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By Electronic Submission
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June 14, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 2020

SUBJECT: CMS–1771–P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation (Vol 87, No 90), May 10, 2022

Dear Administrator Brooks-LaSure:

Toyon Associates, Inc. appreciates CMS's thoughtfulness and transparency in establishing hospital Medicare rates through the Federal Fiscal Year (FFY) Inpatient Payment Prospective System (IPPS) rulemaking process. Toyon works with hundreds of hospitals across the country providing IPPS education and insight, and we are thankful for the opportunity to comment on the IPPS rate setting for FFY 2023. Table 1 listed below is a summary of important issues we are commenting on for FFY 2023.

Table 1
Summary of Issues for Comment

#	Issue	FFY 2023 Proposal	Summarized Comment
1	Market Basket	2.7% Update 3.1% Market Basket -0.4% ACA Adjustment	8.0% Update Based on recent Medicare cost increases[1]

[1] Analysis of Medicare cost per discharge change from FFY 2019 to FFY 2020 per Medicare cost report data from the Healthcare Cost Report Information System (HCRIS). Medicare cost per Worksheet D-1 Part II, Line 49, Column 1. Medicare discharges per Worksheet S-3 Part I L14.00 C13.00.

2	Outliers	$43,214 Fixed Loss Threshold (40% increase from PY)	Reduce threshold in anticipation of less COVID-19 hospitalizations in FFY 2023
3	UC DSH Factor 1	-$542M Reduction to FFY 2023 UC DSH Payments	Increase Factor 1 discharge adjustment considering forecasts of increased Medicare utilization
4	UC DSH Factor 2	65.71% -0.03 from prior yr -0.07 from penultimate yr	Increase Factor 2 to reflect projections of increases to the national uninsured population
5	Empirical DSH Section 1115 Waiver Days	Medicaid patients regarded as eligible from 1115 Waiver w/ essential health benefits (EHB)	Clarification on premium assistance days "for which the premium assistance is equal to or greater than 90 percent of the cost of the coverage"
6	NP95 Respirator Payments	Reimbursement for the incremental cost of using wholly domestically produced N95 respirators	Supported and request CMS reimburse for all patients (not only Medicare) in bi-weekly lump sum payments

1. Market Basket Update

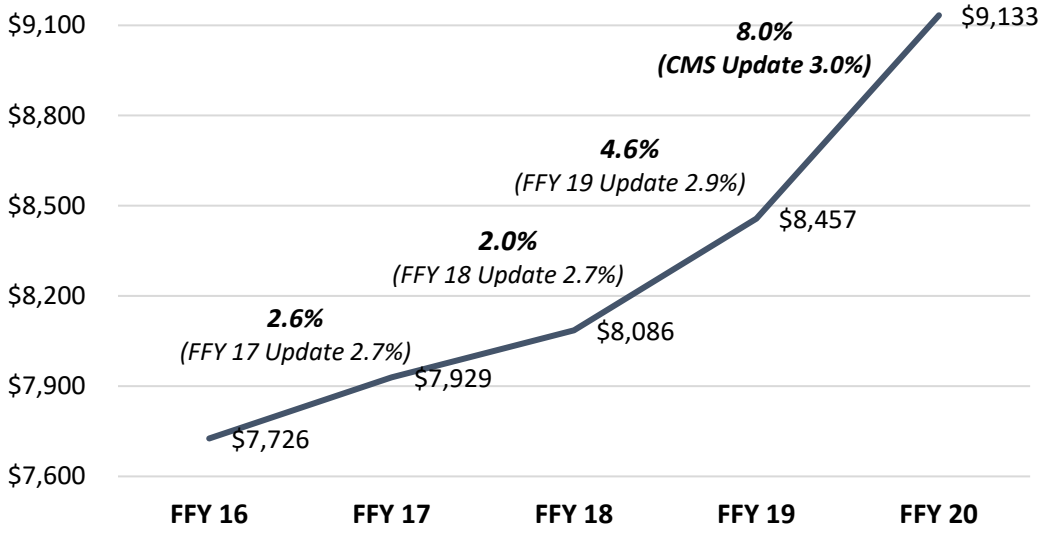
CMS proposes a FFY 2023 update factor of 2.7%. The 2.7% is net of the market basket adjustment of 3.1%, reduced by the ACA Productivity Adjustment of -0.4%. Toyon does not believe the 3.1% market basket reflects current market conditions, especially given the "stranded costs" of COVID-19 impacting hospitals across the country.

Toyon proposes CMS apply a market basket increase of 8.0% representing current trends in the allowable Medicare costs per risk-adjusted discharge (Table 2 below). Toyon also proposes CMS withhold the -0.4% ACA labor adjustment until a federal fiscal year in which hospitals are not operating under the public health emergency (PHE).

The notable increased cost of patient labor[2] is one example of COVID-19 "stranded cost". A March 2022 Report[3] from NSI Nursing Solutions, Inc. states "due to COVID, travel nurse rates jumped over 200%, with premiums averaging $154/hr. and ranging to $225/hr." The NSI report also states registered nurses (RNs) are leaving patient care at an "alarming rate" (8.4% increase over the prior year). NSI estimates, on average, hospitals are annually losing "between $5.2m and $9m" due to this increased turnover.

To highlight recent cost increases, and the need for a larger market basket increase, Toyon performed an analysis of Medicare cost per inpatient discharge using the latest available HCRIS data[4]. Toyon requests CMS consider a market basket update of 8.0%, consistent with the most recent known Medicare cost per discharge. We believe the 8.0% is a better reflection of hospital price inflation.

Table 2
Medicare IP Cost per Discharge (Case Mix Adjusted)
Increase of 8% from FFY 2019 to FFY 2020



2. Outlier Fixed Loss Threshold

CMS proposes a FFY 2023 outlier fixed loss ratio of $43,214. This ratio reflects a significant and aberrant increase of 12,266 (39.5%) as compared to the FFY 2022 outlier ratio of $30,988 (see Table 3 for five-year

[2] Toyon does not believe future wage index adjustments will account for the patient labor cost increase. The wage index system is budget neutral and would not recognize the national "stranded" costs new to the industry. Furthermore, only recognizing these costs through the wage index would cause a great disparity in payments between hospitals in high-cost core-based statistical areas (CBSA) and other IPPS hospitals.

[3] https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

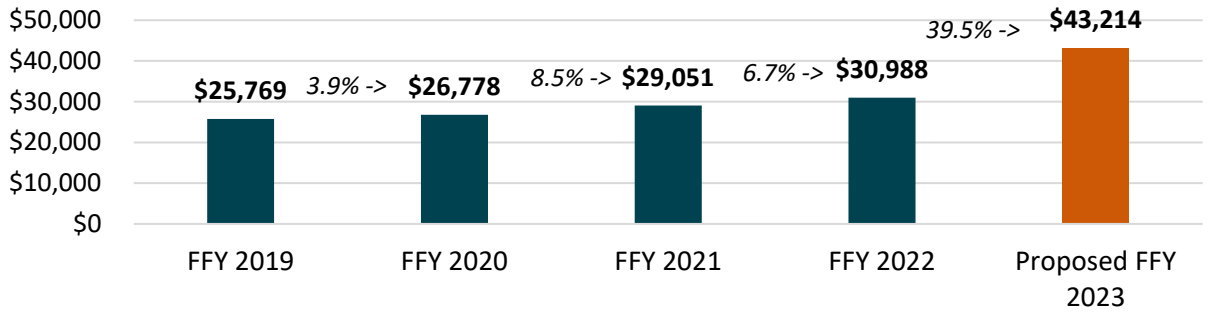
[4] Analysis of Medicare cost per discharge change from FFY 2019 to FFY 2020 per Medicare cost report data from the Healthcare Cost Report Information System (HCRIS). Medicare cost per Worksheet D-1 Part II, Line 49, Column 1. Medicare discharges per Worksheet S-3 Part I L14.00 C13.00.

trend). CMS determines this ratio using claims data from FFY 2021 (MedPAR[5]) and charge increases comparing 2018-2019 (excluding COVID-19 data) from the Provider Specific File (PSF)[6].

Toyon is concerned providers will not be reimbursed outlier payments, for actual outlier cases in FFY 2023, using an over-inflated fixed loss ratio of $43,214. Considering the anticipated decrease in COVID-19 hospitalizations, it will be difficult for providers to be reimbursed for outlier cases with a 39.5% increase to the annual threshold.

Toyon proposes CMS apply claims data from before the COVID-19 PHE (i.e., 2018 – 2019), aligning with years CMS proposes to use for charge inflation. The use of pre-COVID-19 data will result in a more reasonable fixed loss outlier threshold in FFY 2023. As displayed below in Table 3, CMS's Proposed FFY 2023 fixed loss outlier threshold is a significant 39.5% increase and is aberrant compared to the past 4 years.

Table 3
Fixed Loss Outlier Threshold Trend



3. Uncompensated Care (UC) DSH Factor 1

CMS proposes a FFY 2023 Factor 1 update resulting in a reduction of -$542 million from baseline (2019) DSH expenditure estimates. FFY 2023 is the first year under the UC DSH program where anticipated DSH expenditures for the upcoming federal year are less than the baseline year. For instance, in FFY 2021 and FFY 2022 the Factor 1 update increased projected DSH expenditures by $1.2 billion and $100 million, respectively.

The primary factor causing the projected decrease in DSH expenditures is the Factor 1 "discharge" update. As compared to FFY 2022, CMS proposes to reduce its (compounding) estimates of discharges by -0.0660 and -0.0520 for FFY 2021 and FFY 2022, respectively. This is further illustrated in Table 4 below.

[5] Medicare Provider Analysis and Review File (MedPAR)

[6] if charge data from 2020-2021 was applied, it would result in an aberrant fixed-loss ratio of $58,798.

Table 4
Factor 1 Discharge Update Factor

FFY	FFY 2022 Discharge Factor	Proposed FFY 2023 Discharge Factor	Variance
2020	0.8620	0.8570	0.0050
2021	**0.9470**	**1.0130**	**(0.0660)**
2022	**1.0070**	**1.0590**	**(0.0520)**
2023	1.0100	N/A	N/A

Toyon proposes CMS adjust its discharges for FFY 2022 data that is incomplete and impacted by COVID-19 data (e.g., the Omicron variant). Presuming CMS uses FY 2021 MedPAR claims data in its estimate of discharges for the Factor 1 discharge update, any claims from FFY 2022 are limited to less than 3 months of data (Oct. 21 – Dec. 21), and likely atypically impacted by aberrations caused by a spike in COVID-19. Toyon believes a larger data set for the 2022 discharge estimates would result in a more accurate Factor 1 discharge update adjustment.

Furthermore, in CMS's Advanced and Final Notice of 2023 Medicare Advantage rates[7], CMS states "CY 2023 risk scores will utilize diagnoses from 2022 dates of service, and we expect that utilization in 2022 will rebound." **Toyon proposes CMS apply this same expectation (i.e., rebound of 2022 volume) to the Factor 1 discharge factor adjustment.**

4. Uncompensated Care (UC) DSH Factor 2

CMS proposes a FFY 2023 Factor 2 change in uninsured (since pre-ACA in 2013) at 65.71%. After Factor 1 updates, Factor 2 is used to set the national fund of Uncompensated Care DSH payments. In FFY 2023 CMS proposes a total UC DSH fund of $6.6 billion[8], a decrease of $654 million (-9%) and $1.7 billion (-20%) as compared to FFY 2022 and FFY 2021, respectively.

Toyon proposes CMS increase the FFY 2023 Factor 2 adjustment accounting for the impending increase in the uninsured population. Reports by the Urban Institute[9] and the Kaiser Family Foundation[10] estimate an increase to national uninsured population up to 15 million due to patients losing eligibility as states reassess Medicaid eligibility with sunsetting COVID-19 legislation[11].

[7] https://www.cms.gov/files/document/2023-announcement.pdf

[8] Excluding Proposed FFY 2023 $92M in supplemental payments for Indian Healthcare Services (IHS) and hospitals in Puerto Rico.

[9] https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf

[10] https://www.kff.org/medicaid/press-release/kff-analysts-find-that-between-5-3-million-and-14-2-million-people-could-lose-medicaid-coverage-following-the-end-of-the-public-health-emergency-and-continuous-enrollment-requirement-with-an-unknown/

[11] Medicaid continuous coverage requirement of the Families First Coronavirus Response Act (FFCRA) and the enhanced premium tax credits expansion of coverage in the American Rescue Plan (ARP).

5. Empirical DSH Section 1115 Waiver Days

CMS proposes, Medicaid days used for empirical DSH payments are "regarded as eligible" when –

> "the patient receives health insurance through a section 1115 demonstration itself or purchase such health insurance with premium assistance authorized by a section 1115 demonstration, where state expenditures may be matched with Title XIX funds."

CMS states allowable days relate to days with insurance coverage under Essential Health Benefits (EHB), if bought with premium assistance, for which the premium assistance is equal to or greater than 90 percent of the cost of the coverage.

Toyon proposes CMS discuss how CMS and its auditors (i.e., MACs) will ensure days qualify as having "insurance coverage under Essential Health Benefits (EHB), if bought with premium assistance, for which the premium assistance is equal to or greater than 90 percent of the cost of the coverage."

Toyon proposes CMS and the MACs provide this transparency, so providers understand what is required for cost reporting, and if there are any changes in the current process of determining patients for Medicaid eligibility (i.e., eligibility reports from State Medicaid agencies). Toyon recommends CMS and the MACs communicate any changes in the Medicare empirical DSH calculation clearly (i.e., through cost reporting transmittal) so that providers do not inadvertently report non-allowable days which may result in large, extrapolated adjustments. Toyon also requests that CMS consider additional costs and resources in changes to the Medicaid eligibility authentication process.

6. N95 Respirator Payments

CMS proposes to reimburse the program share of domestic produced N95 respirators. CMS also asks commenters to provide feedback as to whether these payments should be made on as claims-based, DRG-add-ons (after 50% purchasing threshold); or as interim bi-weekly payments.

Toyon thanks CMS for its commitment ensuring hospitals have adequate resources to best provide care to their patients, especially given COVID-19 and other airborne illnesses. **Toyon proposes CMS reimburse providers for 100% (rather than the Medicare share) of domestic N-95 respirators.** Other payors are not making a similar investment, and Toyon believes it would best incentivize hospitals to participate in the reporting of this information if 100% of the cost were reimbursed. Toyon recommends CMS works with Congress ensuring proper regulation exists or legislation is enacted to permit the Medicare program reimbursing N95 domestic costs for all payors.

Toyon proposes CMS clarify how a hospital and auditor would authenticate whether an N95 mask was purchased domestically or internationally. Toyon recommends the agency consider and limit any burdensome processes that would weigh in a provider's decision to participate in this program (i.e., collecting and producing locations associated with vendor invoices).

Lastly, **Toyon proposes CMS reimburse providers on a biweekly passthrough basis** and we note a new cost report settlement page may be required. Toyon believes this is the most efficient method of reconciling actual costs during the Medicare cost report audit.

# # # #

Thank you for providing Toyon the opportunity to submit our comments on the FFY 2023 IPPS Proposed Rule. Should you have any questions, please contact Fred Fisher at 888.514.9312 or fred.fisher@toyonassociates.com.

Respectfully,

Toyon Associates, Inc.