a second behavioral offset of 7.69% to the 30-day episode payment rate in CY 2023, which adds to the agency's original behavioral offset of 4.36% in CY 2020. CMS states that the application of an additional offset reflects its statutory requirement to alter HH PPS payments to ensure PDGM budget neutrality. By law, this adjustment process will occur each year through 2026, although the agency deferred action in CY 2022 in response to the COVID-19 pandemic. Therefore, the agency's prior and proposed PDGM behavioral offsets are initial steps in a multi-year series of adjustments that, collectively, carry out the legislative mandate for budget neutrality, which includes two types of behavioral offsets:

- Temporary adjustments to recoup or repay *past* over or underspending; and
- Permanent adjustments to ensure that *future* spending neither increases nor decreases relative to what otherwise would have been paid.

CMS Overlooks Changes in Care Delivery. **AHA supports the analysis commissioned by the Partnership for Quality Home Healthcare, which raises substantial concerns with the need for and accuracy of the CY 2023 proposed budget neutrality cut.** Specifically, we are concerned that CMS's methodology for determining budget neutrality does not account for the drop in average per-episode therapy services under PDGM. This, and other fundamental changes, means that CMS cannot simply "reprice" PDGM claims to estimate what payments would have been under the prior model, as it has done in the past and proposes to do again.

Indeed, as part of implementing a new SNF case-mix system, CMS recognized that budget neutrality calculations must account for the fact that a new system can yield a fundamentally different scope of services than the prior system. In fact, in the FY 2023 proposed rule, CMS ruled out any comparison of SNF services across the former and new case-mix systems because the unit of care had significantly changed due to new incentives to reduce therapy services in SNFs:[1]

> Between October 2019 and December 2019, the 3 months after PDPM implementation and before the onset of the COVID-19 PHE, the average number of therapy minutes SNF patients received per day dropped to approximately 68 minutes per utilization day, a decrease of approximately 27 percent."
>
> Given this reduction in therapy provision since PDPM implementation, we found that using patient assessment data collected under PDPM would lead to a significant underestimation of what RUG-IV case-mix and payments would have been (for example, the Ultra-High and Very-High Rehabilitation assignments are not nearly as prevalent using PDPM-reported data), which would in turn lead to an overcorrection in the parity adjustment.[2]

By contrast, however, the fact that HH agencies reduced therapy under PDGM — the very outcome desired by CMS and prompted by PDGM's design — is deemed a behavioral change for which CMS is penalizing them. However, it actually reflects the fact that, similar to SNFs, the unit of care for HH has significantly changed. Specifically, PDGM shifted incentives away from therapy visits, which dropped by 29.7% in CY 2020, relative to CY 2019. This resulted in a different unit of care with a new clinical and cost profile, which is incomparable to the pre-PDGM unit of care. In addition, the PDGM framework with 432 payment units, a 30-day episode of care and multiple case-mix levers is significantly different, and therefore impossible to crosswalk to the old approach, with 153 payment groups, a 60-day episode, and one dominant case-mix factor (therapy volume). Given these multiple, major differences, consistent with CMS's

[1] CY 2023 SNF PPS Proposed Rule, 87 FR 22720; https://www.federalregister.gov/d/2022-07906/p-193.
[2] Ibid.

position noted above on the SNF PPS parity adjustment, PDGM-era claims from CY 2020 and 2021 cannot simply be recalculated using the prior payment system's parameters to estimate what payments would have been under the prior model. In addition, these claims were also affected by the pandemic. This makes them even more incomparable to the prior case mix system, given the extent to which the PHE globally reduced hospital and post-acute care patient volume and raised average acuity levels for both referring hospitals and every post-acute care setting, including the HH field.

The Partnership-commissioned research found that since therapy volume dropped by 29.7% in CY 2020, the claims from this year actually were paid *less* in aggregate than CMS would have paid under the prior system. In other words, PDGM itself reduced therapy services, relative to the prior system, which translated into CY 2020 payments that were lower than they otherwise would have been. Accordingly, a *positive* budget neutrality adjustment of 2.5% was actually warranted in CY 2020. In contrast, CMS's methodology did not account for this change in therapy volume; thus, it yielded a flawed finding that CY 2020 payments were higher than they otherwise would have been, leading to implementation of a negative 4.36% budget neutrality adjustment in CY 2020. **Both this CY 2020 cut, as well as the proposed CY 2023 cut should be considered over-corrections.** Further, this analysis estimates that this 4.36% cut in CY 2020 has resulted in a cumulative $2.4 billion in HH PPS payment cuts from CYs 2020 through 2023. **These findings call for CMS to revisit both its prior as well as proposed PDGM budget neutrality adjustments. Specifically, we urge the agency to re-evaluate its methodology related to the CY 2020 drop in therapy and reconcile its past budget neutrality adjustment for its impact both that year and also in subsequent years. In the meantime, the agency should not finalize any adjustment for CY 2023.**

PDGM Data Lacking. **We also are concerned that CMS has not made public the data necessary to independently replicate key calculations in the rule, which leaves stakeholders unable to fully comment on CMS's proposals.** For example, unlike it has in the past, CMS did not make available projected CY 2022 payments, which are needed to estimate the rule's fiscal impact. In addition, CMS did not make available the data used to reprice CY 2020 or CY 2021 claims from 30-day to 60-day episodes — the central calculation needed to determine and then compare actual PDGM payments with what would have been paid under the pre-PDGM system. Also, CMS has not yet made available the CY 2021 Outcome and Assessment Information Set (OASIS) data that needs to be paired with claims data to evaluate budget neutrality.

CY 2023 Payment Update

The proposed market basket update of 3.3% for CY 2023, especially when considered together with the proposed behavioral offset of 7.69%, would result in a woefully inadequate payment update. The low market basket update does not capture the unprecedented inflationary environment HH agencies, and the delivery system as a whole, are experiencing. This is because the market basket is a time-

lagged estimate that uses historical data to forecast into the future. When historical data are no longer a good predictor of future changes, the market basket methodology becomes ineffective. Indeed, using more recent data[3], the market basket for CY 2022 is trending toward 5.0%, well above the 3.1% HH PPS update implemented in the CY 2022 final rule. Additionally, while CMS proposes a productivity cut of 0.4 percentage points, the latest data actually indicate *decreases* in productivity, not gains.[4]

We are deeply concerned that these increased costs to HH agencies are not reflected in the market basket adjustment. Therefore, we ask CMS to discuss in the final rule how the agency will account for these increased costs to ensure that beneficiaries continue to have access to quality HH care. We also are concerned about the proposed reduction for productivity, and ask CMS to also elaborate in the final rule on the specific productivity gains that are the basis for the proposed 0.4% productivity offset. Such a cut does not align with HH agencies' PHE experiences related to actual losses in productivity during the pandemic.

Context of the Inflationary Economy. The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems. Health care providers remain on the front lines fighting this powerful virus, while at the same time struggling with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic. **We urge CMS to consider the changing health care system dynamics, including those described below, and their effects on HH agencies. Taken together, these shifts in the health care environment are putting enormous strain on hospitals and post-acute care providers, which will continue in CY 2023 and beyond.**

Historic inflation has continued and heightened the severe economic instability that the pandemic wrought on hospitals and health systems. Specifically, high inflation began to take hold in the second half of CY 2021, with the consumer price index (CPI), a measure of general inflation, ultimately hitting its 12-month high in June 2022 at 9.1%.[5] Fannie Mae forecasts that inflation will remain elevated through at least the end of 2022, averaging 5.5% in the fourth quarter.[6] Because this high rate of inflation is not projected to abate in the near term, it is critical to account for it when considering hospital and health system financial stability in CY 2023 and beyond. As described in a

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[3] IHS Global, Inc.'s (IGI's) forecast of the HH market basket increase, which uses historical data from OACT's 1st quarter 2022 release of market basket information with historical data through the 4th quarter of 2021

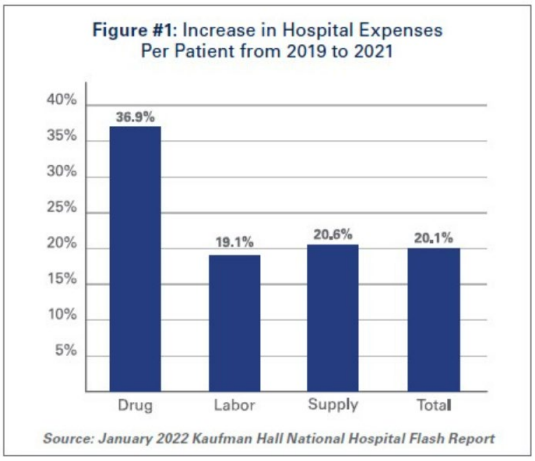
[4] "Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results." U.S. Bureau of Labor Statistics. May 5, 2022. https://www.bls.gov/news.release/pdf/prod2.pdf.

[5] U.S. Bureau of Labor Statistics. "Consumer Price Index Summary" July 13, 2022. https://www.bls.gov/news.release/cpi.nr0.htm; Statista. July 27, 2022. Monthly 12-month inflation rate in the United States from June 2021 to June 2022. https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/

[6] "Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'." Fannie Mae, April 19, 2022. https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing

report by FTI consulting, which is attached to this letter, more recent inflationary pressures also are likely to work their way into wage expectations, particularly in industry sectors such as health care where labor is in short supply, thus driving up costs even further.

Indeed, the financial pressures providers are experiencing are massive. Expenses continue to rise across the board from increasing costs for labor, drugs, purchased services, personal protective equipment (PPE), and other medical and safety supplies needed to care for patients. Specifically, an April 2022 report by the AHA highlights the significant cost growth in hospital expenses across labor, drugs and supplies (as shown in the reproduced chart below), as well as the impact that rising inflation is having on hospital prices. By the end of calendar year 2021, total hospital expenses per adjusted discharge were up 20.1% compared to pre-pandemic levels in 2019.



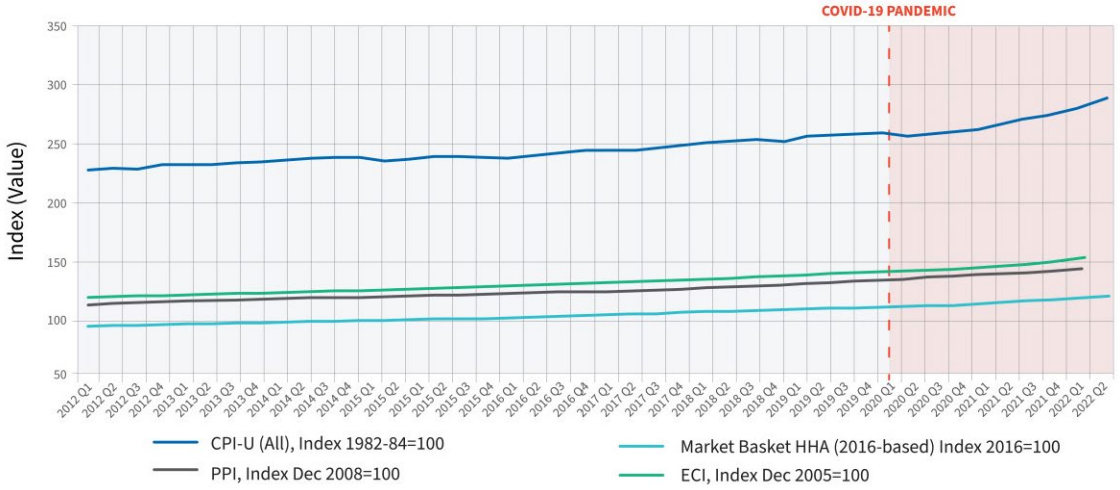
Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the final CY 2023 payment update is essential to ensure that Medicare payments for services more accurately reflect the cost of providing care.

Market Basket. CMS proposes a market basket update of 3.3%, reduced by a productivity adjustment of 0.4 percentage points, resulting in an update of 2.7% for CY 2023. These estimates were produced using historical data through the fourth quarter of CY 2021, forecast into the future. In a steady-state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. That is, the rationale for using historical data as the basis for a forecast is reasonable in a typical economic environment. However, we are not in a typical economic environment. **The end of CY 2021 into CY 2022 should not, in any sense, be considered a steady-state economic environment that is a continuance of past trends. Relying on this timeframe results in a woefully inadequate market basket update that will exacerbate Medicare underpayment if not corrected.**

Specifically, the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs faced by the health care industry beginning in late CY 2021. For its CY 2022 final market basket update of 3.1%, CMS utilized estimates from historical data through the first quarter of CY 2021, forecast into the future. Because this market basket was a forecast of what was *expected* to occur, it missed the *unexpected* trends that actually did occur. For example, the inflation rate in March 2021 was 2.6%, but by December 2021 it skyrocketed to 7%.[7] Clearly, the CY 2022 market basket was unable to capture the extraordinarily high inflationary spikes that occurred towards the latter half of CY 2021.

In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction dulls the impact of any unexpected spikes that occur. For instance, the market basket uses three price proxies to measure price changes over time — the Employment Cost Index (ECI), which measures changes in compensation costs; the Consumer Price Index (CPI), which measures changes in prices paid by consumers; and the Producer Price Index (PPI), which measures changes in price experienced by producers. The figure below,[8] created by FTI, shows the three components that make up the market basket. In particular, CPI has a significantly steeper upward trend than is reflected in the market basket for HH services. This suggests that when the market basket captures shocks, it is much more muted than

Figure 3: Price Index, Cost Index, and CMS Market Basket Index Home Health Agency, Quarterly, Seasonally Adjusted (2012-2022)



[7] https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/

[8] Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group.

what HH agencies actually experience because it is a time-lagged rolling average estimate. Again, in a steady-state economy with small and stable changes in inflation and costs, this may be a reasonable approach. However, in an atypical environment, such as the one we are currently in, payment updates must adequately account for these dynamic changes.

Productivity. Under the Affordable Care Act, the HH payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[9] This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For CY 2023, CMS proposes a productivity cut of 0.4 percentage points.

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. **Thus, this measure effectively assumes that HH agencies can mirror productivity gains across the private nonfarm business sector. However, in an economy marked by great uncertainty due to inflation as well as demand and supply shocks, this assumption generates significant departures from economic reality.**

In fact, CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run. Specifically, research indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[10] Thus, using the private nonfarm business sector TFP to adjust the market basket for providers, including hospital-based HH agencies, exacerbates Medicare underpayments — which is particularly burdensome when coupled with record inflation.

The use of an adjustment that is a 10-year moving average also negates year-to-year fluctuations that might occur. For example, over the last decade, there have been four quarters of productivity decreases. Two of these quarters occurred during the past 12 months — a 0.4 percent decline in the third quarter of calendar year 2021 and a 0.6 percent decline in the first quarter of CY 2022.[11] Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. **Although the productivity adjustment uses a 10-year**

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[9] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

[10] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

[11] U.S. Bureau of Labor Statistics. (May 13, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. https://www.bls.gov/news.release/pdf/prod2.pdf, https://www.bls.gov/opub/ted/2022/nonfarm-business-labor-productivity-down-0-6-percent-from-first-quarter-2021-to-first-quarter-2022.htm.

moving average, two quarter declines in 12 months in this metric is also noteworthy enough that it should be considered when deciding upon the appropriate productivity adjustment to implement for FY 2023.

In addition, whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for health care services. Generally, HH agency service levels have not completely recovered to pre-pandemic levels and it is highly unlikely that providers have achieved the significant productivity gains incorporated into the proposed CY 2023 payment update.

Further, the combination of employee burnout and fewer available staff have forced healthcare providers to rely heavily on contract staff, especially contract nurses. The loss of established employees and the reliance on contract staffing firms to help address staffing shortages all echo our members' experiences related to declines in productivity during the pandemic, not gains. Indeed, an October 2021 survey conducted by Kaufman Hall found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[12]

The AHA has deep concerns about the proposed productivity cut of 0.4%, given the extreme and uncontrollable circumstances all providers, including hospital-based HH agencies, are currently operating in. It is clear that significant uncertainty will continue to persist regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions and the war in Ukraine) continue to affect productivity. This uncertainty, as well as the continued divergence in hospital productivity from overall private nonfarm business sector productivity, as extended to the HH field, must be accounted for in the CY 2023 payment update.

PROPOSED CAP ON WAGE INDEX DECREASES

We support the proposal to implement a permanent 5.0% cap on any decrease to a provider's wage index, relative to the prior year, which would mitigate instability and increase predictability in HH PPS payments from year to year. We note that this proposal was recently implemented in the FY 2023 final payment rules in a budget-neutral manner in combination with an area wage level budget neutrality factor. **However, we continue to urge CMS to modify its proposal to instead implement the change in a non-budget-neutral manner for the HH PPS and well as all other payment systems.**

PROPOSED REASSIGNMENT OF CERTAIN UNSPECIFIED DIAGNOSIS CODES

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[12] https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates

In general, the AHA supports CMS' proposed changes contained within the section for Proposed Reassignment of Specific ICD-10-CM Codes under the Patient Driven Groupings Model (PDGM). These proposed changes seem reasonable given the data and information provided specific to the ICD-10-CM codes, with the exceptions noted below.

The AHA acknowledges that CMS identified 159 ICD–10–CM diagnosis codes currently accepted as a principal diagnosis that have more specific codes available for such medical conditions that would more accurately identify the primary reason for home health services. CMS explained that in accordance with the expectation that the most precise code be used, CMS believes that these 159 ICD-10-CM diagnosis codes are not acceptable as principal diagnoses, and therefore proposes to reassign these codes to "no clinical group'' (NA).

The AHA supports the promotion of complete, accurate documentation and coding application. The AHA also agrees that the most specific code should be used to identify all medical conditions. However, the AHA does not support CMS's decision to not accept these 159 ICD-10-CM diagnoses as acceptable principal diagnoses when by definition within the Medicare Code Edits Manual (Definition of Medicare Code Edits V39.1 (ZIP) these diagnosis codes are supported for use as principal diagnosis. We request that CMS reconsider this decision, as well as consider the fact that that these 159 codes representing unspecified diagnoses codes would require the same treatment and resource consumption as the more specified codes, especially in cases that identify laterality.

The AHA would also like to address CMS' proposal to reassign these 159 ICD-10-CM diagnosis codes to "no clinical group" (NA). There are currently 42,788 of the 72,749 ICD-10-CM codes that are designated as "no clinical group" (NA). (Reference https://www.cms.gov/files/zip/cy-2023-proposed-hh-clinical-group-and-comorbidity-adjustment-diagnosis-list.zip). The AHA acknowledges CMS' notation in this proposed rule, that codes currently in the "no clinical group" (NA) are not relevant to home health. The AHA also recognizes that CMS stated that if an ICD-10-CM diagnosis code is to be reassigned from one clinical group or comorbidity subgroup to another that may affect payment, then CMS believes it is appropriate to propose these changes through notice and comment rulemaking.

The AHA appreciates CMS' explanation that CMS relies on the expert opinion of their clinical reviewers and current ICD-10-CM coding guidelines to determine if the ICD-10-CM diagnosis codes under review for reassignment are significantly similar or different to the existing clinical group and/or comorbidity subgroup assignment. The intent of the clinical groups being to reflect the reported principal diagnosis, clinical relevance, and coding guidelines and conventions. CMS also noted that for purposes of assignment of ICD-10-CM diagnosis codes into the PDGM clinical groups they would not conduct

additional statistical analysis as such decisions are clinically based and the clinical groups are part of the overall case-mix weights.

The AHA acknowledges that under the Patient-Driven Groupings Model (PDGM), each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis as reported on home health claims. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit.

The AHA acknowledges that CMS shared within this CY 2023 Home Health Prospective Payment System (HH PPS) proposed rule the recent changes to the MCE reflected in the FY 2022 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) final rule (86 FR 44940 through 44943). Within that FY 2022 IPPS rule, CMS finalized the implementation of new MCE 20, effective 4/1/2022, to expand the list of unacceptable principal diagnoses for ''unspecified'' ICD-10-CM diagnosis codes when there are other diagnosis codes available in that diagnosis code subcategory that further specify the anatomic site.

The AHA also acknowledged the emphasis by CMS that within the PDGM although all diagnosis codes are used for grouping and validation purposes, if a diagnosis is not assigned to a clinical group, it is either: not a condition that would be primarily treated in a home health setting, or the diagnosis should not be reported as a principal diagnosis according to ICD-10-CM coding guidelines.

Within this CY 2023 proposed HH PPS rule, CMS acknowledged that the ICD-10-CM diagnosis code list is updated each fiscal year, effective October 1st. And, that the HH PPS has at a minimum two (Home Health Grouper Software) HHGS releases, October, and January each year to ensure that claims are submitted with the most current code set available. Additionally, CMS noted that if there are new ICD-10-CM codes created for emergency use or a new or revised edit in the Medicare Code Editor (MCE), additional updates to the HHGS may occur.

Given that the MCE is within the framework of the HHGS, a review was completed comparing the 159 proposed ICD-10-CM codes in Table 1.A unspecified diagnosis codes proposed to be reassigned to "no clinical group" (NA) to the Definitions of Medicare Code Edits, v39.1 April 2022, MCE 20.

- There are currently 3,432 ICD-10-CM codes included in the MCE 20 (FY 2022).
- Forty-five of the 159 proposed ICD-10-CM codes in Table 1.A are included in the MCE 20. The remaining 114 are not included in the MCE 20. (See the attached table with bold items).

The AHA strongly urges that CMS re-consider the proposal to reassign these 159 ICD-10-CM codes to "no clinical group" (NA) for the reasons noted below:

- There are inconsistencies between the list of 159 ICD-10-CM codes on Table 1.A and the current MCE 20 list of ICD-10-CM codes as noted. An unspecified edit

for all health care entities should be consistent in guidance and application according to coding guidelines and the MCE Definition Manual as inconsistencies have potential to create claims submission challenges.

- The AHA supports that the most specific documentation be reflected in all medical records to ensure accurate, specific, and complete ICD-10-CM code assignments. While the greatest specificity should be used whenever possible, there are valid circumstances when unspecified codes can and should be used. Please reference Section I.B.18 of the *ICD-10-CM Official Guidelines for Coding and Reporting "official coding guidelines"* - Use of Sign/Symptom/Unspecified Codes. As stated in these guidelines, it is acceptable to report the appropriate "unspecified" code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.
- The burden of obtaining specificity for some of these codes (e.g., abdominal wall lacerations/ thorax unspecified codes) will be challenging for home health organizations. While some may have access through integration of hospital records, other home health organizations not connected to a hospital record system will experience delays in obtaining needed information from providers or the discharging facility, or they may encounter the inability to obtain the specificity at all. Additionally, since many home health services are provided as a "subsequent encounters," after the active treatment has been completed, specificity regarding the original injury may not be included in any home health documentation.

Providing that the above noted areas of concern are addressed by CMS, the AHA would be supportive of a similar type of MCE edit to address "unspecified" codes for home health claims. However, we request that any type of similar edit be a phased in approach to allow home health providers the time to address documentation improvement initiatives that could better prepare these teams to adapt to potential operational challenges. This approach is like the approach suggested by commenters in response to the IPPS FY 2022 proposed rule, and, in which CMS modified the approach and timeline implementation for MCE 20.

QUALITY REPORTING-RELATED PROPOSALS

HH Quality Reporting Program (HH QRP)

CMS does not propose to adopt any new quality measures or standardized patient assessment data elements (SPADEs) in this rule. The agency does propose to require HHAs to report quality data on all patients, regardless of whether they are Medicare beneficiaries. CMS also solicits comments on potential future measures for inclusion in the HH QRP as well as on how the agency can leverage its programs to advance health equity.

Collection of Quality Data Regardless of Payer. Beginning January 1, 2024, CMS would require all HHAs to submit all-payer patient assessment data from OASIS; the agency would use this data to calculate all OASIS-based measures. While the OASIS has been used since 1999, concerns regarding privacy of non-Medicare patient data as well as burden and workflow disruption led to Congressional action to suspend required application of the patient assessment tool for non-Medicare/Medicaid patients. In this proposed rule, CMS attempts to assuage these concerns with citations of its updated data submission systems and notes that similar requirements for LTCHs and hospices as well as the passage of the IMPACT Act "require" the agency to revisit the suspension.

CMS estimates that this proposed new requirement would result in HHAs having to increase by 30% the number of assessments they complete at each time point (start of care, resumption of care, follow-up and transfer of care), with a corresponding 30% increase in their estimated hourly burden and estimated clinical purposes; this means it would add approximately 296.3 hours of clinician work per HHA. According to the agency, this will cost each HHA a yearly average of $23,529.82, culminating in increased costs to the field of $267,157,680 per year.

The HHA workforce is already overburdened by administrative requirements — many with questionable value — and as CMS adds more and more SPADEs to the OASIS, there is less and less time for patient care. Because of the substantial increase in burden associated with this proposal, **the AHA suggests that CMS extend the timeline for the implementation of this requirement until at least Jan. 1, 2025 to give providers time to prepare.**

Request for Information on Health Equity. CMS asks for input on how it can assess and address drivers of health care quality disparities within the HH QRP specifically. The agency explains that it is considering the adoption of a structural composite measure for the HH QRP that would assess organizational activities to address access to and quality of HH care for underserved populations. The measure would assess performance across three domains — organizational priorities, training and culture — where an HHA would receive a "point" for meeting a domain by submitting data on certain activities to a CMS portal.

A similar measure was recently finalized for adoption in the Hospital Inpatient Quality Reporting Program (IQR); the AHA supported the adoption of the Hospital Commitment to Health Equity quality measure, but recommended specific improvements to the measure and its implementation that we believe will increase its utility and likelihood to meaningfully reduce disparities in health outcomes. Unfortunately, CMS did not incorporate our recommendations and finalized the measure as proposed. We will make similar recommendations in our response to the request for comment in the HH proposed rule in hopes that CMS will give them more serious consideration as it develops a potential measure assessing HHA commitment to health equity.

First, the AHA urges CMS to develop clear definitions of key terms and specific examples to accompany any measure so that HHAs can thoughtfully consider their attestations to the various domains and provide accurate, complete and consistent responses. Across the three domains listed in the proposed rule, there are eight individual attestations reflecting particular equity-related practices. On the whole, we believe the practices included in the attestations reflect relevant and important practices. However, some of the terms used in the attestations could be subject to a range of interpretations, and we are concerned that not all HHAs would respond to them in the same way. CMS could improve the accuracy of responses by developing guidance documents, educational resources and other mechanisms.

For example, Domain 1 assesses a HHA's commitment to reducing disparities by determining whether equity is a key organizational priority; an HHA could demonstrate this commitment by attesting that its strategic plan includes approaches to address health equity in the reporting year. A strategic plan related to equity can take many forms: a standalone document, a pillar of a broader organizational plan, high-level objectives over a long time period or operational objectives on an annual or quarterly basis. CMS should clarify what it's looking for in "data" that an HHA submits that would satisfy this domain. Similarly, this domain would also ask HHAs to report on their community engagement and key stakeholder activities; CMS should provide examples of these activities.

Second, the AHA recommends that CMS avoid an "all or nothing" approach to scoring a potential composite measure, and instead award points for each individual attestation a HHA is able to complete. We believe this approach would make a measure more transparent and usable to both HHAs and the public. As finalized, the similar IQR measure awards a score out of five points based on how many domains a hospital meets; there is no "partial credit," as hospitals must affirmatively attest to all elements within each domain in order to earn the point. As AHA's Institute for Diversity and Health Equity explains in our Health Equity Roadmap, health care providers can be in several positions along a continuum in their journey to eliminate disparities in health outcomes and transform their organizations into a sustainable and equitable ecosystem within the community. It is thus challenging to apply a binary (yes/no) assessment to fluid and nuanced activities.

Further, the "all or nothing" approach used in the IQR measure results in what appears to be inadvertent weighting of the individual attestations within each domain. For example, if one domain comprises four elements and another comprises two, an approach that does not recognize individual elements would apply twice the weight to each element in the latter domain as to those four in the former domain as they would all sum to one point per domain. We note that the "level of effort" for each individual attestation could look quite different; providing resources to staff about health equity may not be as significant an undertaking as implementing certain key stakeholder activities. By rolling up practices into domain scores, CMS may obscure performance on

individual practices, making it harder to know specifically where HHAs need improvement or meaningfully benchmark against other agencies.

Consistent with the steadfast dedication of America's hospitals and other health care providers to advancing health equity within their organizations and in their communities, the AHA supports the concept of a structural measure assessing HHAs' commitment to health equity. We urge CMS to consider these recommendations as they develop such a measure to ensure that it results in meaningful, actionable and transparent information.

Home Health Value-based Purchasing (HHVBP) Program. CMS proposes to change the HHA baseline year for the expanded HHVBP program from CY 2019 (for HHAs certified prior to Jan. 1, 2019)/CY 2021 (for HHAs certified between Jan. 1, 2019 and Dec. 31, 2021) to CY 2022 beginning with the CY 2023 performance year. CMS also proposes to change the Model baseline year from CY 2019 to CY 2022 for the CY 2023 performance year and subsequent years. The agency reasons that CY 2022 would provide a more appropriate baseline for assessing HHA improvement than data from before the PHE for COVID-19. **The AHA supports this proposal, but again reiterates our doubts about the nationwide expansion of the HHVBP program in a "post"-COVID-19 world.** It is unclear whether the HHVBP, which began as a demonstration in a handful of states in 2016, will produce the results CMS expects following the devastation of COVID-19. Thus we encourage the agency to monitor closely not only performance in the national model going forward, but also how that performance compares to the experience of the demonstration program to determine whether substantive changes to the program should be considered.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact me, or have a member of your team contact Joanna Hiatt Kim, vice-president of payment policy, at jkim@aha.org regarding the payment provisions, or Caitlin Gillooley, director of policy, at cgillooley@aha.org regarding the quality and home infusion therapy provisions.

Sincerely,

Stacey Hughes
Executive Vice President for Government Relations and Public Policy
American Hospital Association

TABLE 1.A - Unspecified Diagnosis Codes - those in yellow ARE on the MCE 20 list FY 2022					
ICD-10 CM CODE	CODE DESCRIPTION	CURRENT	CURRENT CLINICAL GROUP DESCRIPTION	REASSIGN	REASSIGNED CLINICAL GROUP DESCRIPTION
G51.39	Clonic hemifacial spasm, unspecified	B	Neurological Rehabilitation	NA	NA
G90.50	**Complex regional pain syndrome I, unspecified**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
H05.20	Unspecified exophthalmos	A	MMTA - Other	NA	NA
H10.229	Pseudomembranous conjunctivitis, unspecified eye	A	MMTA - Other	NA	NA
H20.9	Unspecified iridocyclitis	A	MMTA - Other	NA	NA
H26.30	Drug-induced cataract, unspecified eye	A	MMTA - Other	NA	NA
H44.729	Retained (old) fb in iris or ciliary body, unsp eye	A	MMTA - Other	NA	NA
I80.239	**Phlebitis and thrombophlebitis of unspecified tibial v**	**H**	**MMTA - Cardiac and Circulatory**	**NA**	**NA**
I82.409	**Acute embolism and thombos unsp deep vn unsp low**	**H**	**MMTA - Cardiac and Circulatory**	**NA**	**NA**
I83.899	Varicos vn unsp lower extremity with other complicati	H	MMTA - Cardiac and Circulatory	NA	NA
L97.301	**Non-prs chronic ulcer of unsp ankle limited to brkdwr**	**C**	**Wounds**	**NA**	**NA**
M05.60	Rheu arthritis of unsp site w involv of organs and syste	E	Musculoskeletal Rehabilitation	NA	NA
M05.70	Rheu arthritis w rheu factor of unsp site w/o org/sys in	E	Musculoskeletal Rehabilitation	NA	NA
M50.00	**Cervical disc disorder with myelopathy, unsp cervical**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
M86.8X9	**Other osteomyelitis, unspecified sites**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
N70.91	Salpingitis, unspecified	A	MMTA - Other	NA	NA
N70.92	Oophoritis, unspecified	A	MMTA - Other	NA	NA
O00.109	**Unspecified tubal pregnancy without intrauterine pre**	**A**	**MMTA - Other**	**NA**	**NA**
O00.119	**Unspecified tubal pregnancy with intrauterine pregna**	**A**	**MMTA - Other**	**NA**	**NA**
O00.209	**Unspecified ovarian pregnancy without intrauterine p**	**A**	**MMTA - Other**	**NA**	**NA**
O00.219	**Unspecified ovarian pregnancy with intrauterine preg**	**A**	**MMTA - Other**	**NA**	**NA**
O14.10	Severe pre-eclampsia, unspecified trimester	A	MMTA - Other	NA	NA
O15.00	Eclampsia complicating pregnancy, unspecified trimest	A	MMTA - Other	NA	NA
O88.019	Air embolism in pregnancy, unspecified trimester	A	MMTA - Other	NA	NA
O88.119	Amniotic fluid embolism in pregnancy, unspecified trin	A	MMTA - Other	NA	NA
O88.219	Thromboembolism in pregnancy, unspecified trimester	A	MMTA - Other	NA	NA
O88.319	Pyemic and septic embolism in pregnancy, unsp trimes	A	MMTA - Other	NA	NA
O88.819	Other embolism in pregnancy, unspecified trimester	A	MMTA - Other	NA	NA
O91.119	Abscess of breast associated with pregnancy, unsp trim	C	Wounds	NA	NA
Q71.90	Unspecified reduction defect of unspecified upper limb	A	MMTA - Other	NA	NA
Q72.00	Congenital complete absence of unspecified lower limb	A	MMTA - Other	NA	NA
S15.019D	Minor laceration of unspecified carotid artery, subs en	C	Wounds	NA	NA
S15.029A	**Major laceration of unspecified carotid artery, init en**	**C**	**Wounds**	**NA**	**NA**
S15.119A	**Minor laceration of unsp vertebral artery, init encntr**	**C**	**Wounds**	**NA**	**NA**
S15.119D	Minor laceration of unsp vertebral artery, subs encntr	C	Wounds	NA	NA
S15.129D	Major laceration of unsp vertebral artery, subs encntr	C	Wounds	NA	NA
S15.129S	Major laceration of unspecified vertebral artery, seque	C	Wounds	NA	NA
S21.109A	**Unsp opn wnd unsp frnt wall of thrx w/o penet thor c**	**C**	**Wounds**	**NA**	**NA**
S21.109D	Unsp opn wnd unsp frnt wall of thrx w/o penet thor ca	C	Wounds	NA	NA
S21.109S	Unsp opn wnd unsp frnt wall of thrx w/o penet thor ca	C	Wounds	NA	NA
S21.119A	**Lac w/o fb of unsp frnt wl of thrx w/o penet thor cav,**	**C**	**Wounds**	**NA**	**NA**
S21.119D	Lac w/o fb of unsp frnt wl of thrx w/o penet thor cav, s	C	Wounds	NA	NA
S21.119S	Lac w/o fb of unsp frnt wl of thrx w/o penet thor cav, s	C	Wounds	NA	NA
S21.129A	**Lac w fb of unsp front wall of thrx w/o penet thor cav**	**C**	**Wounds**	**NA**	**NA**
S21.129D	Lac w fb of unsp front wall of thrx w/o penet thor cav,	C	Wounds	NA	NA
S21.129S	Lac w fb of unsp front wall of thrx w/o penet thor cav,	C	Wounds	NA	NA
S21.209A	Unsp opn wnd unsp bk wl of thorax w/o penet thor cav	C	Wounds	NA	NA
S21.209D	Unsp opn wnd unsp bk wl of thorax w/o penet thor cav	C	Wounds	NA	NA
S21.209S	Unsp opn wnd unsp bk wl of thorax w/o penet thor cav	C	Wounds	NA	NA
S21.219A	Lac w/o fb of unsp bk wl of thorax w/o penet thor cav,	C	Wounds	NA	NA
S21.219D	Lac w/o fb of unsp bk wl of thorax w/o penet thor cav,	C	Wounds	NA	NA
S21.219S	Lac w/o fb of unsp bk wl of thorax w/o penet thor cav,	C	Wounds	NA	NA
S21.229A	Lac w fb of unsp bk wl of thorax w/o penet thor cavity,	C	Wounds	NA	NA
S21.229D	Lac w fb of unsp bk wl of thorax w/o penet thor cavity,	C	Wounds	NA	NA
S21.229S	Lac w fb of unsp bk wl of thorax w/o penet thor cavity,	C	Wounds	NA	NA
S21.309A	**Unsp opn wnd unsp front wall of thrx w penet thor ca**	**C**	**Wounds**	**NA**	**NA**
S21.309D	Unsp opn wnd unsp front wall of thrx w penet thor cav	C	Wounds	NA	NA
S21.309S	Unsp opn wnd unsp front wall of thrx w penet thor cav	C	Wounds	NA	NA
S21.319A	**Lac w/o fb of unsp front wall of thrx w penet thor cav**	**C**	**Wounds**	**NA**	**NA**
S21.319D	Lac w/o fb of unsp front wall of thrx w penet thor cav,	C	Wounds	NA	NA
S21.319S	Lac w/o fb of unsp front wall of thrx w penet thor cav,	C	Wounds	NA	NA
S21.329A	**Lac w fb of unsp front wall of thorax w penet thor cav**	**C**	**Wounds**	**NA**	**NA**
S21.329D	Lac w fb of unsp front wall of thorax w penet thor cav,	C	Wounds	NA	NA
S21.329S	Lac w fb of unsp front wall of thorax w penet thor cav,	C	Wounds	NA	NA
S21.409A	**Unsp opn wnd unsp bk wl of thorax w penet thor cav**	**C**	**Wounds**	**NA**	**NA**
S21.409D	Unsp opn wnd unsp bk wl of thorax w penet thor cavity	C	Wounds	NA	NA
S21.409S	Unsp opn wnd unsp bk wl of thorax w penet thor cavity	C	Wounds	NA	NA
S21.419A	**Lac w/o fb of unsp bk wl of thorax w penet thor cavit**	**C**	**Wounds**	**NA**	**NA**
S21.419D	Lac w/o fb of unsp bk wl of thorax w penet thor cavity,	C	Wounds	NA	NA
S21.419S	Lac w/o fb of unsp bk wl of thorax w penet thor cavity,	C	Wounds	NA	NA
S21.429A	**Lac w fb of unsp bk wl of thorax w penet thor cavity,**	**C**	**Wounds**	**NA**	**NA**
S21.429D	Lac w fb of unsp bk wl of thorax w penet thor cavity, su	C	Wounds	NA	NA
S21.429S	Lac w fb of unsp bk wl of thorax w penet thor cavity, sc	C	Wounds	NA	NA
S21.90XA	**Unsp open wound of unspecified part of thorax, init e**	**C**	**Wounds**	**NA**	**NA**
S21.90XD	Unsp open wound of unspecified part of thorax, subs e	C	Wounds	NA	NA
S21.90XS	Unsp open wound of unspecified part of thorax, seque	C	Wounds	NA	NA
S21.91XA	**Laceration w/o foreign body of unsp part of thorax, i**	**C**	**Wounds**	**NA**	**NA**
S21.91XD	Laceration w/o foreign body of unsp part of thorax, sul	C	Wounds	NA	NA

S21.91XS	Laceration w/o foreign body of unsp part of thorax, sec	C	Wounds	NA	NA
S21.92XA	**Laceration w foreign body of unsp part of thorax, init**	**C**	**Wounds**	**NA**	**NA**
S21.92XD	Laceration w foreign body of unsp part of thorax, subs	C	Wounds	NA	NA
S21.92XS	Laceration with foreign body of unsp part of thorax, se	C	Wounds	NA	NA
S25.519A	**Laceration of intercostal blood vessels, unsp side, init**	**C**	**Wounds**	**NA**	**NA**
S25.519D	Laceration of intercostal blood vessels, unsp side, subs	C	Wounds	NA	NA
S27.319A	**Primary blast injury of lung, unspecified, initial encou**	**C**	**Wounds**	**NA**	**NA**
S27.319D	Primary blast injury of lung, unspecified, subs encntr	C	Wounds	NA	NA
S27.319S	Primary blast injury of lung, unspecified, sequela	C	Wounds	NA	NA
S27.329A	**Contusion of lung, unspecified, initial encounter**	**A**	**MMTA - Other**	**NA**	**NA**
S27.329D	Contusion of lung, unspecified, subsequent encounter	A	MMTA - Other	NA	NA
S27.329S	Contusion of lung, unspecified, sequela	A	MMTA - Other	NA	NA
S30.201A	Contusion of unsp external genital organ, male, init en	A	MMTA - Other	NA	NA
S30.201D	Contusion of unsp external genital organ, male, subs e	A	MMTA - Other	NA	NA
S30.201S	Contusion of unsp external genital organ, male, sequel	A	MMTA - Other	NA	NA
S30.202A	Contusion of unsp external genital organ, female, init	A	MMTA - Other	NA	NA
S31.109A	Unsp opn wnd abd wall, unsp q w/o penet perit cav, in	C	Wounds	NA	NA
S31.109D	Unsp opn wnd abd wall, unsp q w/o penet perit cav, su	C	Wounds	NA	NA
S31.109S	Unsp opn wnd abd wall, unsp q w/o penet perit cav, se	C	Wounds	NA	NA
S31.119A	Lac w/o fb of abd wall, unsp q w/o penet perit cav, init	C	Wounds	NA	NA
S31.119D	Lac w/o fb of abd wall, unsp q w/o penet perit cav, sub	C	Wounds	NA	NA
S31.119S	Lac w/o fb of abd wall, unsp q w/o penet perit cav, seq	C	Wounds	NA	NA
S31.129A	Lacerat abd wall w fb, unsp q w/o penet perit cav, init	C	Wounds	NA	NA
S31.129D	Lacerat abd wall w fb, unsp q w/o penet perit cav, subs	C	Wounds	NA	NA
S31.129S	Lacerat abd wall w fb, unsp q w/o penet perit cav, sequ	C	Wounds	NA	NA
S31.609A	**Unsp opn wnd abd wall, unsp quadrant w penet perit**	**C**	**Wounds**	**NA**	**NA**
S31.609D	Unsp opn wnd abd wall, unsp quadrant w penet perit q	C	Wounds	NA	NA
S31.609S	Unsp opn wnd abd wall, unsp q w penet perit cav, sequ	C	Wounds	NA	NA
S31.619A	**Lac w/o fb of abd wall, unsp q w penet perit cav, init**	**C**	**Wounds**	**NA**	**NA**
S31.619D	Lac w/o fb of abd wall, unsp q w penet perit cav, subs	C	Wounds	NA	NA
S31.619S	Lac w/o fb of abd wall, unsp q w penet perit cav, seque	C	Wounds	NA	NA
S31.629A	**Lac w fb of abd wall, unsp quadrant w penet perit cav**	**C**	**Wounds**	**NA**	**NA**
S31.629D	Lac w fb of abd wall, unsp quadrant w penet perit cav,	C	Wounds	NA	NA
S31.629S	Lac w fb of abd wall, unsp q w penet perit cav, sequela	C	Wounds	NA	NA
S32.416A	**Nondisp fx of anterior wall of unsp acetabulum, init**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S32.416B	**Nondisp fx of anterior wall of unsp acetab, init for op**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S32.509D	Unsp fracture of unsp pubis, subs for fx w routn heal	E	Musculoskeletal Rehabilitation	NA	NA
S37.019A	**Minor contusion of unspecified kidney, initial encoun**	**A**	**MMTA - Other**	**NA**	**NA**
S37.019D	Minor contusion of unspecified kidney, subsequent en	A	MMTA - Other	NA	NA
S37.019S	Minor contusion of unspecified kidney, sequela	A	MMTA - Other	NA	NA
S37.069A	**Major laceration of unspecified kidney, initial encoun**	**C**	**Wounds**	**NA**	**NA**
S37.069D	Major laceration of unspecified kidney, subsequent en	C	Wounds	NA	NA
S37.069S	Major laceration of unspecified kidney, sequela	C	Wounds	NA	NA
S42.023S	Displaced fracture of shaft of unspecified clavicle, sequ	E	Musculoskeletal Rehabilitation	NA	NA
S49.149A	**Sltr-haris Type IV physl fx lower end humer, unsp arm**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S52.389A	**Bent bone of unsp radius, init encntr for closed fractu**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S52.616A	**Nondisp fx of unsp ulna styloid process, init for clos f**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S52.699A	**Oth fracture of lower end of unsp ulna, init for clos fx**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S56.919A	Strain of unsp musc/fasc/tend at forarm lv, unsp arm, i	E	Musculoskeletal Rehabilitation	NA	NA
S56.919D	Strain of unsp musc/fasc/tend at forarm lv, unsp arm, s	E	Musculoskeletal Rehabilitation	NA	NA
S56.919S	Strain unsp musc/fasc/tend at forarm lv, unsp arm, sec	E	Musculoskeletal Rehabilitation	NA	NA
S56.929A	**Lacerat unsp musc/fasc/tend at forarm lv, unsp arm,**	**C**	**Wounds**	**NA**	**NA**
S56.929D	Lacerat unsp musc/fasc/tend at forarm lv, unsp arm, su	C	Wounds	NA	NA
S56.929S	Lacerat unsp musc/fasc/tend at forarm lv, unsp arm, se	C	Wounds	NA	NA
S58.129S	Part traum amp at level betw elbow and wrist, unsp ar	E	Musculoskeletal Rehabilitation	NA	NA
S59.109A	Unsp physeal fracture of upper end of radius, unsp arm	E	Musculoskeletal Rehabilitation	NA	NA
S62.163S	Displaced fracture of pisiform, unspecified wrist, seque	E	Musculoskeletal Rehabilitation	NA	NA
S62.253A	Disp fx of neck of first metacarpal bone, unsp hand, ini	E	Musculoskeletal Rehabilitation	NA	NA
S62.319A	Disp fx of base of unsp metacarpal bone, init for clos fx	E	Musculoskeletal Rehabilitation	NA	NA
S62.608D	Fracture of unsp phalanx of finger, subs for fx w routn	E	Musculoskeletal Rehabilitation	NA	NA
S62.608G	Fracture of unsp phalanx of finger, subs for fx w delay	E	Musculoskeletal Rehabilitation	NA	NA
S62.608K	Fracture of unsp phalanx of finger, subs for fx w nonun	E	Musculoskeletal Rehabilitation	NA	NA
S62.608P	Fracture of unsp phalanx of finger, subs for fx w malun	E	Musculoskeletal Rehabilitation	NA	NA
S62.608S	Fracture of unspecified phalanx of other finger, sequel	E	Musculoskeletal Rehabilitation	NA	NA
S72.066A	**Nondisplaced articular fracture of head of unsp femu**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S72.116A	**Nondisp fx of greater trochanter of unsp femur, init**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S72.116B	**Nondisp fx of greater trochanter of unsp femr, 7thB**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S72.116C	**Nondisp fx of greater trochanter of unsp femr, 7thC**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S72.356A	**Nondisp comminuted fracture of shaft of unsp femur,**	**E**	**Musculoskeletal Rehabilitation**	**NA**	**NA**
S82.446A	Nondisplaced spiral fracture of shaft of unsp fibula, init	E	Musculoskeletal Rehabilitation	NA	NA
S85.139S	Unsp injury of anterior tibial artery, unsp leg, sequela	E	Musculoskeletal Rehabilitation	NA	NA
S85.519S	Laceration of popliteal vein, unspecified leg, sequela	E	Musculoskeletal Rehabilitation	NA	NA
S91.009S	Unspecified open wound, unspecified ankle, sequela	E	Musculoskeletal Rehabilitation	NA	NA
T20.02XA	Burn of unspecified degree of lip(s), initial encounter	C	Wounds	NA	NA
T20.02XD	Burn of unspecified degree of lip(s), subsequent encou	C	Wounds	NA	NA
T69.019A	Immersion hand, unspecified hand, initial encounter	A	MMTA - Other	NA	NA
T69.019D	Immersion hand, unspecified hand, subsequent encoun	A	MMTA - Other	NA	NA
T69.019S	Immersion hand, unspecified hand, sequela	A	MMTA - Other	NA	NA
T69.029A	**Immersion foot, unspecified foot, initial encounter**	**A**	**MMTA - Other**	**NA**	**NA**
T69.029D	Immersion foot, unspecified foot, subsequent encount	A	MMTA - Other	NA	NA
T69.029S	Immersion foot, unspecified foot, sequela	A	MMTA - Other	NA	NA

REPORT

Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System

Overview

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule for the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS), projecting a market basket update of 3.1 percent, to be reduced by a 0.4 percent productivity adjustment.[1] This year marks the third consecutive rate setting period mired in pandemic-related uncertainty. While federal relief funding sustained hospitals and health systems through the initial waves of COVID-19, providers continue to grapple with myriad financial pressures, from supply chain disruptions to labor shortages to rising inflation. FTI Consulting's analysis finds that reliance on lagging indicators of hospital costs to determine prospective market basket and productivity adjustments in this highly dynamic and uncertain health care environment would likely result in significant underpayments to acute care hospitals in FY 2023.

[1] FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

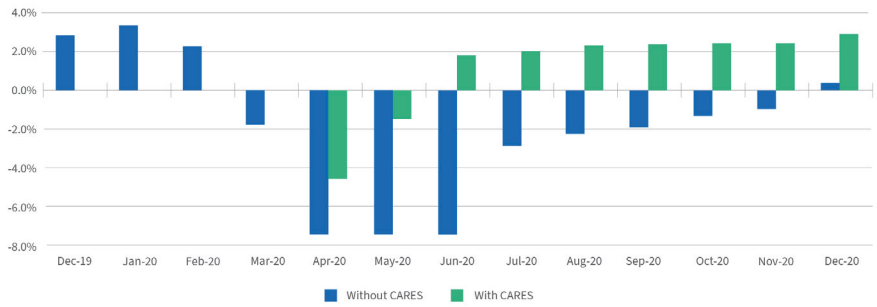
Background: Financial Condition of U.S. Hospitals

Impacts of COVID-19 Continue to Reverberate

The U.S. health care system has undergone a period of severe disruption in recent years driven by the COVID-19 pandemic and record-high inflation. In the early stages of the pandemic, hospitals curtailed elective procedures to free up capacity to care for COVID-19 patients while demand for emergency services dropped as a result of lockdowns.[2,3] Coupled with a rise in the number of uninsured patients, this dramatic decline in patient volume cut off many hospitals' most essential revenue streams,[4] just as the cost of providing care began to rise. Although Congress and the Biden Administration implemented numerous policies to lessen the adverse impact of the pandemic, including the creation of the Provider Relief Fund (PRF), which allocated over $170 billion to heath care providers,[5] financial challenges persist for many hospitals.

Though many hospitals have long struggled to stay afloat on narrow margins, the COVID-19 pandemic put additional, unforeseen strains on hospitals and health systems, particularly in rural and underserved areas. Skyrocketing expenses – driven by the rising cost of supplies, supply chain issues, and labor shortages – led to a 14.4 percent increase in labor expenses per adjusted discharge in 2020 compared to pre-pandemic levels.[6] As a result of this and other pandemic-related challenges, hospitals' median operating margins fell 55.6 percent in 2020 and have yet to fully recover (Figure 1).[7] More recently, during the peak of the Omicron surge in early 2022, government assistance to hospitals was insufficient to fully offset inflationary pressures, alongside continuing supply chain challenges, and widespread labor shortages that caused wage escalation, leaving many hospitals in the red.[8] In April 2022, total expenses and total labor expenses were 25.2 and 26.2 percent higher than 2020 levels, respectively.[9] As federal COVID-19 funds are depleted and inflationary pressures continue to escalate, hospitals are likely to remain embroiled in a precarious financial position throughout the remainder of 2022 and into FY 2023.

Figure 1: Kaufman Hall Operating Margin Index YTD by Month



Source: "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021.

[2] Mattingly, Aviva S., Liam Rose, Hyrum S. Eddington, Amber W. Trickey, Mark R. Cullen, Arden M. Morris, and Shery M. Wren. "Trends in US Surgical Procedures and Health Care System Response to Policies Curtailing Elective Surgical Operations During the COVID-19 Pandemic." JAMA Network Open. JAMA Network, December 8, 2021. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786935.

[3] Hartnett, Kathleen P., Aaron Kite-Powell, Jourdan DeVies, Michael A. Coletta, Tegan K. Boehmer, Jennifer Adjemian, and Adi V. Gundlapalli. "Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019–May 30, 2020." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, June 11, 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm.

[4] Boserup, Brad, Mark McKenney, and Adel Elkbuli. "The Financial Strain Placed on America's Hospitals in the Wake of the COVID-19 Pandemic." The American Journal of Emergency Medicine. Elsevier Inc., July 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7347328/#:~:text=The%20financial%20strain%20created%20by,the%20current%20surge%20in%20unemployment.

[5] Biniek, Jeannie Fuglesten, Nancy Ochieng, MaryBeth Musumeci, and Tricia Neuman. "Funding for Health Care Providers during the Pandemic: An Update." KFF, January 27, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/.

[6] "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2021.

[7] "High Hospitalization Rates, Consumer Fears Hit Hospitals, Physician Groups Hard." Kaufman Hall, January 25, 2021. https://www.kaufmanhall.com/news/high-hospitalization-rates-consumer-fears-hit-hospitals-physician-groups-hard.

[8] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

[9] Ibid.

Even setting aside pandemic-related pressures, Medicare has historically under-reimbursed hospitals for their services, putting them in a deficit position. Hospitals' aggregate Medicare margins have ranged from -5.4 percent to as low as -9.9 percent over the last decade according to the Medicare Payment Advisory Commission (MedPAC).[10,11] In its most recent report to Congress, MedPAC predicted that IPPS hospitals' Medicare margins will be around -9 percent in 2022 even after COVID-19 relief funds are factored in, and nearly -10 percent without COVID-19 relief.[12] These persistent negative margins in uncertain economic times demonstrate the importance of ensuring that adjustments to IPPS payment rates reflect the current financial reality faced by hospitals and health systems.

Macroeconomic-Level Factors

IPPS, which determines payments for acute care hospital inpatient stays under Medicare Part A, relies on lagging indicators of hospital costs to set reimbursements prospectively.[13] For example, the FY 2023 proposed payment adjustments incorporate FY 2021 Medicare Provider Analysis and Review (MedPAR) data, as well as FY 2020 Medicare Cost Reports, while relying upon a 2018-based market basket to determine cost and expenditure weights and the third quarter 2021 Employment Cost Index (ECI) to predict changes in the price proxies.[14] This results in a projected market basket update of 3.1 percent, which is then reduced by 0.4 percentage points to account for a productivity adjustment.[15] To the extent that historical data are good predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment. To that end, these lagging indicators and outdated data do not adequately capture and thereby cannot predict the significant disruptions created by the COVID-19 pandemic for hospitals, health systems, and other providers.

"To the extent that historical data are good predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment."

The demand and supply shocks experienced during the early years of the pandemic and continuing well into this year strongly indicate that great caution and consideration must be factored into calculating the market basket and productivity adjustments in setting prospective payment rates. In the FY 2023 IPPS proposed rule, price proxies in the market basket reflect IHS Global Inc.'s (IGI's) fourth quarter 2021 forecast, which is based on a four-quarter percentage change in the moving average. Although these adjustments are based on forecasts using the most recent data available at the time of the proposed rate setting, the results are released on a lagged basis, usually three to four months after preparation of the forecast. As such, they do not adequately account for recent economic trends that have significantly increased costs to hospitals, including labor and inflation.

Hospital Labor Costs and Workforce Shortages

Hospitals and health systems have been especially hard hit by the workforce shortages associated with the pandemic. The pandemic exacerbated existing shortages of physicians, nurses, and other hospital personnel by increasing competition for workers, as well as driving up the burnout rate among clinicians.[16] With hospital workers stretched to the limit due to the demand for hospital services and the burden of caring for severely ill patients in record numbers, widespread burnout placed enormous pressure on health

[10] "March 2021 Report to the Congress: Medicare Payment Policy." MedPAC, March 15, 2021. https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/.

[11] "March 2022 Report to the Congress: Medicare Payment Policy." MedPAC, March 15, 2022. https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/.

[12] Ibid.

[13] "FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

[14] Ibid.

[15] Ibid.

[16] "Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce." The Office of the Assistant Secretary for Planning and Evaluation (ASPE). Department of Health and Human Services, May 3, 2022. https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.

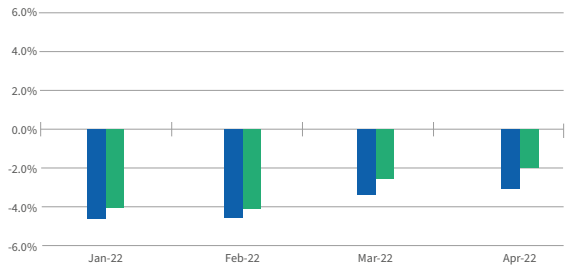
systems to pay more to attract and retain workers. That trend has yet to abate: a March 2022 report from Elsevier Health found that 47 percent of U.S. clinicians plan to leave their jobs in the next two to three years.[17]

Moreover, hospitals face more competition than ever from travel and temporary nurse staffing firms that are attracting a greater share of the workforce with higher pay and more generous benefits, a trend driving up hospital labor costs.[18] The cost of contract labor relative to total labor expenses increased five-fold in 2022 compared to 2019, primarily due to the need to replace departing staff nurses with travel or agency nurses.[19] Median wages for contract nurses reached triple the median wages of employed nurses in March 2022.[20] Due to rising labor expenses coupled with only small increases in volume and revenue, hospitals saw large declines in operating margins in January through March 2022.[21]

Although the inflated wages and benefits offered by traveling and temporary staffing nursing agencies have somewhat moderated in recent months,[22] it is unlikely that the upward pressures on labor costs for hospitals will be mitigated anytime soon. An October 2021 survey by Kaufman Hall indicated that 92 percent of hospitals have experienced challenges in attracting and retaining support staff.[23]

Significant increases in hospitals' labor costs, coupled with workforce shortages, continue to place immense strain on the health care system. All told, as of March 2022, hospital labor expenses had increased by more than one-third relative to pre-pandemic levels.[24] Hospital financials for the first quarter of 2022 returned to worrisome levels due to the Omicron surge in early 2022 (Figure 2).[25] Inflationary pressures within the economy and fierce competition for health care workers will continue to put upward pressure on wages and benefits through 2022 and likely into 2023. Using data that typically lags two to four years to project labor costs in this uncertain economic environment will fail to account for the ongoing staffing challenges faced by acute care hospitals. CMS should recognize in its market basket adjustments how the understated market basket forecasts for 2021 and 2022 due to COVID-19 and inflation are embedded in payments, as well as how upward pressure on wages and benefits, and costs of supplies and pharmaceuticals, will likely be a mid- to long-term factor adversely affecting hospital operating costs and margins.

Figure 2: Kaufman Hall Operating Margin Index YTD by Month



Source: Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022.

[17] "Clinician of the Future Report 2022." Elsevier, March 15, 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf.

[18] Yang, Y. Tony, and Diana J. Mason. "Covid-19's Impact on Nursing Shortages, The Rise of Travel Nurses, And Price Gouging." Health Affairs, January 28, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220125.695159/.

[19] "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report.

[20] Ibid.

[21] Ibid.

[22] Norman, Hannah. "Travel Nurses Raced to Help during Covid. Now They're Facing Abrupt Cuts." NBCNews.com. NBCUniversal News Group, May 8, 2022. https://www.nbcnews.com/health/health-news/travel-nurses-raced-help-covid-now-facing-abrupt-cuts-rcna27716.

[23] "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid creates#:~:text=2021%20State%20of%20Healthcare%20Performance%20Improvement%20Report%3A%20COVID%20Creates%20a%20Challenging%20Environment,-October%2018%2C%202021&text=The%20COVID%2D19%20pandemic%20continues,health%20systems%20across%20the%20country.

[24] "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report.

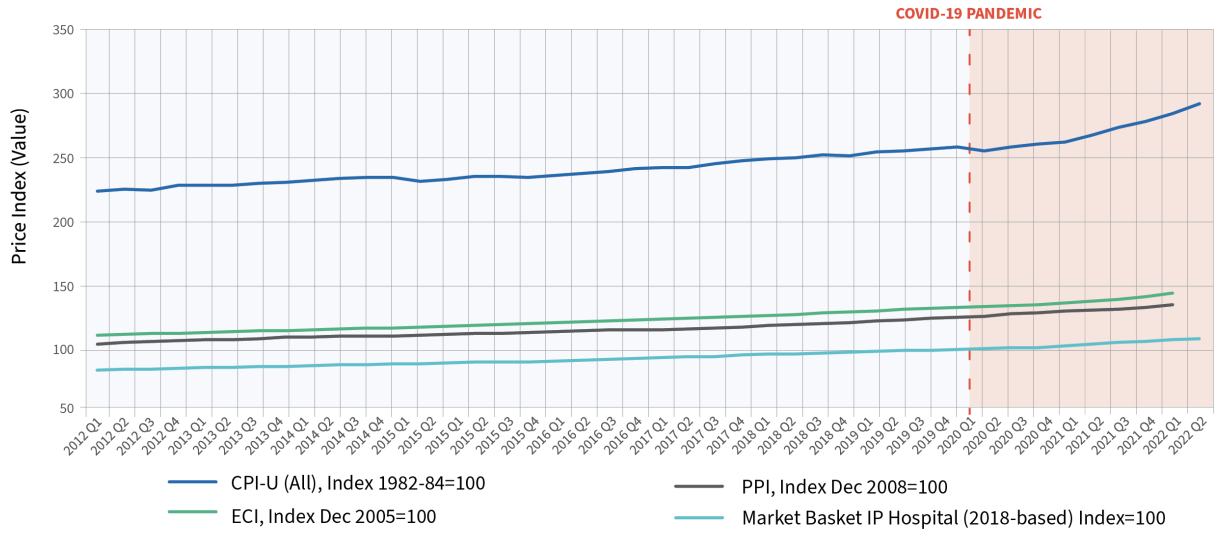
[25] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

Current and Projected Inflation

In an era of historic inflation across the broader economy, the Altarum Institute notes that health care inflation hovers close to its historic average of two percent as a result of prospective rate-setting.[26] This contrasts sharply with the Consumer Price Index (CPI), a measure of general inflation, which hit 8.6 percent over the 12-month period ending in May 2022.[27] The differential exists because health care costs paid by consumers typically reflect rates negotiated in the year prior, rather than the actual cost of inputs borne by hospitals and health systems at the time of care delivery.[28]

In a steady state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. That is the rationale for using historical data and adjusting IPPS price proxies using the ECI, a measure of compensation costs, despite its reliance on lagging indicators. However, significant changes in the CPI, which measures changes in prices paid by consumers, and the Producer Price Index (PPI), which tracks changes in price experienced by producers, can have a major impact on wage and salary expectations that can feed into future changes to the ECI. Higher inflation can create upward pressure on wage expectations as workers seek an increase in wages to better meet the increasing cost of living. This can be exacerbated when labor is in short supply, as is currently the case in the hospital sector. Figure 3, below shows the major price indices relevant to understanding these inflationary pressures for hospital workers. These data reveal that – despite shocks in price indices over time – the market basket captures these in a muted way that is in stark contrast to what hospitals and health systems actually experience.

Figure 3: Price Index, Cost Index, and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)

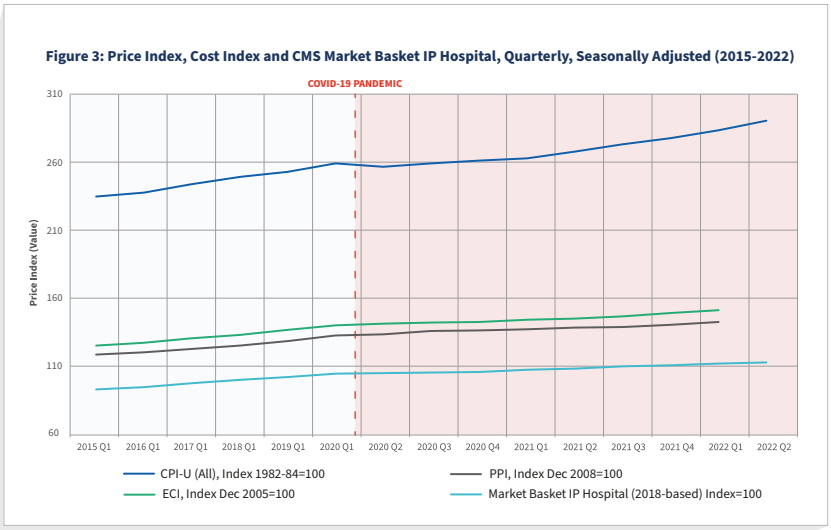


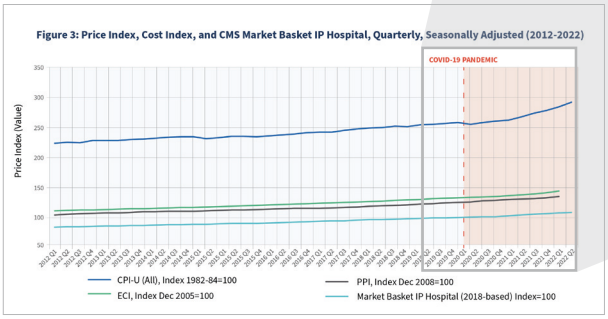
Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

[26] "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. https://www.advisory.com/daily-briefing/2022/04/15/inflation-us.

[27] "Consumer Price Index Summary - 2022 M05 Results." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, June 10, 2022. https://www.bls.gov/news.release/cpi.nr0.htm.

[28] "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. https://www.advisory.com/daily-briefing/2022/04/15/inflation-us.





Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

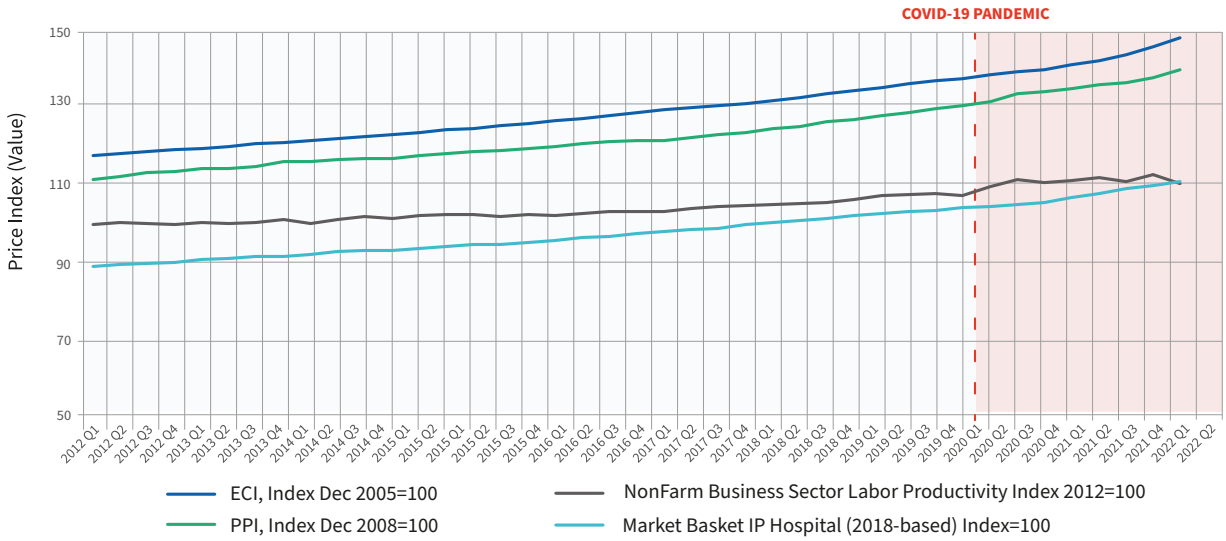
The CPI for All Urban Consumers (CPI-U) for all services shows a significantly steeper upward trend than is reflected in the market basket for inpatient hospital services. Since the start of the pandemic, this growth has exceeded growth in the Market Basket for Inpatient Hospital Services (Figure 3).[29] These more recent inflationary pressures are likely to work their way into wage expectations, particularly in industry sectors where labor is in short supply, thus driving up labor costs even further.

Using the third quarter 2021 data for market basket forecasting, as the FY 2023 IPPS Proposed Rule would do, risks capturing only the very beginning of this upward pressure on prices and wages in the economy (Figure 4).[30] Although the ECI has historically been fairly stable with annual growth rates ranging from a low of about 1.6 percent to a high of 2.8 percent just prior to the beginning of the pandemic, compensation costs have increased rapidly over the past year. From 2.6 percent in April 2021 to the most current estimate of 5.0 percent in January 2022, workers are commanding significantly higher wages. Historical data from the fourth quarter of 2021 misses this continuing upward trend in early 2022.

[29] Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

[30] Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

Figure 4: Cost Index and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)



Source: Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

Although it may reach its peak in 2022, the high rate of inflation the U.S. economy is experiencing is not projected to abate in the near term, furthering the critical need to consider the likelihood that these inflationary pressures will factor into costs and wage expectations. Fannie Mae projects that inflation, as measured by the CPI, peaked in March 2022 at an annual rate of 8.5 percent, although month-to-month changes may continue.[31] Nonetheless, Fannie Mae forecasts inflation to remain elevated, averaging 5.5 percent in the fourth quarter of 2022.[32] With respect to ECI, the Congressional Budget Office (CBO) projects a 5.4 percent increase for 2022 and a 4.1 percent increase for 2023.[33] The CBO estimates the ECI increased 5.0 percent in 2021. The CBO's projections typically fall in the middle range of the likely outcomes under current law, suggesting the possibility that the actual increase in compensation costs could be even higher.[34]

Accounting for recent and future trends in inflationary pressures and cost increases in the Hospital Market Basket will be essential to ensuring that Medicare payments for acute care services in FY 2023 more accurately reflect the cost of providing hospital care.

[31] "Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'." Fannie Mae, April 19, 2022. https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing#:~:text=Inflation%2C%20as%20measured%20by%20the,and%20declines%20in%20auto%20and.

[32] Ibid.

[33] "The Budget and Economic Outlook: 2022 to 2032." Congressional Budget Office, May 25, 2022. https://www.cbo.gov/publication/58147.

[34] Ibid.

Productivity

Under the Affordable Care Act (ACA), CMS is required to annually adjust hospital payments under the IPPS to reflect anticipated gains in productivity over time.[35] The productivity adjustment is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[36] The measure is intended to contain health care spending by ensuring payments more accurately reflect the true cost of providing hospital care. In the FY 2023 IPPS Proposed Rule, CMS proposes using IHS Global, Inc.'s (IGI's) fourth-quarter 2021 forecast of the IPPS market basket rate of increase, which uses data through third-quarter 2021.[37] This produces a projected productivity adjustment of 0.4 percentage points to the proposed FY 2023 market basket adjustment of 3.1 percent, reducing the update to 2.7 percent.[38,39]

The use of nonfarm business TFP by CMS in its productivity adjustment formula is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills, and changes in production.[40] Using private nonfarm business TFP effectively assumes the hospital sector should be able to mirror productivity gains across the broad private nonfarm business sector. However, in an economy marked by great uncertainty in performance due to the demand and supply shocks of dealing with a public health crisis such as COVID-19, this assumption may generate significant departures from economic reality.

Basing the adjustment on a 10-year moving average of the change in TFP also mitigates large year-to-year fluctuations that might occur. Over the last decade, there have been only four periods of productivity decreases. Notably, two of the periods of decreased productivity occurred during the COVID-19 pandemic – a 0.4 percent decline in July 2021 and a 0.6 percent decline in January 2022.[41] Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. Although the productivity adjustment uses a 10-year moving average for private nonfarm business productivity gains, two declines in this productivity metric should be noteworthy when considering the appropriate payment updates in the FY 2023 IPPS.

CMS has acknowledged the disconnect between Medicare productivity and the 10-year moving average private nonfarm business TFP. A 2016 analysis by the CMS Office of the Actuary (OACT) found that the average growth rate of hospital multi-factor productivity (now referred to as TFP) ranged from 0.1 percent to 0.6 percent compared with the average growth of private nonfarm business multifactor productivity (MFP) of 1.0 percent.[42] More recent research cited in the CMS OACT analysis indicates that hospitals could achieve productivity gains of 0.4 percent per year over the long run compared with an assumed growth in private nonfarm business MFP of 1.1 percent, representing just over one-third (36.3 percent) of the gains in the private nonfarm business sector.[43] Particularly in a period of record inflation and unprecedented public health challenges, using the 10-year moving average nonfarm business sector TFP to adjust the market basket percentage increase could exacerbate Medicare underpayments to hospitals.

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[35] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[36] "Compilation Of The Social Security Laws." Social Security Administration. Accessed June 1, 2022. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm.

[37] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[38] Total factor productivity is calculated as follows: *TFP growth = Output growth - [(labor input growth * labor share) + (capital input growth * capital share)].* This is a measure of changes in efficiency that cannot be accounted for by the change in total combined inputs (i.e., hours worked, capital and intermediate purchases).

[39] "FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

[40] Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[41] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[42] Spitalnic, Paul, Stephen Heffler, Bridget Dickensheets, and Mollie Knight. "Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies." CMS, February 22, 2016. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf.

[43] Ibid.

The COVID-19 pandemic continues to negatively affect hospital services, unlike other areas of private nonfarm business economy. Whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services.[44] Generally, hospital services have been slower to return to pre-pandemic levels,[45] and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the FY 2023 IPPS prospective rate adjustments. An October 2021 survey conducted by Kaufman Hall found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[46]

CMS currently relies on the most recent TFP forecast available even when economic trends, such as employment and labor productivity, are uncertain or highly variable. Recently, the COVID-19 pandemic, along with the trillions of dollars in relief funds appropriated in response, injected significant volatility into the U.S. economy. This in turn exacerbated the disconnect between projections used in the proposed rules and the most recent data available prior to finalizing the IPPS productivity adjustment. For example, in FY 2021, CMS initially proposed a negative productivity adjustment of .4 percent to the IPPS market basket,[47] which was ultimately set to zero in the final rule.[48]

According to the Bureau of Labor and Statics' (BLS) most recent release on TFP, nonfarm business sector labor productivity decreased 7.3 percent in the first quarter of 2022 as output decreased 2.3 percent and hours worked increased 5.4 percent.[49] This represents the largest decline in quarterly productivity since the third quarter of 1947.[50] This decrease in TFP is more akin to FY 2021 productivity adjustments where a decrease in productivity of 0.1 percent points resulted in a zero productivity adjustment.[51] Here, if the decrease in productivity continues into the second quarter, we should expect to see a significant reduction in the productivity adjustment, possibly even a zero productivity adjustment. It is important to note that the FY 2021 zero adjustment is based on a forecast of a 0.1 percentage point decline in TFP that pales in comparison to the most recent productivity declines.

Significant uncertainty will persist into the first half of 2023, and likely beyond, regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions, and the war in Ukraine) have affected productivity. This uncertainty, as well as the likely greater divergence of hospital services productivity from overall private nonfarm business sector productivity, should be considered in settling on a productivity adjustment for FY 2023.

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[44] "Employment Recovery Continues In 2021, With Some Industries Reaching or Exceeding Their Prepandemic Employment Levels." U.S. Bureau of Labor Statistics, May 2022. https://www.bls.gov/opub/mlr/2022/article/employment-recovery-continues-in-2021.htm.

[45] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

[46] "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates#:~:text=2021%20State%20of%20Healthcare%20Performance%20Improvement%20Report%3A%20COVID%20Creates%20a%20Challenging%20Environment,-October%2018%2C%202021&text=The%20COVID%2D19%20pandemic%20continues,health%20systems%20across%20the%20country.

[47] "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P), CMS, May 11, 2020. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute.

[48] "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule (CMS-1735-F)." CMS, September 2, 2020. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

[49] "Productivity and Costs, First Quarter 2022, Revised." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, May 5, 2022. https://www.bls.gov/news.release/pdf/prod2.pdf.

[50] Ibid.

[51] FY 2022 IPPS productivity adjustment was proposed at 0.2 percentage points based on IGI's fourth quarter 2021 forecast of TFP but IGI's second quarter 2021 forecast reflected a significant change in the estimate to 0.4 percentage points for FY 2022. The FY 2021 productivity adjustment proposed was 0.4 percentage points using IGI's fourth quarter 2019 forecast. More recent data based on IGI's June 2020 forecast indicated a -0.1 percentage point growth for FY 2021. As section 1886(b)(3)(B)(xi)(I) of the Act requires a reduction not an increase for the productivity adjustment, the adjustment was set to zero.

Conclusion: Current Economic Realities Are Not Reflected in Proposed IPPS Update, Put Hospitals' Financial Viability at Risk

As CMS prepares to finalize the FY 2023 IPPS and LTCH PPS Rule – as well as Fiscal Year 2023 Inpatient Rehabilitation Facility (IRF), Inpatient Psychiatric Facility (IPF), and Medicare Hospital Outpatient Prospective Payment System (PPS) Final Rules – considering the ongoing impacts of COVID-19 and recent inflationary pressures will be essential to ensuring the stability and resiliency of the health care system as it emerges from a global pandemic. Hospital operating margins in 2022 reveal the adverse impact of higher costs and a change in the mix of resources needed to respond to new surges and new COVID-19 variants. The proposed FY 2023 IPPS rate adjustment effectively attempts to return to the steady-state lagged adjustment methodology used prior to the pandemic without fully accounting for dynamics like the continuing effects of wage and inflationary pressures. Given the long history of Medicare underpayments, the failure to account for these pressures in the latest IPPS rule will likely exacerbate the deficit in Medicare funding that hospitals already experience and create further challenges for our hospitals and health system, at a time when they remain vulnerable to financial distress.

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