



*We care about Iowa's health*

June 10, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: CMS-1808-P Medicare and Medicaid Programs and the Children's Health Insurance Program: Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, etc.**

Dear Administrator Brooks-LaSure:

On behalf of Iowa's 123 hospitals, including 33 prospective payment system hospitals, the Iowa Hospital Association (IHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the Fiscal Year (FY) 2025 Inpatient Prospective Payment System (PPS). IHA also wishes to express support for the comments to the proposal submitted by the American Hospital Association.

To understand the context within which Iowa hospitals are operating and the rationale behind our feedback to the proposed rule, it is important to consider their pivotal role in supporting both the health and economic stability of the state and its communities. Their impact is substantial, as evidenced by the following:

**Economic Contributions**

- **Employment:** Iowa hospitals provide \$5.7 billion in wages and benefits, supporting 77,000 direct jobs.
- **Job Support:** They indirectly support an additional 145,000 jobs across the state.
- **Economic Impact:** Hospitals contribute \$21.5 billion to Iowa's economy, accounting for 12% of the state's gross domestic product.

**Community Benefits**

- **Annual Contributions:** Hospitals provide \$1 billion in community benefits each year.
- **Charity Care:** In 2023, they delivered \$286 million in charity care, aiding those unable to afford medical services.

Despite these significant contributions, Iowa hospitals face several challenges that threaten their financial stability and capacity to serve the community effectively. Key trends and issues include:

### **Shift in Care Patterns**

- There is a notable increase in outpatient care combined with a decrease in inpatient care, impacting the revenue models of hospitals.

### **Public Payer Dependence**

- The 2023 average payer mix for Iowa hospitals shows a heavy reliance on public payers, with more than 60% of patients covered by these programs. Specifically, Traditional Medicare and Medicare Advantage cover 44.5% of patients, while Medicaid covers 16.3%.

### **Financial Pressures**

- A sizable portion (70%) of Iowa hospitals operate with negative or unsustainable margins, having incurred combined operational losses of \$600 million from 2022 to 2023.
- Cost increases due to inflation and other factors from 2019 to 2023 have further strained resources, including:
  - An additional \$247 million was spent on supplies.
  - An increase of \$420 million in contracted labor costs.
  - A rise of \$490 million in pharmaceutical expenses.
  - An increase of \$1.34 billion in payroll and benefits costs.
  - A total expense increase of \$2.8 billion.

Iowa hospitals are essential to the state's health and economic well-being but are currently operating under severe financial strain. These challenges underscore the importance of supportive policies and adequate funding to ensure these institutions can continue to provide vital services and maintain their crucial role in the community.

### **Inpatient PPS Payment Update**

For FY 2025, CMS proposes a market basket update of 3.0%, less a productivity adjustment of 0.4 percentage points, resulting in a net update of 2.6%. This update, when combined with previous inadequate adjustments, exacerbates Medicare's underpayments to hospitals. It fails to consider the persistently high input costs hospitals and health systems face, including the challenges discussed above and other hard-to-anticipate events such as the cyberattack on Change Healthcare.

Therefore, IHA urges CMS to use its "special exceptions and adjustments" authority to implement a retrospective adjustment for FY 2025. This adjustment should account for the disparity between the market basket update implemented for FY 2022 and the actual market basket for that year. The actual market basket for FY 2022 was 5.7%, which is 3.0 percentage points higher than what hospitals received in 2022. Additionally, we recommend CMS eliminate

the productivity cut for FY 2025. These actions are essential for the long-term sustainability of hospitals and ensuring continued access to care.

By addressing these adjustments, CMS would more accurately reflect the financial realities hospitals face, promoting a more stable health care system and helping hospitals manage rising costs and unforeseen challenges.

### **Medicare Graduate Medical Education**

Iowa hospitals have struggled with significant workforce challenges for many years. According to a 2023 survey by IHA, Iowa hospitals reported more than 7,000 full-time and more than 3,200 part-time vacant positions. These difficult-to-fill positions span various roles, including registered nurses, physicians, physical therapists, laboratory technologists, ultrasound technologists, and radiology technologists. Given that health care is one of Iowa's largest industry sectors, with hospitals among the top employers with the most job openings, IHA supports all efforts to attract and retain individuals in health careers.

Medicare direct graduate medical education (GME) and indirect medical education (IME) funding are crucial for educating the physician workforce and maintaining access to care. However, the current funding levels and restrictions on the number of residents for which each teaching hospital can receive GME reimbursement significantly hinder efforts to reduce the national physician shortage. IHA appreciates that Congress, through the Consolidated Appropriations Act of 2021 and again in the Consolidated Appropriations Act of 2023, allocated funds for additional Medicare-funded residency positions. These legislative actions provide essential resources for hospitals.

IHA urges CMS to continue collaborating with Congress to enhance these initiatives. Funding more residency positions will help address the physician workforce shortage, particularly in regions with the most critical needs. Additionally, it is important to extend recruitment and support efforts to other health care professions, ensuring a comprehensive approach to workforce development in the health care sector.

### **CoP for Acute Respiratory Illness Data Reporting**

Within the proposed rule, CMS suggests making permanent its Medicare Condition of Participation (CoP) requiring hospitals to report certain data on acute respiratory illnesses, including during times outside of a public health emergency (PHE). IHA acknowledges the importance of sharing data on acute respiratory illnesses to inform public health efforts but believes that using CoPs to compel hospitals to share data with the federal government is excessive and misaligned with the CoPs' intent. The concern is that CMS could require hospitals to report an unlimited scope of data during PHEs or vaguely defined potential PHEs, risking hospitals' Medicare participation status.

Instead of this compulsory approach, IHA advocates for CMS, the Department of Health and Human Services, and the Centers for Disease Control and Prevention (CDC) to invest in infrastructure to facilitate the voluntary sharing of infectious disease data. This investment should be part of a collaborative effort involving various stakeholders to create a sustainable

system for data sharing.

As detailed in AHA's comments, the CMS requirement for acute respiratory illness data reporting does not align with Medicare CoPs' core purpose, which is to set standards for health and safety in health care delivery. The intent of CoPs is to improve quality and protect patients, not to mandate extensive data reporting. While CMS claims these reporting requirements fit within its Infection Control CoPs, hospitals argue that community prevalence data, which is used to manage infection control within hospitals, differs from reporting the number of hospitalized patients with specific respiratory illnesses.

IHA recommends adopting a voluntary reporting process for acute respiratory illness data using the National Healthcare Safety Network platform with streamlined reporting fields. This approach would avoid disruptions in hospital operations and eliminate the threat of losing Medicare participation due to missed reporting. Historical data shows that hospitals are willing to voluntarily share crucial data, as evidenced by the high reporting rates during the COVID-19 pandemic prior to mandatory rules.

In the long term, IHA urges CMS, CDC, and other federal agencies to develop infrastructure for automated, efficient, and timely public health data sharing that minimizes the burden on health care providers. This effort should involve a public-private collaboration, including various stakeholders such as hospitals, post-acute care providers, clinician offices, and electronic health record vendors. Initial work by the U.S. Digital Service on automated COVID-19 data reporting could serve as a foundation for these efforts, enhancing the effectiveness of responses to acute respiratory illnesses.

### **CMMI Transforming Episode Accountability Model (TEAM)**

Within the proposal, CMS proposes a new mandatory payment model that would bundle payment to acute care hospitals for five types of surgical episode categories, making the hospitals responsible for the quality and costs of all services provided during select surgical episodes, from the date of inpatient admission or outpatient procedure through 30-days post-discharge. IHA supports the overarching goal of advancing toward more accountable and coordinated care but has several critical concerns and recommendations that we believe CMS should consider to ensure the feasibility and success of the TEAM model.

### **Allow Voluntary Participation**

We urge CMS to make participation in the TEAM model voluntary. Mandating participation for all acute care inpatient PPS hospitals in select geographies is neither practical nor advisable. Many hospitals, especially smaller ones or those in weaker financial positions, are not prepared to make the necessary investments for a successful transition to bundled payment models. Moreover, forcing hospitals to transition a significant volume of procedures to mandatory bundles in a short timeframe could lead to substantial operational challenges and financial strain.

Furthermore, we recommend that participants be allowed to select specific clinical episodes rather than being required to take on risk for a broad range of diverse episodes. Analysis from the AHA shows that more than 72% of costs for four out of the five proposed bundles occur during

the anchor hospitalization or outpatient procedure, leaving minimal room for cost savings in post-acute care. Allowing hospitals to choose the episodes where they can most effectively manage costs would lead to better outcomes and greater savings.

### **Lower the 3% Discount Factor**

The proposed 3% discount factor is too high and unfairly reduces potential savings for hospitals. Given that a sizable portion of spending for the proposed episodes occurs during the anchor hospitalization or outpatient procedure, hospitals have limited opportunities to achieve further savings. This challenge will only increase as target prices decline over time, forcing hospitals to compete against their own best performance. We recommend reducing the discount factor to 1% to provide a fairer opportunity for hospitals to achieve savings and qualify for reconciliation payments.

### **Revise Critical Design Elements**

Several design elements of the TEAM model need significant revisions to create a more balanced risk-reward equation and to ensure the model's success.

- **Modify the Risk Adjustment Factors**

The proposed risk adjustment factors do not adequately account for differences in patient complexity and resource use across hospitals. This inadequacy penalizes hospitals treating the most complex patients. We recommend that the risk adjustment factor include complication or comorbidity flags from the anchor hospitalization, hierarchical condition codes (HCC) flags prior to the hospitalization, and HCC flags for 36 months prior to the hospitalization, rather than the proposed 90 days. Additionally, target prices should be adjusted based on more granular factors than just MS-DRG, such as distinguishing between emergent and elective cases, as well as fracture and non-fracture cases.

- **Establish a Longer Glidepath to Two-sided Risk**

The proposed one-year period of upside-only risk is insufficient, given the significant infrastructure investments required and the risk versus reward equation. Other CMS alternative payment models, such as the Medicare Shared Savings Program, provide a much longer period of upside-only risk. We recommend extending the upside-only period to a minimum of two years. Also, safety-net, rural, and special designation hospitals should be allowed to operate under upside-only risk for the model's duration.

- **Revise the Low-volume Threshold**

The proposed low-volume threshold of 31 cases across five-episode categories and three years is too low and does not ensure statistical significance. This threshold would unnecessarily expose low-volume hospitals to outlier cases and volatility. We recommend increasing the threshold to ensure statistical significance, establishing separate thresholds for each clinical episode category, and fully excluding organizations not meeting those thresholds from participation. At a minimum, the threshold should be increased to 40 cases within an individual episode category, like the Bundled Payments for Care Improvement Advanced Model.

IHA believes that the changes we recommend will better facilitate hospitals' ability to provide quality care to Medicare beneficiaries, achieve savings for the Medicare program, and have an opportunity for reward that is commensurate with the risk they are assuming. By making the TEAM model voluntary, lowering the discount factor, and revising critical design elements, CMS can create a more balanced and feasible pathway towards achieving its goals of accountable and coordinated care.

Thank you for considering this feedback. We look forward to continued collaboration on these critical issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Mitchell". The signature is fluid and cursive, with a prominent initial "C" and "M".

Chris Mitchell  
President/CEO  
Iowa Hospital Association