Congress of the United States

Washington, DC 20515

January 24, 2024

The Honorable Xavier Beccera
Secretary
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington DC 20201

Dear Secretary Becerra,

As you know, rural hospitals have unique financing challenges, resulting in nationwide closures. This problem is especially pervasive in Alaska and Hawaii. Many of our hospitals are struggling to keep their doors open with the low-volume and high-cost services they provide in some of the most remote regions of the country. You have the ability to provide much needed financial stability to these hospitals. We write regarding Medicare reimbursements under the inpatient prospective payment system (IPPS), specifically the cost-of-living adjustment (COLA) that is applied to the non-labor related share of costs for hospitals in Alaska and Hawaii.

When the IPPS was created in the *Social Security Amendments of 1983*, a provision was specifically included giving the Secretary significant flexibility over payments to hospitals located in Alaska and Hawaii.[1] This provision, *42 USC 1395ww(d)(5)(H)*, says;

> "The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii."[2]

Until 2013, the Secretary had provided such adjustments for hospitals in Alaska and Hawaii by multiplying the non-labor related share of costs by a cost-of-living adjustment obtained from the U.S. Office of Personnel Management (OPM).[3] However, subtitle B of title XIX of the *National Defense Authorization Act (NDAA) for Fiscal Year 2010* redetermined OPM's broader cost of living formula for Alaska and Hawaii to locality pay with a three year phase-in period.[4] CMS then used a "frozen" COLA rate from 2009 for FY2011 through FY2013 while determining the new methodology.[5]

In 2012, CMS released its proposed rule for the FY2013 IPPS and created a new methodology for determining adjustments for hospitals in Alaska and Hawaii. The rule outlines a process using the consumer price indexes (CPI) for Anchorage, Alaska, and Honolulu, Hawaii, compared

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[1] Social Security Amendments of 1983, PL98-21.
[2] 42 USC 1395ww(d)(5)(H)
[3] Center for Medicare and Medicaid Services. Proposed Rule. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013." (May 11, 2012). https://www.govinfo.gov/content/pkg/FR-2012-05-11/pdf/2012-9985.pdf
[4] Ibid
[5] Ibid

to the national CPI, both of which use data published by the Bureau of Labor Statistics (BLS). Because the CPI produced by BLS is a different mix of commodities and services than the non-labor related share of the IPPS reimbursement, CMS uses a reweighted CPI that is approximately 60 percent commodities and 40 percent services.[6] The adjustment is then determined by using the ratio of local reweighted CPI to the national reweighted CPI to adjust the frozen COLA rate from 2009. The rule continued to use the 25% cap that had been in place since 1983, and has historically been applied to OPM COLAs. The FY2013 rule set the first COLA determination for fiscal year 2014 with subsequent updates every four years to align with updates to the labor related share of the IPPS market basket.[7] On August 31, 2012, this rule was finalized without receiving any public comments and without modification.[8]

As noted above, many hospitals and providers in Alaska are struggling financially to remain in operation – while this is true for hospitals across the country, Alaska and Hawaii are in a unique position. Given your statutory authority to adjust the payments to hospitals in these states when appropriate, we request your consideration of a new adjustment methodology that does not rely on urban CPIs in order to better recognize the regional differences in Alaska, which create significant variance in hospital costs. Additionally, we request raising the 25 percent cap on Alaska and Hawaii cost-of-living adjustments to provide adequate flexibility for payment adjustments.

In selecting the CPI as the proper tool to adjust the COLA, the FY2013 proposed rule notes "We believe that the relative price differences between these cities and the U.S. are appropriate proxies for the relative price differences between the ''other areas'' of Alaska and Hawaii and the U.S."[9] Alaska is the largest state in the country with over 570,000 square miles, accounting for roughly 15% of the total land mass in the United States.[10] While the urban CPI of Anchorage, Alaska, is a convenient and readily available measure, it does not accurately reflect the cost disparities facing hospitals across the state. Anchorage is Alaska's largest city and is home to about 291,000 Alaskans out of 733,000 – the vast majority of goods coming into Alaska pass through Anchorage by boat or plane before travelling further to their final destination, whether it be Bethel, Fairbanks, Kenai, or Mat-Su.[11] Many hospitals outside of Anchorage face high transportation costs for supplies and serve populations that are on average older, sicker, and lower-income than their urban counterparts. Tying all reimbursements for Alaskan hospitals to the Anchorage CPI is a remarkably insufficient adjustment that does not account for the added costs to hospitals outside of Alaska's urban centers. In order to ensure adequate access to care across such a vast state, it is critical that CMS explore alternative measures to the CPI that can better reflect the reality of costs facing rural hospitals in Alaska. Further, while we appreciate the

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[6] Ibid
[7] Ibid
[8] Center for Medicare and Medicaid Services. Final Rule. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates." (August 31, 2012). https://www.govinfo.gov/content/pkg/FR-2012-08-31/pdf/2012-19079.pdf
[9] Ibid
[10] United States Census Bureau. "Alaska: 2020 Census." (August 25, 2021). https://www.census.gov/library/stories/state-by-state/alaska-population-change-between-census-decade.html
[11] Ibid

necessity and precedence of the COLA cap, raising it would provide much needed flexibility over these adjustments. Since this rule was finalized in 2012, CMS has updated the COLA for Alaska and Hawaii three times, in 2014, 2018, and 2022, with the next update due in FY2026. The 25 percent cap has effected COLA rates for Alaska and Hawaii in all three updates.[12] [13] [14]

Thank you for your consideration of this request. We hope this can be the start of a productive conversation and ultimately a revision of the COLA methodology. Such changes would come at a much needed time and would provide meaningful support to some of the most rural providers in the nation – these hospitals serve vulnerable populations that deserve our unwavering support.

Sincerely,

Lisa Murkowski
United States Senator

Dan Sullivan
United States Senator

[12] Center for Medicare and Medicaid Services. Final Rule. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates." (August 19, 2013). https://www.govinfo.gov/content/pkg/FR-2013-08-19/pdf/2013-18956.pdf

[13] Center for Medicare and Medicaid Services. Final Rule. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2018 Rates." (August 14, 2017). https://www.govinfo.gov/content/pkg/FR-2017-08-14/pdf/2017-16434.pdf

[14] Center for Medicare and Medicaid Services. Final Rule. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2022 Rates." (August 13, 2021). https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf