CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

July 10, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

SUBJECT: CMS-1735-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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Rule, Federal Register (Vol. 85, No. 104) May 29, 2020

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule updating the Medicare inpatient prospective payment system (IPPS) for federal fiscal year (FFY) 2021.

California's hospitals — like hospitals across the nation — are currently facing an unprecedented challenge in responding to the COVID-19 public health emergency (PHE). Early in the crisis, California hospitals stepped in to assist the federal government in the treatment of patients arriving on cruise ships. Then, as community spread became evident, hospitals canceled non-emergency and elective surgeries, bought large quantities of personal protective equipment (PPE), and in some cases retrofitted facilities in order to prepare for a potential surge of COVID-19 patients. All this preparation came at great expense and led to a significant decline in inpatient volumes, at the same time many patients were avoiding the emergency department. Recent analysis by Kaufman Hall, a nationally renowned health care consulting firm, estimates that even with federal stimulus funds, California hospitals still face $11.2 billion in lost net revenue by the end of 2020.

Though the full extent and duration of the pandemic are unknown, hospitals expect to be operating in this challenged environment well into 2021. Hospitals across California — including those located in communities that have not emerged as hot spots — continue to dedicate significant resources to obtaining PPE, readying their facilities to surge patient capacity as needed, and ensuring that front-line health care workers are ready to meet the community's needs. As such, we appreciate that CMS has limited its rulemaking to statutory requirements with additional focus on essential policies and proposals that reduce provider burden and may help providers in the COVID-19 response. However, we are concerned that CMS has proposed policies that will further challenge hospitals that are laser focused on delivering the acute care services that only they can provide to the patients who depend on them.

In summary, CHA:

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

- Strongly opposes CMS' proposal to continue its low-wage index policy and reduce the standardized amount for all IPPS hospitals to increase the wage index for hospitals with wage index values in the bottom quartile of the nation. CHA continues to believe such a policy is inappropriately redistributive and penalizes all IPPS hospitals in an effort to benefit low-wage hospitals.
- Opposes CMS' proposal to require that hospitals report the median payer-specific negotiated charge by Medicare Severity-Diagnosis Related Group (MS-DRG) for Medicare Advantage (MA) plans and all third-party payers on the Medicare cost report, and to use that data to revise the methodology for determining MS-DRG relative weights.
- Supports the use of a single year of data from the audited federal fiscal year (FFY) 2017 Worksheet S-10 in distributing the Medicare disproportionate share hospital (DSH) uncompensated care (UCC) dollars in FFY 2021. However, we urge the agency not to finalize its proposal to carry forth the use of a single year of most recently audited data for FFY 2022 and beyond, and instead consider approaches to mitigate volatility in these payments by considering a blend as additional years of Worksheet S-10 data are audited.
- Urges CMS to maintain the current electronic clinical quality measure (eCQM) reporting requirements to submit a single self-selected quarter of eCQM data for CY 2021 for both the hospital inpatient quality reporting (IQR) and Medicare and Medicaid Promoting Interoperability programs.
- Strongly supports the adoption of a continuous 90-day reporting period for the Promoting Interoperability program through 2022.

Our detailed comments on CMS' payment and quality proposals follow.

Area Wage Index

In the FFY 2020 IPPS final rule, CMS finalized a policy that increases the wage index values for certain hospitals with low wage index values (the "Low Wage Index Hospital Policy"). CMS implemented this Low Wage Index Hospital Policy through a budget neutrality adjustment that reduced the standardized amount for all IPPS hospitals in FFY 2020. In finalizing the policy for FFY 2020, CMS stated that the "policy will be effective for at least 4 years."

In the FFY 2021 IPPS proposed rule, CMS proposes to continue to apply the Low Wage Index Hospital Policy and concomitant budget neutrality adjustment to the standardized amount for all IPPS hospitals. CHA opposed this policy in comments on the FFY 2020 IPPS proposed rule[1] and continues to strongly oppose decreasing payments to all hospitals to offset an increase in the area wage index (AWI) for the hospitals in the lowest AWI quartile.

In the proposed rule, CMS continues to assert that the policy will "help mitigate wage index disparities." However, CMS has not provided any further rationale or justification for its continuation of the Low Wage Index Hospital Policy and the associated reduction to the standardized amount for all IPPS hospitals (the "Low Wage Index Redistribution"). CMS' previously stated rationale, as set forth in the FFY 2020 IPPS final rule, did not adequately address concerns raised by CHA and other commenters from last year. Furthermore, CMS does not have the legal authority to make this reduction under IPPS. **CHA strongly opposes any reduction to payments under IPPS that would result from the continued implementation of the Low Wage Index Redistribution.**

[1] CHA also submitted comments in opposition of the CY 2020 outpatient prospective payment system proposed rule, which incorporated the Low Wage Index Redistribution from the FFY 2020 IPPS final rule.

The Policy to Increase Area Wage Index Values for Low-Wage Index Hospitals at the Expense of All IPPS Hospitals Violates the Medicare Act

CHA cannot support CMS' continuation of the policy to increase the wage index values of low-wage index hospitals by decreasing the standardized amount for all hospitals. This is because the Low Wage Index Redistribution violates the provision of the Medicare Act, which requires the agency to adjust payments to reflect area difference in wages; additionally, the reasons given by CMS in the FFY 2020 IPPS final rule for this policy are inadequate. Also, the policy is not supported by the exceptions and adjustments provision on which CMS may be relying. Rather, the Low Wage Index Redistribution will result simply in a shift of Medicare funds from high and middle-wage hospitals to low-wage hospitals, completely untethered from labor costs incurred by hospitals.

A. The Low Wage Index Hospital Policy and Standardized Amount Reduction Are Beyond CMS' Legal Authority under 42 U.S.C. § 1395ww(d)(3)(E)

1. CMS' Policy Is Contrary to the Plain Language of 42 U.S.C. § 1395ww(d)(3)(E)

In finalizing its Low Wage Index Redistribution in FFY 2020, CMS asserted that it has the legal authority under 42 U.S.C. § 1395ww(d)(3)(E) ("Section 1395ww(d)(3)(E)") to increase the wage index values for hospitals in the lowest quartile above the values that were calculated based on actual wage data. Section 1395ww(d)(3)(E) provides a process for adjusting hospital payments to account "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level," requires that factor to be updated annually "on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of [IPPS-participating] hospitals in the United States," and requires those adjustments to be budget neutral. CMS appears to understand Section 1395ww(d)(3)(E) as giving it such broad authority to institute a wage index proposal which, in essence, makes inaccurate the wage data values for 25% of hospitals in the nation. However, nothing in Section 1395ww(d)(3)(E) or any other provision of the Medicare Act permits CMS to alter payment in order to influence and skew the wage market by altering the wage index for a subset of hospitals. The Low Wage Index Redistribution violates 42 U.S.C. § 1395ww(d)(3)(E) by altering wage index values for the lowest quartile so that they are not based on actual data.

The Low Wage Index Redistribution is contrary to the plain language of the statute because it adjusts IPPS payment rates in a way that does not reflect the actual difference between the relative hospital wage levels in a geographic area compared to the national average. Indeed, the Low Wage Index Redistribution is designed to do the opposite by artificially and inaccurately inflating wage index values for a quarter of IPPS hospitals. CMS acknowledged this in the FFY 2020 IPPS final rule, when it stated that the redistribution "is based on the actual wages we expect low-wage hospitals to pay," rather than the actual wages paid by these hospitals.

Moreover, CMS has instituted a process — the Wage Index Development Timetable — with detailed instructions to ensure that CMS has accurate wage index data from all IPPS hospitals with which to create the annual wage index. This is a laborious process, and a hospital will not have an opportunity to later fix any wage data errors if it fails to follow this process. It is important to note that where the wage data are reported on Worksheet S-3 of the Medicare cost report is the **only** section of the cost report that is subject to a Medicare administrative contractor (MAC) review every single year. In addition to the MAC review, there is a subsequent additional secondary auditor with oversight of the MACs to ensure data are reported accurately. CMS has invested significant resources to ensure the data reported and reflected in each year's cost reports are reliable and valid for the purposes of payment. Yet, CMS is

proposing to continue a policy that violates its own rules by adopting and continuing to implement the Low Wage Index Redistribution, which improperly increases the wage index for 25% of IPPS hospitals without any wage data to support the increase.

In the FFY 2020 IPPS final rule, CMS said the policy increases the accuracy of the wage index by giving low-wage hospitals an opportunity to increase wages to levels that CMS believes they would pay if they could, but this rationale is hard to justify. Moreover, CMS stated, but did not explain why, "the lag in the process between when a hospital increases its employee compensation and when that increase is reflected in the calculation of the wage index[]" harms low-wage index hospitals. 84 Fed. Reg. at 42,327. CMS did not assert that hospitals with wage index values above the lowest quartile do not experience this "lag in the process" in the same manner as hospitals in the lowest quartile. Rather, the lag between any changes in employee compensation relative to the national average applies to all IPPS hospitals, whether they are low- or high-wage hospitals. There is no reason to believe that this phenomenon disproportionately impacts the lowest quartile of hospitals and, in fact, the lag might help low-wage hospitals in labor markets with falling hospital wages avoid being assigned even lower wage index values. Moreover, Congress only authorized the Secretary under Section 1395ww(d)(3)(E) to consider survey data in updating the wage index. Therefore, when adjusting payments to hospitals to account for geographic wage differences, the Medicare Act confines CMS to consideration of actual wage costs — not concerns for "data lag" or any other policy concerns. Accordingly, CMS considered factors that Congress did not intend it to consider in promulgating the Low Wage Index Redistribution, in that CMS based the policy on the data lag and its speculation that hospitals in low-wage areas would increase their wages if their wage indices were increased, rather than basing it on the survey data.

In the FFY 2020 IPPS final rule, CMS conflated low-wage cost hospitals with poor and/or rural hospitals. Undeniably there is some overlap, but low-wage costs cannot be synonymous with poor or unprofitable hospitals any more than high-wage costs can be synonymous with rich and profitable ones. California rural hospitals have high-wage costs compared to hospitals across the nation, but these are labor costs that rural California hospitals experience because of real geographic labor cost differences that CMS acknowledges exist across the nation. To suppose that these rural hospitals in high-wage cost areas are not in need of more reimbursement indicates that CMS is using the wage index as a policy vehicle, not as a "technical correction," as CMS claimed numerous times in the FFY 2020 IPPS final rule.

Neither in the FFY 2020 IPPS final rule, nor in this proposed rule, has CMS explained why or how Section 1395ww(d)(3)(E) gives it the broad authority to institute a policy that creates wage index values for a quarter of the nation's hospitals that are not based on evidence and are, in fact, contrary to the evidence. CMS' policy is also contrary to the wage index statute, which requires the Secretary to adjust IPPS payments by a factor "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level" and is permitted to update this factor based only on "a survey . . . of the wages and wage-related costs" of IPPS hospitals in the United States. 42 U.S.C. § 1395ww(d)(3)(E).

2. CMS' Redistribution Contradicts Congressional Purpose

While certain of the details of the creation and implementation of the wage index may have been delegated by Congress to the agency, the statute nevertheless "requires the Secretary to develop a mechanism to remove the effects of local wage differences." *See Methodist Hospital of Sacramento v. Shalala*, 38 F.3d. 1225, 1230 (D.C. Cir. 1994). Moreover, the payment adjustments to reflect area wage differences must be accurate. *See id.* at 1227 (citing H.R. Rep. No. 98-25, at 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351; S. Rep. No. 98-23, at 47 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 187) ("[A]t any

given time the wage index must reflect the Secretary's best approximation of relative regional wage variations."). CMS' Low Wage Index Hospital Policy does not "remove the effects of local wage differences" but instead disregards accurately reported wage data for 25% of the nation's hospitals. This is beyond the authority delegated to the agency by Congress.

Congress instructed CMS in Section 1395ww(d)(3)(E) to identify actual differences in geographic labor costs relative to the national average and to account for them in the payments to hospitals, subject only to limited statutory exceptions adopted by Congress.[2] Over time, Congress amended Section 1395ww(d)(3)(E) to (a) add a budget neutrality adjustment as part of subsection (d)(3)(E)(i); (b) fix the wage-related portion of the standardized amount at 62% where the wage index value is less than or equal to 1.0 in subsection (d)(3)(E)(ii); and (c) impose a wage index "floor" for frontier hospitals in subsection (d)(3)(E)(iii). In adopting subsection (d)(3)(E)(ii) in particular, Congress has already sought to temper the impact of the wage index on low-wage index hospitals by reducing the labor-related portion of the standardized amount from 68.3% to 62% for hospitals with a wage index value of less than the median (1.0). Congress, however, did not authorize CMS to take any further steps to mitigate the impact of the wage index on low-wage index hospitals. Rather, Congress instructed that all updates to the wage index must be based on actual wage data.

Moreover, when Congress established limited wage index exceptions in subsection (d)(3)(E)(ii) and (d)(3)(E)(iii), it ensured that these policies would not be funded with budget neutrality payment reductions by providing that the Secretary "shall apply" the budget neutrality provision of subsection (d)(3)(E)(i) as if clauses (ii) and (iii) "had not been enacted." 42 U.S.C. § 1395ww(d)(3)(E)(i). In other words, Congress has reserved for itself the power to adopt exceptions to the data-driven wage index process and has only exercised this power in a non-budget neutral manner that ensures that hospitals do not pay for these exceptions through payment reductions.

Up until last year, CMS had acted consistently with Congress' directives by calculating the wage index based on actual wage data, subject only to modifications specifically permitted by Congress. Congress has not authorized the Secretary to adjust the wage index based on anything other than the actual area differences in hospital wage data, and it certainly has not authorized the Secretary to adopt a budget neutrality payment adjustment to fund the counterfactual inflation of wage index values. Thus, CMS' Low Wage Index Redistribution contradicts the will of Congress.

3. CMS' Policy Is *Ultra Vires*

Section 1395ww(d)(3)(E) illustrates that Congress writes rules and exceptions. In Section 1395ww(d)(3)(E) Congress did both, establishing the basic requirements that the wage index must be based on actual wage data in clause (i), and adopting narrow exceptions in clauses (ii) and (iii). These are the only exceptions that Congress made to the data-driven wage index policy required under clause (i). Congress did not grant CMS the authority to institute the Low Wage Index Redistribution or craft any policy (whether disguised as a "technical adjustment" or not) to adjust the wage index. Because CMS is not authorized to adjust wage index values in the absence of supporting wage data, a budget neutrality payment reduction associated with any such adjustment is likewise not authorized under Section 1395ww(d)(3)(E). As such, the Low Wage Index Redistribution is *ultra vires*.

[2] "The purpose of a wage index is to recognize real differences in wages across labor market areas, including changes over time in a labor market area's relative wages." MedPAC, Potential Refinements to Medicare's Wage Indexes for Hospitals, June 2007.

B. The Standardized Amount Reduction Is Beyond CMS's Legal Authority under 42 U.S.C. § 1395ww(d)(5)(I)

1. Section 1395ww(d)(5)(I) Does Not Create a Broad Exception Allowing for the Standardized Amount Reduction

In the FFY 2020 IPPS final rule, CMS invoked the exceptions and adjustments authority in 42 U.S.C. § 1395ww(d)(5)(I) ("Section 1395ww(d)(5)(I)") as alternative authority to implement the Low Wage Index Redistribution, including the 0.2016% payment reduction, if Section 1395ww(d)(3)(E) did not give it such authority.[3] Section 1395ww(d)(5)(I) states "(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."

The use of Section 1395ww(d)(5)(I)(i) for a global rate reduction does not fit within the language, structure, or intent of the statute. The IPPS is an extraordinarily detailed framework with very specific subsections and paragraphs specifying how the complicated payment methodology is to work. Subparagraphs (A)-(H) that precede Section 1395ww(d)(5)(I) identify distinct exceptions and adjustments to the payment rates prescribed under the IPPS in very specific circumstances that include: outliers ((d)(5)(A)); indirect costs of medical education ((d)(5)(B)); special needs of rural referral centers ((d)(5)(C)); sole community hospitals ((d)(5)(D)); reimbursement for services described in 1395y(a)(14) ((d)(5)(E)); low-income patients ((d)(5)(F)); Medicare-dependent, small rural hospitals ((d)(5)(G)); and Alaska and Hawaii ((d)(5)(H)). In the context of the statute as a whole, Section 1395ww(d)(5)(I)(i) does not convey sweeping authority for CMS to apply across-the-board rate reductions but, rather, only exceptions and adjustments of the kind similar to what appears in the preceding clauses.

Section 1395ww(d)(5)(I) cannot be interpreted to give CMS such broad authority as to wipe away all the specific reimbursement methodology set forth in the relevant statute. Otherwise, the only limit would be whatever CMS deems to be appropriate. This sort of unfettered delegation of power by Congress to the agency would violate the separation of powers doctrine and is inconsistent with the reimbursement methodology designed by Congress. CHA does not believe the exception can mean that CMS can do anything it deems appropriate to implement whatever policy CMS wishes to advance. This is especially the case where the wage index statute is specific as to how the wage index is supposed to work.[4]

Moreover, read in context, the provision follows a list of exceptions and adjustments and then precedes a clause that would be rendered completely superfluous if Section 1395ww(d)(5)(I) was given the breadth of authority that CMS requires to effectuate the reduction to the standardized amount associated with the Low Wage Index Reduction. First, under the canon of *ejusdem generis* — where general words follow specific words, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words — the exceptions and adjustments authority should be limited due to the context that precedes it.

[3] CMS may also be relying on this provision as an alternative basis for increasing the AWI of the lowest quartile hospitals, although it has been far from clear regarding this point and did not attempt to clarify itself in the proposed rule. However, this position is unsupported by the language of Section 1395ww(d)(5)(I), which authorizes exceptions and adjustments only to "payment amounts," not to any wage index value established under Section 1395ww(d)(3)(E).

[4] Otherwise, if the only limit of Section 1395ww(d)(5)(I) was whatever CMS deems to be appropriate, it could change the IPPS reimbursement system to a per diem system, for example. This cannot be the breadth of authority delegated to CMS by Congress, given the text of the provisions of Section 1395ww(d).

The payment exceptions and adjustments from (d)(5)(A)-(H) concern particular categories of hospitals or unique cases where Congress has offered an exception to the way the reimbursement methodology will function so as to reward, and not punish, hospitals that might need additional reimbursement given their unique circumstances. They do not concern the overall wage index scheme, which is set forth in Section 1395ww(d)(3)(E) and incorporated into the overall reimbursement methodology, but rather concern smaller adjustments and exceptions that add on to the overall reimbursement methodology. Given the ways in which the exceptions and adjustments are limited in (d)(5)(A)-(H), the "catchall" provision in Section 1395ww(d)(5)(I) is similarly limited in scope and cannot be used to unravel the IPPS reimbursement methodology that is specifically set forth in the rest of the statute.

Second, Section 1395ww(d)(5)(I) has two clauses. The first sets out the exceptions and adjustments authority discussed above. The second states, "In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year." If CMS can continue to interpret the exceptions and adjustments catchall provision as broadly as it is claiming in the FFY 2020 IPPS final rule, then the second clause would be irrelevant; the canon against surplusage shows that CMS' interpretation is too broad.

The second clause gives CMS the authority, when making adjustments for transfer cases, to adjust the standardized amounts to achieve budget neutrality. This would be entirely superfluous and unnecessary if the first clause already granted CMS the sort of broad authority needed to institute and continue the Low Wage Index Redistribution.

Even if the exceptions and adjustments provision can be read to afford broad authority to CMS, the exercise of that authority must be consistent with, and cannot frustrate, the intent of Congress. Congress has mandated an adjustment to reflect the geographic differences in area wages. Congress has mandated that the adjustment be based on relative hospital wages from different areas of the country. CMS may not unilaterally implement (and continue) a rule designed to further a policy of its own making to provide additional funding to low-wage hospitals to supposedly incentivize them to increase wages.

Certainly, Congress could adopt such a policy and direct CMS to implement it, but Congress has not done this. Rather, the policy adopted by Congress as set forth in the Medicare Act is to recognize actual wage differences, not to ignore those differences so as to provide funding to hospitals in certain areas in the hope that they increase employee wages. Furthermore, where Congress has wanted to increase the wage index for low-wage states, it has explicitly done so (e.g., frontier floors under Section 1395ww(d)(3)(E)(iii)). CMS has no authority under the exceptions and adjustments provision or otherwise to act in a manner that is inconsistent with Congress' intent. If CMS believes it would be good payment policy to provide additional funding to low-wage hospitals, CMS should work with Congress to seek its authority to do so, and not make unilateral changes inconsistent with previous Congressional action, as it has done.

CMS cannot claim to have unfettered authority limited only by what CMS deems appropriate. Such an interpretation would violate separation of powers principles, especially as the executive is attempting to claim that Congress delegated to it extraordinarily broad authority in a manner that would vitiate the rest of the Medicare Act. Therefore, the catchall provision cannot be read to grant CMS authority to implement and continue the standardized amount reduction associated with its Low Wage Index Redistribution.

2. The Secretary Did Not Act by Regulation as Required by Section 1395ww(d)(5)(I)

Even if the catchall provision could be read to provide for such broad authority to institute (and continue) the payment reduction associated with the Low Wage Index Redistribution, CMS has not followed the requirements of Section 1395ww(d)(5)(I). Section 1395ww(d)(5)(I)(i) requires adjustments made under this exception to be "provide[d] by regulation." Similarly, 42 U.S.C. § 1395hh(a) requires that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for service . . . shall take effect unless it is promulgated by the Secretary by regulation. . . ." CMS did not promulgate a regulation to effectuate the payment reduction, but merely applied it as a rate adjustment in the preamble to the FFY 2020 IPPS final rule (and proposed to apply it as a rate adjustment in the preamble of this proposed rule).

The term "regulation" in Section 1395ww(d)(5)(I) must mean something different than "rule" as defined in the Administrative Procedures Act (APA). Otherwise, Congress would have used the word "rule" rather than regulation. The mere discussion of the Low Wage Index Redistribution in the preamble to the FFY 2020 IPPS proposed or final rule is not a regulation. Neither the FFY 2020 IPPS proposed and final rules, nor the proposed rule for FFY 2021, contain a provision embodying the Low Wage Index Redistribution that was added to the Code of Federal Regulations. It is, of course, well established that preambles to regulations are not themselves regulations. *See Utah Power & Light Co. v. Sec 'y of Labor*, 897 F.2d 447, 450 (10th Cir. 1990) ("[P]reamble to the regulations . . . is not part of the regulations as published in the Code of Federal Regulations."); ("[I]t is well-settled that preambles, though undoubtedly 'contribut[ing] to a general understanding' of statutes and regulations, are not 'operative part[s]' of statutes and regulations." (quoting *Nat'l Wildlife Fed'n v. EPA*, 286 F.3d 554, 569-70 (D.C. Cir. 2002)). Moreover, publication in the *Federal Register* simply does not suffice to create a "regulation;" instead, publication in the Code of Federal Regulations is required. *See Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 538-39 (D.C. Cir. 1986). ("The real dividing line between regulations and general statements of policy is publication in the Code of Federal Regulations"). Therefore, even if CMS had the authority to implement and continue a payment reduction (which it does not), CMS implemented it (and proposes to continue to implement it) in a way that violates the statutory requirements of its allegedly authorizing statute (and others) and, therefore, is invalid.

3. CMS' Exceptions and Adjustments Authority Does Not Authorize Budget Neutrality Adjustments, Except with Respect to Transfer Cases

Even if CMS had the authority to institute the Low Wage Index Redistribution under Section 1395ww(d)(5)(I)(i) (which it does not), such exceptions and adjustments authority does not permit the implementation of the policy in a budget neutral manner. Rather, subsection (d)(5)(I)(ii) provides CMS with limited authority to adopt budget neutrality adjustments only in the context of adjustments for transfer cases and does not provide any similar budget neutrality authority for any other type of adjustment.

C. CMS Failed to Provide a Valid Rationale for the Low Wage Index Redistribution in the FFY 2020 IPPS Final Rule and the Proposed Rule for FFY 2021

In the FFY 2020 IPPS final rule, CMS provided a confusing rationale for the Low Wage Index Redistribution, stating that the policy "would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected

in the calculation of the wage index." CMS continued that its "proposal to increase the wage index for low wage index hospitals will increase the accuracy of the wage index by appropriately reflecting the increased employee compensation that would occur (to attract and maintain a sufficient labor force) if not for the lag in the process between when a hospital increases its employee compensation and when that increase is reflected in the calculation of the wage index." CMS further stated that "the intent of [the Low Wage Index Redistribution] is to increase the accuracy of the wage index as a technical adjustment, and not to use the wage index as a policy tool to address non-wage issues related to rural hospitals, or the laudable goals of the overall financial health of hospitals in low-wage areas or broader wage index reform." It is irrational, however, for CMS to assert that it makes the wage index, which is required by statute to be data-driven, more accurate by changing the wage index values for 25% of IPPS hospitals so that they are not based on actual data.

CMS continued in the FFY 2020 IPPS final rule that under this Low Wage Index Redistribution "the wage index for low wage index hospitals will appropriately reflect the relative hospital wage level in those areas compared to the national average hospital wage level [, b]ecause our proposal is based on the actual wages that we expect low wage hospitals to pay[.]" *Id.* Essentially, CMS asserted that by making wage index values inaccurate for 25% of the nation's hospitals, it was making it more accurate because the data would reflect what CMS conjectures it could possibly become if low-wage index hospitals adjust their wages under the policy. This circularity is illogical and does not provide a legitimate basis for the Low Wage Index Redistribution.

Furthermore, CMS denied it was using the wage index as a policy tool while implicitly acknowledging that it was using the Low Wage Index Redistribution to change hospital labor markets because it expected wage payments in low-wage markets to increase under the policy. CMS emphasized that the redistribution provides "an opportunity for low-wage hospitals to increase their employee compensation." But CMS did not require low-wage hospitals to use the increased payments to pay for higher wages. CMS' assertion that the wage index for the lowest wage area hospitals will increase in the future is nothing more than wishful speculation, at best, and thus, the redistribution lacks a factual predicate.

Moreover, CMS' rationale — that making wage data inaccurate will actually make it more accurate — is patently unreasonable. First, CMS is required by statute to determine the wage index by using actual wage data, not a projection of what it speculates the data might be if it were to artificially increase the wage index based on an unsupported guess as to how the lowest quartile hospitals may behave.[5] Second, in both the FFY 2020 IPPS final rule and the proposed rule CMS has offered no data, analysis, survey, or other evidence to support the notion that bottom quartile hospitals will pay higher wages if

[5] Neither CMS, nor any other federal agency, can know how private actors will act in the future. Even CMS accepted this as true in the FFY 2020 IPPS final rule, responding to comments that the Low Wage Index Redistribution does not have any method to ensure that low-wage hospitals actually increase employee compensation by stating that the policy "is intended to provide an *opportunity* for low-wage hospitals to increase their employee compensation." (84 Fed. Reg. 42327) (emphasis in original). CMS continued that because the policy is not a permanent one, that "[a]t the expiration of the policy, hospitals that have not increased their employee compensation in response to the wage index increase may experience a reduction in their wage index compared to when the policy was in effect." CMS added that "[t]he future wage data from those hospitals will help us assess our reasonable expectation based on comments received in response to the request for information as well as proposal that low-wage hospitals would increase employee compensation as a result of our proposal." In other words, while CMS claims to be making the wage index more accurate, it effectively admits this is an experiment and the results are uncertain. Rather than being a "technical adjustment," CMS is clearly attempting to implement policy changes through the wage index, despite its statements to the contrary in the FFY 2020 IPPS final rule.

their AWI is increased. Third, hospitals, like other employers, pay salaries based on the local labor market, which is largely unaffected by the payments received by a hospital. That labor market is affected by local factors such as the labor supply in the area, the availability of a labor force with appropriate skills and education, the demand for labor, and the cost of living. CMS has offered no information to the contrary. Fourth, the lag issue referenced by CMS in the FFY 2020 IPPS final rule as to why low-wage index hospitals cannot benefit from wage increases applies to all IPPS hospitals, not just those with low wages. Any hospital that increases wages to respond to the local labor market will not see the impact of the wage increase in the AWI for several years. In fact, some low-wage hospitals are benefited by the lag where their wages decrease from year 1 to year 2. The only way to truly address the lag would be to retroactively correct the wage index and adjust Medicare payments after the actual data for a period are known, which of course is not compatible with a prospective payment system.

While CHA can appreciate CMS' desire to limit costs to the Medicare system, there is no requirement that it help hospitals in the lowest quartile by harming all other IPPS hospitals. The disparities in average hourly wages paid across the country, reported as part of audited cost reports and used to calculate the area wage index, are real. While the wage index is imperfect, as noted by several nationally recognized studies — including those of MedPAC, the Institute of Medicine, and CMS — the object is to capture accurate wage data that reflect the significant cost-of-living differences among states, more generally. The following data are illustrative:

State	Average Annual Nurse's Salary[1]	Median Household Income[2]	Median List Price of Houses for Sale[3]
CA	$113,240	$75,277	$533,500
NY	$87,840	$67,844	$429,000
NJ	$84,280	$81,740	$340,000
TN	$62,570	$52,375	$257,904
AL	$60,230	$49,861	$220,000
MS	$59,750	$44,717	$189,000

1. Source: Bureau of Labor Statistics, Occupational Employment Statistics, May 2019 State Occupational Employment and Wage Estimates 2. Source: US Census Bureau 2018 Median Household Income in the United States 3. Source: Zillow.com Home Prices & Values. Data as of June 29, 2020

The labor costs incurred by hospitals are largely a function of the market in their respective geographic areas. CMS has offered no data or other evidence to the contrary.

While we appreciate that CMS wishes to address the financial challenges of our nation's rural hospitals, CMS has finalized (and seeks to continue) a broad policy to help only hospitals in the lowest quartile, rural or not. **CHA agrees that helping rural hospitals is a laudable goal. Doing so in a permissible manner is an effort we would support. But as finalized in the FFY 2020 IPPS final rule and as continued in this proposed rule, the policy harms numerous rural hospitals, including all of California's rural hospitals, and it fundamentally fails to recognize the legitimate differences in geographic labor markets.**

In summary, there are no bases for implementing and continuing this policy at all, let alone in a budget-neutral manner, since Section 1395ww(d)(5)(I)(i) does not authorize budget neutrality. CMS' decision to continue to do so irrationally penalizes all IPPS hospitals in an effort to benefit the low-wage hospitals that CMS views as deserving. Far from a technical adjustment, this is CMS weaving policy into the area wage index to create inaccurate wage index values to benefit 25% of the nation's IPPS hospitals. Neither Section 1395ww(d)(5)(I) nor Section 1395ww(d)(3)(E) provides CMS with

authority to do this. We, therefore, ask CMS not to continue the Low Wage Index Redistribution in FFY 2021.

Market-Based MS-DRG Relative Weight Proposed Data Collection and Potential Change in Methodology for Calculating MS-DRG Relative Weights

CMS proposes to collect MA and third-party payer contracted rate data in the Medicare cost report and use it to calculate new relative MS-DRG weights beginning in FFY 2024. CMS says that its proposals are intended to achieve the agency's goals of reducing Medicare's reliance on the hospital chargemaster and support the development of a "relative market-based payment methodology under the IPPS."

CHA strongly opposes CMS' proposal to require hospitals to report the median payer-specific negotiated rates by MS-DRG for MA plans and all of its third-party payers. CHA also opposes the proposal to use this data to change the methodology for calculating the MS-DRG weights, which would revise the methodology for establishing MS-DRG weights from a methodology based on hospital costs to a methodology based on rates in contracts between hospitals and payers. As our comments will demonstrate, CMS' proposals are inextricably linked. As CMS has not provided a serious rationale for requiring hospitals to report the median negotiated charge data apart from potentially changing the manner in which MS-DRG weights are established — a change in the methodology that is not supported by the Medicare Act — CMS should not require the data to be reported.

As discussed further below, (1) CMS' proposal to base the DRG weights on hospital payer-specific negotiated charge data — or contracted rates — and to require reporting of the data on the Medicare cost report is inconsistent with the Medicare Act's provisions concerning the establishment of the MS-DRG weights requiring that the weights be based on the relative resources used to treat patients in each MS-DRG; (2) CMS' proposal is arbitrary and capricious because contracted rates do not reasonably establish the relative costliness or provider inputs among the MS-DRGs; (3) CMS has failed to articulate a rational basis for the data collection or basing MS-DRG weights on contracts weights, (4) the hospital price transparency final rule itself on which this proposal is based is invalid for the reasons asserted by the plaintiffs in the pending litigation, notwithstanding the recent decision of the U. S. District Court for the District of Columbia; (5) CMS lacks authority to require hospitals to report contracted rates; (6) CMS' proposal is not mandated by nor reasonably related to the Executive Orders cited in the proposed rule; and (7) CMS has substantially underestimated the amount of time it would take hospitals to comply with the proposed reporting requirement.

1. <u>CMS' Proposal is Inconsistent with and Violates the Medicare Act</u>

Section 1886(d)(4)(B) of the Social Security Act contains Congress' directive to the Secretary concerning establishment of the MS-DRG weights, as follows:

> For each such DRG the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

Since FFY 2008, CMS has determined the weights based on the costs incurred by subsection (d) hospitals nationally in treating patients within each MS-DRG. CMS determines such costs by multiplying each hospital's average charges for patients within each MS-DRG by applicable cost-to-charge ratios. This approach is consistent with Congress' requirement that the weights be based on the relative resources used with respect to the DRGs, as costs clearly align with the resources and may be the best indication of the resources used.

The contract rate data CMS proposes may be used to establish the weights does not reflect relative resources used in treating patients within each DRG. Specifically, CMS states it is considering using the median payer-specific negotiated charge for each MS-DRG with payers that are MA organizations — or alternatively — the use of median payer-specific negotiated charges for MA plans and all third-party payers, or other similar data based on negotiated rates in contracts between hospitals and payers. However, these rates are not tied to costs or resources, but rather reflect myriad factors relating to negotiations between hospitals and private payers. These approaches will not provide any reasonable measure of the relative resources used to treat patients among MS-DRGs and will not provide data that are more accurate than the current cost information.

California hospitals report that hospital contract rates in MA contracts are most frequently based on the current Medicare IPPS. As CMS recognizes in the proposed rule, MA plans frequently pay the amount that would have been paid under IPPS perhaps multiplied by a factor that may be slightly more or slightly less than 100%. Indeed, the Berenson study cited by CMS in the proposed rule indicates that MA plans pay between 100% and 105% of IPPS rates.

The data from MA contracts, therefore, will simply reflect what Medicare has been paying under IPPS; that is, this data will report the most recent IPPS rates based on the most recent IPPS MS-DRG weights. Any weights calculated based on this data will necessarily be the same, or almost the same, as the weights CMS has most recently used under IPPS. These weights would, therefore, be based on old cost data, as the IPPS weights are based on older, not current, cost data. In fact, if MA plans continue to pay hospitals based on IPPS rates, using MA contracted rates to determine MS-DRG weights will freeze the weights beginning with the weights in place when the methodology change is implemented. Thus, using rates from MA contracts will not reasonably reflect the current resource utilization, and certainly will be far less accurate than the current cost methodology.

Many commercial, non-MA contacts with hospitals also use IPPS rates, so using this data will result in the same problems as using the MA contract rate data.[6] Other contracts, including some MA contracts, may be based on per diem rates. Per diem rate contracts typically involve either a single per diem rate or multiple rates based on the unit in which the patient is receiving services. These rates are rarely based on the patient's diagnoses, and virtually never based on MS-DRGs. Mapping these rates to MS-DRGs — and using them to calculate the MS-DRG weights — will result in weights based primarily on length of stay, rather than on hospital resource use.

Also common in California — for both MA and non-MA contracts — are contracts that use capitation, under which the hospital is paid a fixed amount per member, per month who is assigned to that hospital. Mapping these rates to MS-DRGs becomes highly arbitrary and completely disconnected with the MS-DRG resource utilization. Rather, capitation rates represent negotiated amounts reflecting the forecasted average cost of treating the payer's members assigned to the hospital.

There are numerous variations on contract arrangements. Many contracts have stop-loss provisions and/or risk-sharing arrangements. Other contracts have rates reflecting various trade-offs, including volume levels and a consideration of rates globally as they apply to the entire complement of services subject to the contract. These arrangements may reflect risk allocation or other factors, but do not reflect resource utilization.

[6]There is also a lack of comparability between a Medicare patient population and a commercial insurance patient population, making the use of commercial insurance contract rates a poor basis for determining the resource use among MS-DRGs for purposes of establishing Medicare payment rates.

In sum, rates in contracts between hospitals and payers do not reasonably reflect comparative resource utilization among MS-DRGs. Use of these rates will yield arbitrary results that are much less accurate than the current cost-based methodology. The use of contracted rates — whether MA rates or rates based on all payer contracts — to determine MS-DRG rates would, therefore, be inconsistent with the governing statute and would be invalid. As the use of the contracted rates to set MS-DRG rates would be invalid, there is no legitimate rationale to require hospitals to report the median contract rates.

2. Using Contract Rates to Set MS-DRG Weights Would be Arbitrary and Capricious Because CMS Has Not Considered the Key Relevant Factor

An agency's action must be based on a consideration of the relevant factors. The agency must demonstrate a reasonable connection between the factors considered and the agency's decision. The agency's decision may be supported, if at all, based on the explanation given by the agency when it makes the decision. See *Department of Homeland Security v. Regents of the University of California*, Case Nos. 18-587, 18-588, 18-589 (U.S. Supreme Court June 18, 2020).

The key relevant factor to be considered when establishing MS-DRG weights is the relative use of resources among discharges assigned to the various MS-DRGs. As discussed above, contracted rates do not reasonably reflect such relative resource utilization, and certainly do not do as well as the current cost-based approach. CMS has not provided a reasonable explanation regarding how resource utilization can be determined from contract rates, or a reasonable explanation of why hospitals should report the contract rate data where it will not support the determination of relative resource use among the MS-DRGs.

3. CMS Has Failed to Provide a Reasonable Explanation for the Potential Use of Contract Rates to Set MS-DRG Rates

CMS indicates that it is exploring using contracted rates because it wants to move away from relying on charges as set forth in hospital charge description masters (CDMs), explaining that such charges are paid by few, not closely tied to costs, and not reflective of market rates. Even assuming this is correct, this rationale does not justify using contract rates to set the weights.

As CMS acknowledges, the weights are not based on charges, but are based on costs, determined by reducing charges to costs by applying cost-to-charge ratios. The IPPS is clearly not a charge-based payment system, and to the extent CMS indicates it wishes to move away from paying based on CDM charges, the fact is that the Medicare program is not paying based on CDM charges, but merely using charges as a factor in determining the cost of specific services. A desire to move way from using CDM charges, therefore, is not a legitimate reason for determining MS-DRG weights based on contracted rates, which have little to do with resource utilization, rather than using costs — which have everything to do with resource utilization.

Whether CDM charges are consistent with negotiated rates, whether few patients and payers actually pay them, or whether they are a multiple of costs has nothing to do with the usefulness of charges as a factor in determining the costs of care for a specific patient and, therefore, the resource utilization of that patient. Again, the charges are reduced to costs, which is the best measure of resource utilization. Moreover, the question is the *relative* resource utilization among the MS-DRGs, which is largely unaffected by the fact that charges may be a multiple of costs so long as the charges themselves at least roughly represent the relative value of a hospital's items and services, and there is nothing in the proposed rule indicating they do not.

CMS mentions the issue that arose a number of years ago with some hospitals increasing their CDM charges more rapidly than their costs increased, resulting in higher Medicare outlier payments. That concern does not undercut the current approach to determining MS-DRG weights. First, CMS revised the Medicare regulations years ago to reconcile outlier payments using current period data where a hospital's charges increase significantly, thereby removing the incentive to increase charges. There is no evidence addressed in the proposed rule that indicates this remains a problem. Even if a hospital's charges are significantly increased from one year to the next, they are still reduced to costs. Furthermore, even if the cost-to-charge ratio derives from an earlier period than the charges to which it is applied, the key is the relative costliness among the MS-DRGs, not the absolute costs of a particular patient. That relative cost calculation is largely unaffected by charge increases.

CMS mentions that hospitals are reluctant to decrease charge levels because of Medicare payment policies that rely on charges to determine payments. As CMS notes, however, the IPPS payment policy that takes charges into account is the outlier methodology, and CMS' regulations allow for adjustments so that hospitals will not be penalized if they reduce charges. CHA and its members rigorously explored the issues concerning charge reductions, including discussions with CMS, and concluded that neither Medicare outlier policy nor any other Medicare policy was a barrier to charge decreases. Rather, the principal barrier was obtaining changes to managed care contracts with payers to ensure that charge reductions would be budget neutral, as the payers were disinclined to remove standard contract provisions limiting payments for a particular inpatient stay or outpatient services to billed charges. This meant that charge reductions would not be budget neutral but would instead result in significant payment reductions. CMS does not present evidence indicating that the current approach by Medicare to determine MS-DRG weights has any effect on hospital decisions concerning increasing or decreasing CDM charges.

CMS also states a desire to move toward market-based pricing under fee-for-service (FFS) Medicare. However, Congress has carefully crafted IPPS in substantial detail, and it is not a market-based system. Rather, it is a regulatory system designed to establish payments for different categories of cases based on resource utilization, not negotiations in a free market. The manner in which the standardized amount is calculated to be applied to the MS-DRG weights is well prescribed by Congress, and Congress on occasion has stepped in to limit the rate of increase in these amounts. For example, Congress has established adjustments to take into account area wage differences, provided additional funding for medical education expenses and payments for DSH hospitals, and many other factors. This intricate payment system represents Congress' policy choices concerning the best way to expend limited resources in the Medicare system, and CMS has no authority to change it to a market-based system.

Taking into account market factors would introduce the consideration of a factor that Congress did not authorize the agency to consider in establishing IPPS rates. Indeed, Congress has enacted a market-based Medicare program under MA. Where Congress wishes a Medicare program to be market-based, it clearly knows how to do so.

4. CMS Should Not Implement the Proposed Data Collection

CHA urges CMS not to finalizes its proposed requirement that hospitals report median payer-specific negotiated charges for MA plans or all other third-party payers on the Medicare cost report. The only purpose identified by CMS in gathering the contract rates is to explore using the median contract rates to set the MS-DRG weights. As discussed above, CMS may not validly make this policy change, and this change would result in far less accurate MS-DRG weights than using the current cost-based approach. Therefore, there is no rational basis for requesting the information.

Second, CMS believes that the burden on hospitals of providing the median rate data will not be substantial, as providers are required to publish payer-specific rates under the hospital price transparency final rule. That rule itself, however, is invalid for the reasons previously set forth in comments to CMS by CHA and others in conjunction with the promulgation of the rule and for reasons articulated by the plaintiffs, including the American Hospital Association (AHA), in *American Hospital Association v. Azar*, Civil Action No. 1:19-cv-03619. Because the hospital price transparency final rule is invalid, the proposal to require reporting of median contract rates is also invalid as it is predicated on the implementation of that rule, and for many of the same reasons that the hospital price transparency final rule is invalid.

CHA recognizes that the district court in *American Hospital Association v. Azar* recently ruled in favor of the Secretary in upholding the price transparency rule. CHA understands that the AHA and other plaintiffs intend to appeal that ruling. At the very least, CMS should not implement the proposed rule to require the reporting of median rates until that appeal is resolved and there is a final court decision on the validity of the hospital price transparency final rule. Otherwise, CMS would be implementing a requirement to report median contract rate data that is justified by a rule that may turn out to be invalid and enjoined.

Third, requiring the reporting of median MA contract rates will be misleading to the public, and upset the delicate balance between hospitals and payers in rate negotiations. The data will be misleading for various reasons, including that hospitals are frequently not paid based on MS-DRGs, so that the crosswalks from contract rates to MS-DRGs will necessarily be inaccurate and provide little meaningful information. The data will certainly not provide the public with an accurate understanding of hospital contract rates, or an accurate picture of median contract rates by MS-DRGs.

There is a delicate balance between hospitals and payers in contract negotiations, and CHA is concerned that this proposal will further tip the balance of these negotiations toward the payers. Payers will assuredly rely on the median rate information reported by hospitals to attempt to ratchet rates down to no higher than the median, and likely seek rates that are lower than the median. A median, however, is simply a data point in which half of the rates are higher than the median and half of the rates are lower than the median. As plans that pay rates higher than the median would have data to move to the median if hospitals report median contract rates, hospitals will lose substantial revenue they can ill-afford to lose, particularly now as hospitals are struggling financially due to the COVID-19 pandemic. Over time the median will be driven lower, creating a downward spiral on contracted rates. CMS should not put its thumb on the scale by requiring that hospitals report median payer-specific negotiated rates.

Fourth, a requirement imposed on hospitals to report the contract rate information would be beyond CMS' authority. CMS cites sections 1815(a) and 1833(e) of the Social Security Act as authority for reporting the contract rate data. These provisions allow CMS to require hospitals to provide information to determine the amount of payments due the provider under the Medicare program for the current or prior periods. The contract rate information is not used by CMS to determine the amount of payments due to hospitals for the current period or for prior periods. CMS has no authority to require hospitals to report this information.

Similarly, CMS cost reimbursement regulations cited in the proposed rule, 42 C.F.R. sections 413.20 and 413.24, provide no authority to collect contract rate data. These regulations require providers to maintain records to properly document costs and statistics reported in a Medicare cost report. Contract rates, of course, have nothing to do with the determination of allowable costs on a Medicare cost report.

5. The Executive Orders Do Not Support the Proposed Rule

CMS refers to Executive Orders 13813 and 13890 as support for the collection of hospital rates and potential use of those rates to set MS-DRG rates. Neither Executive Order provides this support.

Executive Order 13813 has nothing to do with Medicare or price transparency. It certainly does not direct CMS to collect contract rate data, or to consider basing MS-DRG rates on hospital contract rates. Rather, its stated administration objective is to promote the purchase of health insurance across state lines and more generally the development of a health care system that provides high-quality care at affordable prices. CMS fails to explain how the proposed rule furthers either policy objective. Rather, the Executive Order appears focused on health care coverage purchased by individuals or employers, rather than coverage provided by the government under the Medicare program where the "price" is paid by the government and not the individual.

Executive Order 13890 does address Medicare, and requires the Secretary to identify approaches "to modify Medicare FFS payments to more closely reflect the prices paid for services in MA and the commercial insurance market, to encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement." However, the Executive Order does not authorize a requirement that hospitals report contracted rates. While it directs the Secretary to explore modifying Medicare rates to align with rates in MA contracts and the commercial insurance market, the weighting of MS-DRGs based on contracted data will not meet this objective. All the weights do is divide — in a budget-neutral manner — IPPS funding among the MS-DRGs. They are not Medicare payment rates, and using contract rates to set the MS-DRG rates will not move Medicare FFS rates closer to MA and commercial contract rates. Furthermore, the Medicare population is so different from the population with commercial insurance that rates paid for Medicare services may not be rationally tied to rates paid for services under commercial insurance.

Of course, even if the Executive Orders did authorize collection of the contract rate data, or the potential use of contract rates to set MS-DRG weights, the Executive Orders cannot extend CMS' authority beyond the authority granted to it by Congress. As discussed above, Congress has not authorized CMS to require hospitals to report contract rates; such reporting would be inconsistent with the authority granted by Congress under the Medicare Act. Similarly, the use of contract rates to establish MS-DRG weights would contravene Congress' directive that weights be based on relative resource utilization. Accordingly, the Executive Orders cannot be read to authorize the proposed rule.

6. The Burden Imposed by the Data Reporting Requirement

In addition, CMS has greatly underestimated the burden imposed on hospitals under its proposal to require the reporting of median payer-specific negotiated contracted rates for MA plans and all third-party payers by MS-DRG, which CMS estimates to be 15 hours per hospital — five hours for recordkeeping and 10 hours for reporting. CHA anticipates that this task will be very difficult given the variability of contract arrangements discussed earlier in our comments. Furthermore, most hospitals have many contact arrangements that are not uniform with different rate methodologies, and that are periodically revised. This makes gathering and maintaining the necessary data and transforming the rate data on an ongoing basis to MS-DRGs an extraordinarily complex and time-consuming task. As hospital resources are currently stretched very thin due to the challenges in responding to the COVID-19 pandemic, this is the wrong time to impose additional burdens on hospitals.

Finally, CMS provides no guidance to hospitals on how the information required for reporting under the Hospital Price Transparency final rule should be crosswalked to MS-DRGs. In addition to increasing

burden, we are concerned that the lack of guidance on how to crosswalk these varying contracting arrangements will lead to inconsistent reporting among hospitals, rendering data collected unusable for the purposes of revising the methodology for establishing relative MS-DRG weights. **We urge CMS to withdraw its proposals.**

Medicare DSH Payments

As required by the Affordable Care Act (ACA) — beginning with FFY 2014 — Medicare DSH payments are split into two separate payments. Hospitals receive 25% of the overall Medicare DSH funds under the traditional DSH formula, known as the "empirically justified" DSH payments, and the remaining 75% flows into a separate pool for DSH hospitals. This pool is reduced for decreases in the uninsured population since FFY 2013 and is allocated based on each hospital's share of national UCC costs.

For FFY 2021, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $15.359 billion. Hospitals would receive 25% of these funds — or $3.840 billion — as empirically justified DSH payments. The remaining $11.519 billion becomes Factor 1 of the three-factor formula to establish the UCC payments. Factor 2 of the formula adjusts Factor 1 based on the percent change in the uninsured since implementation of the ACA. In the proposed rule, CMS determines that the percentage of uninsured for FFY 2021 would be 9.5% using the CMS' Office of the Actuary National Health Expenditure Accounts. After inputting that rate into the statutory formula, CMS proposes to retain 67.86% — or $7.817 billion — for the UCC pool for FFY 2021. This would result in a decrease of about $534 million in UCC payments in FFY 2021 compared to FFY 2020.

Notably, CMS' estimates of both the overall DSH payments and percentage of uninsured were made prior to the COVID-19 PHE and the economic crisis it has precipitated. A recent report by the California Health Care Foundation (CHCF), *The Financial Impact of COVID-19 on California Hospitals,* found that the economic recession would result in significant shifts in insurance coverage status. Specifically, CHCF estimates an approximate loss of 5 million California jobs, with nearly 3 million individuals losing employer-sponsored health insurance. CHCF further estimates that this would result in an additional 1.48 million enrolled in California's Medicaid program, and an increase of 770,000 uninsured individuals in the state, increasing the percent of uninsured in California by 2% compared to the pre-COVID-19 environment. **CHA urges CMS to identify more recent or alternative data sources that take into account the increasing percentage of uninsured individuals and Medicaid beneficiaries due to the impacts of COVID-19 to establish the available UCC payments.**

Proposed Use of Audited FFY 2017 Worksheet S-10 Data to Calculate Factor 3

Factor 3 of the DSH formula is equal to the hospital's amount of UCC relative to the amount of UCC for all DSH hospitals expressed as a percentage. The UCC pool established by Factors 1 and 2 multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

In FFY 2018, CMS began transitioning to use of Worksheet S-10 as the data source for estimating the UCC attributable to a hospital. Worksheet S-10 of the Medicare cost report is used to record charges and costs for UCC. For FFY 2018, CMS used a blend of two years of low-income patient days and one year of Worksheet S-10 data (FFY 2014). In FFY 2019, CMS continued that transition by using one year of low-income patient days and two years of Worksheet S-10 data (FFY 2014 and FFY 2015). In FFY 2020, CMS transitioned to using a single year of data from the audited FFY 2015 Worksheet S-10 cost report data.

CMS proposes to continue the use of a single year of data – from FFY 2017 cost reports – to calculate Factor 3 in the FFY 2021 methodology for all eligible hospitals except for Indian Health Service (IHS) and Tribal hospitals and Puerto Rico hospitals. CMS notes that UCC payments to hospitals whose FFY 2017 Worksheet S-10 data have been audited represent about 65% of the proposed total UCC payments for FFY 2021. In addition, FFY 2017 cost reports reflect the revisions to the Worksheet S-10 instructions that were effective on October 1, 2017.

CHA has long been supportive of efforts to improve the Worksheet S-10 instructions and audits of the Worksheet S-10 cost report data. We applaud CMS for its commitment to improving the Worksheet S-10 data to ensure an equitable distribution of a limited and fixed pool of uncompensated care payments. We share the concerns of the agency that blending audited and unaudited data would be inappropriate and potentially lead to a less accurate result. **For FFY 2021, CHA supports the use of a single year of data from the audited FFY 2017 Worksheet S-10 data to calculate Factor 3.**

Proposal to Use Most Recent Available Single Year of Audited Worksheet S-10 Data to Calculate Factor 3 for All Subsequent Fiscal Years

CHA does not support CMS' proposal to carry forth its policy and establish that beginning with FFY 2022 and all subsequent years, it would use the most recent single year of cost report data that have been audited for a significant number of hospitals receiving substantial Medicare UCC payments to calculate Factor 3. While CMS believes that such a policy would give providers greater predictability for planning purposes, we remain concerned that the use of a single year of cost report data could result in significant year-to-year volatility in UCC payments for hospitals. As CMS continues to expand its audits of Worksheet S-10 data, we urge the agency to assess the level of stability in UCC payments and consider in the future a blend of multiple years of audited data should there be a need to mitigate volatility. We urge CMS not to finalize its proposal for FFY 2022 and subsequent years.

CHA continues to believe that all hospitals should be audited using the same audit protocols and that auditor education is paramount. As a fixed amount is available for UCC, CHA does not believe it is equitable to subject only some hospitals to desk reviews. In addition, we encourage CMS to work with the MACs to improve the Worksheet S-10 audit process to further promote clarity, consistency, and completeness in the audits. For example, CMS should establish a standardized process across auditors, including standard timelines for information submission and acceptable documentation to meet information requirements. We also urge CMS to develop a transparent timeframe for the audit, with adequate lead time and communication to providers about expectations, and to establish a process for timely appeals.

Medicare Bad Debt

CMS proposes a number of changes to Medicare bad debt policies that it says are necessary to clarify certain policies that have been the subject of litigation and generated interest and questions from stakeholders over the past several years. In particular, CMS proposes a number of changes that would codify policies included in Chapter 3, Part 1 of the Provider Reimbursement Manual (PRM) into the regulations.

Many of the changes CMS proposes would be effective both retroactively and prospectively and apply for cost report periods before, on, or after October 1, 2020. CMS believes this is appropriate because the changes reflect longstanding policies included in the PRM. **CHA opposes the retroactive adoption of changes to the regulations.**

CHA disagrees that the changes are not burdensome and that "failing to adopt the clarification and codification of longstanding Medicare bad debt policies with a retroactive effective date might lead some providers to believe that those policies did not apply to earlier cost reporting periods, and thus might cause those providers to resubmit previously submitted cost reports." In fact, retroactive adoption of such policies may have the effect that CMS is intending to avoid, as hospitals may want to invest the time and resources in the resubmission of cost reports under regulatory requirements that were previously provided only in sub-regulatory guidance. This would also require the government to expend resources in the review of such cost report submissions. **CHA urges that any changes finalized for Medicare bad debt policies are done so prospectively.**

Determining Indigency

CMS proposes to codify requirements under Chapter 3, Section 312 of the PRM on how hospitals should determine the indigency of non-Medicaid patients for the purposes of claiming a beneficiary's unpaid deductible and/or coinsurance as Medicare bad debt. CMS proposes to apply these changes retroactively. Specifically, CMS proposes to require that providers independently verify a patient's indigent status, meaning they will not be able to rely solely upon signed declarations by the patient, be required to take into account a patient's "total resources" in determining indigence, including assets, liabilities, income and expenses, and confirm that no source other than the beneficiary is legally responsible for the bill. In addition, CMS proposes to require that the patient's file contain documentation of the method by which indigence was determined in addition to all information to substantiate the decision.

Notably, CMS proposes language that includes a key change from the PRM. Specifically, as part of the "total resources" test, the PRM states, "The provider ***should*** take into account a patient's total resources, which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses." The proposed regulation states, "The provider ***must*** take into account a beneficiary's total resources which includes, but is not limited to, an analysis of assets (only those convertible to cash and unnecessary for the beneficiary's daily living) liabilities, and income and expenses." **The change from "should" to "must" is a significant change to the requirements that should not be applied retroactively.**

Furthermore, CHA has concerns related to changing this policy from a guideline that providers should consider to a requirement that providers must comply with, and we urge CMS to not finalize its proposal. Specifically, the proposed change is contrary to preceding requirements under Section 312 that says for non-Medicaid beneficiaries, "The provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines." However, the customary methods for determining indigence of patients under a hospital's established financial assistance policy may not include the same total resources test that is included as a guideline in the PRM and proposed as a new requirement in the regulations. For example, many hospitals' charity care or financial assistance policies focus solely on a patient's income. Under the proposal, a provider would not be able to claim reimbursement for indigent bad debt unless the hospital's financial assistance policy includes the four requirements as proposed for §413.89(e)(2)(ii)(A). In addition, the proposed requirement for a provider to evaluate a patient's assets directly conflicts with California law prohibiting hospitals from considering a patient's assets when determining eligibility for discounted care (*see* Calif. Health and Safety Code Section 127405(b) and (c)). Given this constraint, the proposal would result in substantial reductions in the amount of allowable bad debt for California hospitals, contravening Medicare's responsibility to reimburse hospitals for the costs of care rendered to Medicare beneficiaries.

Dual Eligible Beneficiaries

Dual eligible beneficiaries are Medicare beneficiaries enrolled in both Medicare and Medicaid. Some of these dual eligible beneficiaries have full Medicaid coverage, while others have partial Medicaid coverage where Medicaid may pay some or all of their Medicare cost sharing. CMS proposes to codify reasonable collection effort requirements for dual eligible beneficiaries so that a provider would be required to (1) bill the state Medicaid program to determine that no source other than the patient would be legally responsible for the patient's medical bill; and (2) obtain and submit to the MAC, a Medicaid remittance advice (RA) from the state Medicaid program. However, CMS acknowledges in the proposed rule that providers encounter challenges when states do not comply with the federal statutory requirements and seeks comment on potential alternatives to the "must bill" and Medicaid RA policies that it could adopt in the final rule.

CHA is concerned that CMS' proposal is overly burdensome to providers and urges the agency to accept a provider's estimate of the state's cost sharing when the provider submits documentation that it has billed the state but the state does not provide a remittance advice. In California there is an established path for hospitals to support their claims. As recognized by CMS in the proposed rule, state Medicaid programs, including Medi-Cal, make their cost sharing responsibility publicly known either as a part of their state plan or though posting the information on their websites. This allows hospitals to accurately determine — and for the MAC to audit — the amount Medicaid will pay toward the dual eligible beneficiary co-pays.

Accounting Standard Update (ASU) Topic 606 and Accounting for Medicare Bad Debt

The Financial Accounting Standards Board's (FASB) ASU 2014-09, Revenue from Contracts with Customers (Topic 606), was published in May 2014 with the first implementation period in 2018. Under the ASU Topic 606, an amount representing a bad debt would generally no longer be reported separately as an operating expense in the provider's financial statements, but will be treated as an "implicit price concession," and included as a reduction in patient revenue in external financial statements. To implement Topic 606, CMS proposes to modify the regulations to add that, effective for cost reporting periods beginning on or after October 1, 2020, "bad debts, also known as 'implicit price concessions' are amounts considered to be uncollectible from accounts that were created or acquired in providing services," and, "bad debts, also known as 'implicit price concessions,' charity, and courtesy allowances represent reductions in revenue."

CHA supports CMS' efforts to better align its documentation requirements with existing accounting standards. However, we urge CMS to state in the final rule that when reporting bad debt on Worksheet S-10 hospitals should include "implicit price concessions" on the same line as bad debt, and to issue guidance to both providers and MACs to clarify that implicit price concessions are a component of bad debt for Medicare purposes. We also recommend that CMS develop a line in Worksheet S-10 to properly document and account for implicit price concessions for calculating uncompensated care. We urge CMS to delay the effective date of this policy until appropriate guidance and documentation have been made available to providers.

CMS also proposes to clarify that, effective for cost reporting periods beginning on or after October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts. However, this contradicts the proposed regulations at §413.89(c)(1) that say, "Effective for cost reporting periods beginning before reporting periods beginning before October 1, 2020 bad debts, charity and courtesy allowances represent reductions in revenue." This proposal would require hospitals to write off bad debts/implicit price concessions to revenue accounts instead of bad debt accounts. ASU Topic 606 requires providers to

report implicit price concessions as reductions to revenue in their financial statements. **CMS' proposal to require Medicare bad debts to be charged to an expense account is administratively burdensome and would require hospitals to maintain their accounting records in a manner that is not consistent with their financial statements. The requirement does not impact the economic nature or substance of what constitutes a bad debt or contractual allowance, but rather directs hospitals to follow a specific and outdated accounting presentation for Medicare bad debts that is contrary to the current industry standard in accordance with ASU Topic 606. CHA opposes this proposal.**

Chimeric Antigen Receptor (CAR) T-Cell Therapy

CAR T-cell therapy is a cell-based gene therapy in which a patient's T-cells are genetically engineered to add a chimeric antigen receptor on the T-cells that will bind to a certain protein on the patient's cancerous cells. The CAR T-cells are then administered to the patient by infusion. In FFY 2019, CMS finalized the assignment of CAR T-cell therapy ICD-10-PCS procedure codes XW033CS (Introduction of engineered autologous chimeric antigen receptor t-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 3), and XW043C3 (Introduction of engineered autologous chimeric antigen receptor t-cell immunotherapy into central vein, percutaneous approach, new technology group 3) to MS-DRG 016 (Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy). In response to comments from CHA and other stakeholders, CMS proposes to establish an MS-DRG specifically for CAR T-cell treatments. Specifically, CMS proposes to assign cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a proposed new MS-DRG 018 CAR T-cell therapy, and to remove those codes from MS-DRG 016 and rename it "Autologous Bone Marrow Transplant with CC/MCC."

CHA strongly supports the establishment of MS-DRG 018 for CAR T-cell therapy. Furthermore, we applaud the agency for responding to our comments and excluding clinical trial claims from the calculation of the average cost in determining the relative weight methodology for MS-DRG 018. As the high-cost therapy product is typically furnished to the hospital at no cost in clinical trials, this will help ensure the relative weight of MS-DRG 018 is more reflective of the typical costs of providing CAR T-cell therapies. We also support the proposed payment adjustment for clinical trial cases. However, we urge CMS to re-evaluate codes that it will use to identify clinical trials to ensure this adjustment is applied correctly only for CAR T-cell specific clinical trials. Specifically, CMS should be aware that there are other cases coded as clinical trials in which a commercial CAR T-cell therapy product was purchased. In these trials, the Standard of Care includes providing CAR T-cell therapy, but a secondary therapeutic or treatment regimen under investigation is something other than CAR T. CMS' proposal for identifying CAR-T clinical trial cases (those reported with Z00.6) could inappropriately reduce payment in cases where the investigated intervention is something other than the CAR T-cell therapy product.

While CHA is pleased that CMS is taking steps to address the extraordinarily high cost of CAR T-cell therapy, we are concerned that there is still not adequate payment to cover the costs hospitals will pay to provide this lifesaving treatment. To ensure the integrity of the IPPS and beneficiary access in the long-term, additional solutions will be necessary. This is especially true given that both new and existing therapies are expected to be approved for additional indications. The current payment systems — of any payer, not just Medicare — were not built to sustain access to therapies with costs of these magnitudes. As technology continues to advance, such therapies will become more prevalent, and it is critical that CMS set a precedent that ensures beneficiary access to care. This requires not only appropriate payment, but also provider certainty of coverage determinations, as one post-care-provision denial would be devastating to both providers and beneficiaries. **We urge CMS to continue to engage all stakeholders to ensure we have long-term sustainable solutions that can be adapted over time and account for innovations that transform how we treat disease.**

Hip and Knee Joint Replacements

In response to stakeholder input that clinically effective treatment of patients undergoing hip replacement following hip fracture tend to have greater resource requirements than those without hip fracture, CMS proposes to create two new MS-DRGs for hip replacement with a principal diagnosis of hip fracture: MS-DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC) and MS-DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC). CHA agrees that hip fracture patients have needs that are often more complex than those requiring hip replacement because of degenerative joint disease, and we support the creation of MS-DRGs 521 and 522.

CMS also seeks comment on the impact of this proposal on the Comprehensive Care for Joint Replacement (CJR) model, including whether the proposed MS-DRGs should be incorporated into the model. CHA has long stated the clinical differences between hip replacement patients with fracture and non-fracture elective episodes of care within the CJR model, and the creation of new MS-DRGs for patients with fracture would certainly impact the current CJR model, which currently includes episodes triggered by MS-DRG 469 and MS-DRG 470. Under the CJR model, CMS sets four separate target prices for each hospital: for MS-DRGs 469 and 470, for patients with and without hip fractures. If the new MS-DRGs are finalized, CMS would need to account for these episodes under the CJR model.

CMS recently proposed a rule that would extend the CJR model for three additional years – through 2023 – and would modify the program to include outpatient episodes of care. **In comments on that proposed rule, CHA urged CMS to end the model as scheduled at the end of the current performance year 5 and evaluate the results of the five-year model to inform the development of future hospital-initiated voluntary payment models that could potentially include outpatient joint replacement episodes and the newly proposed MS-DRGs. CHA urges CMS to consider our previous comments on the impact that COVID-19 will have on the CJR model and not finalize proposals to extend and modify the model.**

Reporting Requirements for eCQMs

Currently – for both the Hospital IQR and Medicare and Medicaid Promoting Interoperability Programs – hospitals are required to report one self-selected calendar quarter of data for four self-selected eCQMs from the list of eight available eCQMs. Beginning with the CY 2022 reporting period hospitals must report on the Safe Use of Opioids – Concurrent Prescribing eCQM and three self-selected eCQMs. While the eCQM measure set would be retained, CMS proposes to expand reporting of these measures for both programs gradually so that by 2023 hospitals would report on data for a full calendar year. Specifically, CMS proposes that for CY 2021 hospitals would report data for two self-selected calendar quarters, for CY 2022 hospitals would report data for three self-selected calendar quarters, and for CY 2023 hospitals would report data for the full calendar year.

CHA does not support increased reporting of eCQM data beginning in CY 2021. While we appreciate that CMS is proposing an incremental approach intended to give hospitals and vendors time to plan and build upon existing Electronic Health Records (EHR) infrastructure, we do not believe it will be feasible for hospitals to increase their reporting in 2021. While the overall goals of increasing adoption of eCQMs are commendable, the pace of change is challenging for a health care system responding to the unprecedented challenges of the COVID-19 PHE.

Currently, hospital resources are focused on projects that most directly impact the needs of their communities in addressing the spread of COVID-19. This includes significant expansion of telehealth and virtual visits, expanded testing and screening sites requiring additional IT capabilities, and overall

infrastructure resources diverted to support surge planning. In addition, hospitals are complying with numerous federal and state data reporting requirements related to COVID-19 lab testing, patient volumes, and bed capacity, which are constantly evolving. While the duration of the pandemic remains uncertain, hospitals expect to be operating in this challenging environment well into 2021. **We urge CMS to maintain the current eCQM reporting requirements to submit a single self-selected quarter of eCQM data for CY 2021.**

Hospitals are supportive of efforts to improve and expand eCQM reporting in the future. However, significant challenges in reporting eCQM data to the QualityNet system make current reporting requirements difficult. We are concerned that as hospitals are required to submit additional data that create larger QRDA-I files, the strain on CMS' data systems will increase and require multiple submission attempts by hospitals, further increasing burden. We urge CMS to improve the capacity of the QualityNet portal to receive test and production QRDA-I files and send submission summary and performance reports before considering additional eCQM data reporting requirements.

Public Display of eCQM Data

Currently, hospital performance on eCQMs is not publicly reported on *Hospital Compare*. Having analyzed eCQM data from 2017 and 2018, CMS proposes to begin public reporting of eCQM data for the 2021 reporting period as early as the fall of 2022. CMS notes that hospitals would have the opportunity to review their data before they are made public; however, hospitals that have participated in eCQM validation continue to report concerns with inconsistencies in their validation reports that are not easily explained. As part of CMS' proposals to align the eCQM and chart-abstracted measure validation process, the agency proposes to expand the data validation educational review process to include hospital queries regarding eCQM validation. This is a welcome proposal, and we believe it will help to increase the reliability and validity of eCQM measures over time. However, until that process is expanded and improved, hospitals will be challenged in understanding how to improve measure performance.

Further in its validation proposals, CMS notes that eCQMs are not currently validated for accuracy, and CMS does not anticipate when the measures data will be ready for accuracy scoring validation. CHA does not believe it is appropriate to publicly report measures that have not been validated for accuracy. Finally, we are concerned that even if CMS finalizes its proposal to expand eCQM reporting to two self-selected quarters of data for 2021, it will not result in enough cases to capture trends in performance across hospitals. **CHA urges CMS to reconsider its proposal to begin public reporting eCQM data with the 2021 reporting year and instead focus agency efforts on improvements to the eCQM reporting systems and validation process.**

Medicare and Medicaid Promoting Interoperability Program

Reporting Periods

CMS previously adopted a reporting period of a minimum of any continuous 90 days for the Medicare Promoting Interoperability Program for 2021. CMS proposes to extend this continuous 90-day reporting period for 2022. **CHA strongly supports the proposed 90-day reporting period, which will provide hospitals with stability under the program as implementation of additional regulations to support interoperability and patient access to health information are ongoing.**

Voluntary Reporting of Query of Prescription Drug Monitoring Program (PDMP) Measure

The Query of PDMP measure — currently available for voluntary reporting — assesses the number of Schedule II opioid prescriptions for which Certified EHR Technology (CEHRT) data are used to conduct a

Query of a PDMP for prescription drug history (except where prohibited and in accordance with applicable law) as a percentage of the number of all Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or critical access hospital (CAH) during the EHR reporting period. CMS notes that a recent assessment of PDMPs by the Office of the National Coordinator for Health Information Technology found that less than half of hospitals reported integration of PDMP queries into the EHR workflow.

As a result, CMS proposes to continue the Query of PDMP measure as a voluntary measure for EHR reporting periods in 2021. Hospitals electing to report this measure report "yes" if, for at least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH used data from CEHRT to conduct a Query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. Hospitals that voluntarily report the measure would receive five bonus points under the proposed 2021 Promoting Interoperability Program scoring methodology. **CHA strongly supports this proposal. We agree that consultation of a PDMP is important for tracking prescribed controlled substances. However, the technology to integrate this process into the EHR is still under development.**

CHA appreciates the opportunity to share our comments on the proposed rule. If you have any questions, please contact Megan Howard, senior policy analyst, at (202) 488-3742 or mhoward@calhospital.org.

Sincerely,

/s/
Anne O'Rourke
Senior Vice President, Federal Relations