California Hospital Association

June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, as well as their related post-acute care providers, 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) 2023.

CHA's members remain appreciative of the federal government's efforts to support hospitals during the COVID-19 public health emergency (PHE). This includes CMS-provided waivers offering flexibility that remain in place and financial support through the Provider Relief Fund that offsets costs and lost revenue related to COVID-19 and incurred through March 31, 2021. These continued flexibilities and financial support are crucial if hospitals are to continue operations and invest in the staffing, supplies, and infrastructure necessary to maintain access for all who need care.

Three years into the PHE, California's hospitals — like other hospitals across the nation — continue to face unprecedented challenges posed by COVID-19. Despite these challenges, California's hospitals are providing care to those afflicted by COVID-19, addressing the backlog of services that has resulted in sicker patients, and taking steps to address the conditions that give rise to inequitable health outcomes. And our member hospitals are doing this in the face of considerable financial headwinds. At the same time, federal support for COVID-19 relief has evaporated — leaving hospitals to shoulder the expenses of protecting patients and communities from the PHE alone — while labor and supply costs are increasing in an unsustainable manner.

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A recent analysis by Kaufman Hall[1], a nationally renowned consulting firm, estimates that even after federal support, California's hospitals lost more than $12 billion in 2020 and 2021. Median expenses per discharge for California hospitals rose 15% in 2021, outpacing the 11% national average. These cost increases were largely driven by higher labor costs (+16%) and supply chain shortages impacting pharmaceuticals (+41%) and medical supplies (+19%)[2]. As a result of COVID-19-related losses and increasing costs per adjusted discharge that outstrip Medicare payment updates, 51% of California's hospitals had negative margins in 2021. These margins are unsustainable and jeopardize the stability of the delivery systems that are essential to continuing efforts to respond to the pandemic, ensuring access for all who need care, and addressing conditions in communities that give rise to inequitable outcomes. If negative margins persist, hospitals and health systems that are experiencing them will be forced to discontinue services that are financially unsustainable and rationalize those whose financial viability is questionable.

Given these losses, CHA's members are deeply concerned by many of the provisions in the FFY 2023 IPPS proposed rule. Considering the cost and margin pressures described above, we believe that the market basket update is inadequate and does not reflect input costs. Further, we believe that proposed payment cuts to uncompensated care disproportionate share hospitals (UCC DSH) do not reflect the reality of both the anticipated decrease in health insurance coverage that will occur because of the PHE and the increase in patient acuity that has occurred during the PHE due to forgone care.

Despite these concerns, CHA appreciates that in the FFY 2023 proposed rule CMS has taken necessary steps to further minimize the negative impact of the PHE on hospitals. We strongly support CMS' efforts to suppress quality measures from the calculation of value-based payment programs when they were impacted by the pandemic.

In summary, CHA:

- Is deeply concerned that the proposed market basket update is wholly inadequate given the input cost inflation providers have experienced and will continue to experience in the face of ongoing labor shortages and supply chain disruptions. CHA respectfully asks CMS to use alternative sources of data that better reflect input price inflation to calculate the FFY 2023 market basket update. Additionally, we respectfully ask CMS to use its existing authority to eliminate the productivity adjustment from the market basket update calculation for any year impacted by the COVID-19 PHE.
- Believes that CMS has overestimated the fixed-loss outlier threshold. We ask the agency to calculate the outlier threshold using data that better reflects the lower anticipated COVID-19 caseload hospitals will experience in FFY 2023.
- Appreciates CMS' request for information on the use of Z codes to better capture social determinants of health (SDOH) that may adversely impact patient outcomes and increase the resources necessary to provide high-value care. If CMS moves forward with any policy related to Z code reporting, we strongly encourage the agency to begin with reporting on a voluntary basis before imposing any mandatory requirement. Further, we strongly encourage the agency to limit initial efforts to capture Z codes for homelessness.

[1] https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf
[2] Expense increases based on per adjusted discharge.

- Strongly opposes CMS' proposal to continue its low-wage index policy that increases the wage index for hospitals with wage index values in the bottom quartile of the national distribution at the expense of all IPPS hospitals. CHA continues to believe — as the United States District Court for the District of Columbia found in *Bridgeport v. Becerra*— this policy is inappropriately redistributive, penalizes all IPPS hospitals in an effort that is mistargeted and ineffective to achieve the agency's stated goal, and is well beyond the agency's statutory authority.
- Encourages CMS to recalculate Factors 1 and 2 of UCC DSH calculation. Based on comments in the calendar year (CY) 2023 Medicare Advantage Rate Letter, CHA is concerned that CMS has significantly underestimated the growth in utilization and acuity in the Medicare Fee for Service (FFS) population, which has negatively impacted Factor 1. Further, CHA is concerned that the uninsured rate used to calculate Factor 2 does not account for the loss of coverage of up to 10 million individuals that is projected to occur when Medicaid redeterminations resume after the PHE ends, and enhanced exchange subsidies expire at the end of 2022.
- Strongly supports CMS' proposal to calculate Factor 3 of the UCC DSH calculation using multiple years of audited data from Worksheet S-10 of the Medicare Cost Report. We encourage CMS to finalize this proposal as we believe it will bring much-needed stability to Medicare payments for UCC DSH.
- Supports CMS' proposal to create an add-on payment to encourage hospitals to use domestically produced N95 respirators. However, given our members' experience with broad personal protective equipment (PPE) shortages during the PHE, we encourage the agency to expand the payment to additional domestically produced items that are essential during any PHE. Further, we are deeply concerned that if CMS limits this payment to only the PPE used in providing care to Medicare beneficiaries, the volume will not be sufficient to support the domestic manufacture of key PPE items.
- Supports CMS' proposals to address the impact of the PHE on the Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (VBP) Program, and the Hospital-Acquired Conditions (HAC) Reduction Program for FFY 2023. We urge the agency to continue to carefully analyze the impact of the ongoing PHE on performance data prior to finalizing proposals for FFY 2024.
- Supports many of CMS' priorities under the Hospital Inpatient Quality Reporting (IQR) Program — including advancing health equity and improving outcomes for maternal care — but urges the agency to prioritize fewer new measures and allow hospitals additional flexibility under electronic clinical quality measure (eCQM) reporting requirements.
- Responds to requests for information (RFI) on measuring health care quality disparities across CMS quality programs, assessing climate change impacts on outcomes, care, and health equity, and advancing maternal health equity.
- Cautions CMS against implementing significant changes to the Promoting Interoperability Program (PIP) during the PHE and opposes the addition of a new mandatory measure and requirements to advance levels of engagement under the Public Health and Clinical Data Exchange Objective.

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

Inpatient Hospital Operating Update

CMS proposes a market basket increase for FFY 2023 of 3.1%. This is then reduced by the 0.4 percentage point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed

IPPS market basket update equals 2.7% (3.1% minus 0.4 percentage points for productivity reduction) before the application of the documentation and coding adjustment.

CHA is deeply disappointed in the proposed 2.7% market basket update[3] as it is wholly inadequate relative to the input cost inflation experienced by acute care hospitals. This is a continuation of a longstanding trend of market basket updates that have failed to keep pace with hospital input cost inflation. As discussed below, we believe this is the result of methodological issues. CHA is aware that between FFY 2016 and 2020, the market basket update calculated with the "actual" IHS Global Inc. (IGI) data for the given federal fiscal year compared to the final rule market basket update calculated with forecasted data suggests that the market basket has been overstated by 2.5 percentage points[4,5].

IPPS Forecast (Final Rule) vs. "Actual" Market Basket Updates:
FFY 2016 – 2020

	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	Summary
Forecast Used in the Update[1]	2.40%	2.70%	2.70%	2.90%	3.00%	
Actual Based on Later Information[2]	1.80%	2.50%	2.50%	2.40%	2.00%	
Difference[3]	0.60%	0.20%	0.20%	0.50%	1.00%	2.50%

Notes:
1) These figures do not reflect total factor productivity or other legislative adjustments.
2) All of the information in this row is from OACT's 4th quarter 2021 release of market basket information with historical data through the 3rd quarter of 2021.
3) Positive values indicate CMS' final market basket overstated cost growth between fiscal years – overpaying hospitals, negative values indicate CMS understated cost growth between fiscal years and as a result under paid hospitals

However, analysis of growth in costs per risk-adjusted Medicare beneficiary discharge from Medicare cost reports for that time frame suggests the "actual" market basket update would have understated Medicare payments by 6.9% per discharge relative to the growth in allowable costs experienced by hospitals when they provide inpatient care to Medicare beneficiaries.

IPPS "Actual" Market Basket Update vs.
Medicare Risk Adjusted Per Discharge Cost Growth:
FFY 2016 – 2020

	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	Summary
Actual Based on Later Information[1]	1.80%	2.50%	2.50%	2.40%	2.00%	
CMI Adj. Medicare Per Discharge Cost Growth	0.93%	2.63%	2.03%	4.52%	7.99%	
Difference[2]	0.87%	-0.13%	0.47%	-2.12%	-5.99%	-6.90%

Notes:
1) All of the information in this row is from OACT's 4th quarter 2021 release of market basket information with historical data through the third quarter of 2021.
2) Positive values indicate CMS" final market basket overstated cost growth between fiscal years – overpaying hospitals, negative values indicate CMS understated cost growth between fiscal years and as a result under paid hospitals

[3] Net of productivity adjustment does not include documentation and coding adjustment.
[4] Health Policy Associates analysis of CMS Office of the Actuary Data.
[5] CHA notes during the five-year period from 2018 to 2022 hospitals were underpaid by .2 percentage points (-.2) when comparing the "actual" market basket update to the forecasted market basket update included in the final rule. However, for purposes of comparing the "actual" market basket update to growth in risk adjusted Medicare per beneficiary cost per discharge this letter focuses on the period 2016 to 2020.

Further, Medicare actually under-reimbursed hospitals by 4.4% when comparing the market basket update in the final rules from 2016 to 2020 to the growth in risk-adjusted beneficiary per discharge costs for the same period.

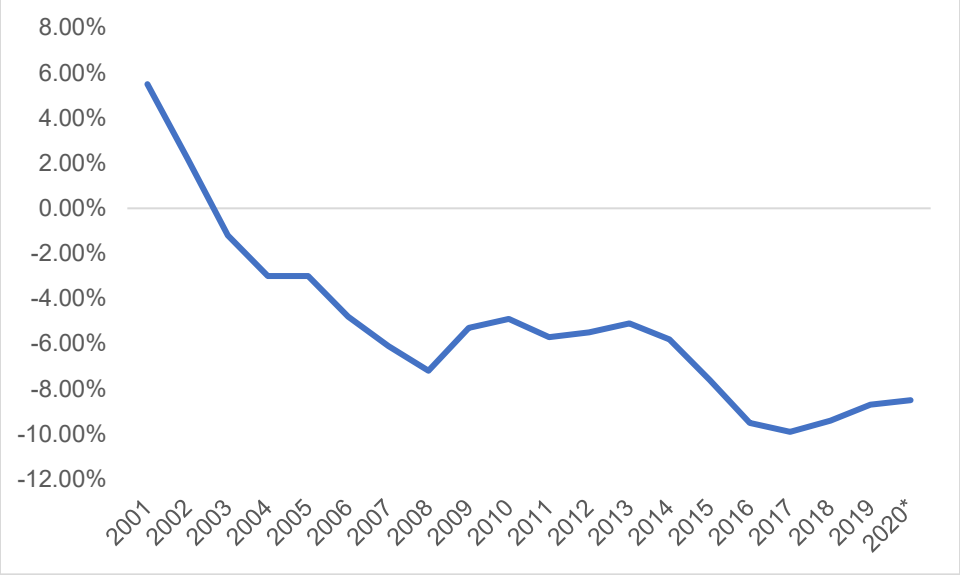
IPPS Final Rule Market Basket Update vs.
Medicare Risk Adjusted Per Discharge Cost Growth:
FFY 2016 – 2020

	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	Summary
Forecast Used in the Update[1]	2.40%	2.70%	2.70%	2.90%	3.00%	
CMI Adj. Medicare Per Discharge Cost Growth	0.93%	2.63%	2.03%	4.52%	7.99%	
Difference[2]	1.47%	0.07%	0.67%	-1.62%	-4.99%	-4.40%

Notes:
1) These figures do not reflect total factor productivity or other legislative adjustments.
2) Positive values indicate CMS' final market basket overstated cost growth between fiscal years – overpaying hospitals, negative values indicate CMS understated cost growth between fiscal years and as a result under paid hospitals.

Despite sustained cost reduction and efficiency efforts by hospitals, Medicare margins have declined over the last 20 years — as illustrated below. CHA believes this is due to persistently inadequate Medicare market basket updates as illustrated by the data provided above.

IPPS Hospital Medicare Margin: 2001 to 2020[6,7]



*Includes provider relief funds.

In FFY 2022 this longstanding trend has been exacerbated by the labor dislocations and supply chain breakdowns resulting from the pandemic and other geopolitical forces beyond the control of hospitals. These exacerbations are expected to persist through 2023, driving further inflation in input costs. Expenses per adjusted discharge have accelerated dramatically, offsetting the limited increases in revenue hospitals have experienced, which has resulted in reduced margins that threaten hospitals' financial viability. As an example, total California hospital expenses rose 15% in 2021 from pre-pandemic

[6] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[7] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch3_sec.pdf

(2019) levels, compared with 11% nationally[8]. Labor-related costs — based on CMS' own analysis of the Labor Related Share in the proposed rule — make up 67.6% of acute care hospital expenses in FFY 2023. In California, they increased 16% on an adjusted discharge basis from pre-pandemic to 2021.

While CHA appreciates that CMS will refresh the market basket update in the final rule with more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor. For instance, 53% of the hospital market basket is attributed to wages and salaries and total benefits for hospital-employed workers. IGI's FFY 2023 forecast figure for this element of the market basket is based on a historical figure of 2.7% for the four quarters ending September 30, 2021 — a figure that is considerably lower than what California's hospitals have recently been experiencing.

The employment cost index (ECI) that is the basis for the above number only includes hospital-employed staff. Driving the growth in labor expenses has been an increased reliance on contract staff, especially contract nurses, due to persistent clinical labor shortages. These are integral members of the clinical care team; without them, inadequate staffing would force hospitals to reduce services. In 2019, hospitals spent a median of 4.7% of their total nurse labor expenses for contract travel nurses. This skyrocketed to a median of 38.6% in January 2022. A quarter of hospitals — those who have had to rely disproportionately on contract travel nurses — saw their costs for contract travel nurses account for over 50% of their total nurse labor expenses.[9] CHA understands the ECI that is used for 53% of the hospital market basket will not account for these higher labor costs associated with contract nurses. This illustrates one of the flaws with the current data CMS is proposing to use for the FFY 2023 market basket update.

Even before the application of the productivity adjustment (discussed further below) the methodology — based on IGI data — has failed to keep up with cost growth year-over-year as illustrated above. Inflation has reached levels not seen in 40 years,[10] which predates the implementation of the IPPS in October 1983. It is clear, based in particular on rapidly rising labor costs, that CMS' current inputs for updating the IPPS market basket update are ill-suited to a highly inflationary environment, as CMS readily admits[11]. **Therefore, we ask CMS to identify more accurate data inputs and use the "exceptions and adjustments" authority found in Section 1886(d)(5)(I)(i) of the Act to use these more accurate inputs to calculate the final rule "base" (before additional adjustments) market basket update that better reflects the rapidly increasing input prices facing hospitals.**

CHA asks CMS to consider using the growth rate in allowable Medicare costs per risk adjusted discharge[12] for IPPS hospitals between FFY 2019 and FFY 2020 to calculate the FFY 2023 final rule market basket update. The data for this calculation can be obtained from Worksheets D-1, Part II, Lines 48 and 49 and S-3, Part 1, Column 13 of Medicare cost report. Based on CHA analysis, this would yield an unadjusted market basket update of 7.99%. A market basket update of 7.99% for FFY 2023 better reflects

[8] https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf
[9] Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems, American Hospital Association, April 2022.
[10] https://www.npr.org/2022/02/10/1079260860/january-inflation-consumer-prices-cpi-economy-federal-reserve
[11] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf

the actual input price inflation California's hospitals anticipate facing in the coming year than the 2.7%[13] market basket update proposed by CMS.

Section 1395ww(b)(3)(B)(iii) of the Act defines the "market basket percentage increase" to mean:

> *... with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.*

CHA believes that Medicare cost report data described above meets the statutory requirement. These data capture all allowable costs, including personnel costs and excluding non-operating costs that comprise routine, ancillary, and special care unit inpatient hospital services. Given that these data comprise all the costs — on a volume and risk-adjusted basis — necessary to deliver hospital care it represents "appropriately weighted indicators of changes in wages and prices which are representative of the mix of good and services ..." necessary to provide inpatient hospital care to Medicare beneficiaries. We believe these data are a more accurate projection of the cost inflation anticipated by hospitals during FFY 2023 than the forecast IGI data used in the proposed rule.

Further, CMS typically uses proxy data wherever possible to avoid circularity issues. However, CHA does not believe this is a reasonable argument against using cost report data. In many instances, the "proxy data" used to construct the market basket update are based on Bureau of Labor and Statistics' (BLS) surveys of hospitals[14]. Therefore, we do not believe that using cost report data in this instance introduces any additional circularity to CMS' calculation of the market basket update than already exists.

Additionally, while any hospital data obtained from the BLS are only a representative sample, using as-filed cost report data will allow CMS to base the market basket update on all IPPS hospitals. The cost reports that supply this data won't be audited and "finalized." However, CHA notes that BLS data are not audited either. The data reported on Worksheets D-1, Part II and S-3 Part I of the Medicare cost report are likely to be more accurate than data reported to the BLS. Hospitals have decades of experience completing these worksheets (which have detailed instructions) and the data input into Worksheets A (hospital expenses) and C (hospital revenue) — from which Worksheet D-1, Part II is derived — must reconcile to the hospital's audited financial statements when the cost report is filed. Neither of these things can be said about the BLS data, which calls its accuracy into question relative to Medicare cost report data. Finally, changes in volume and intensity are accounted for in the market basket update when CMS rebases or revises it. These changes to account for volume and intensity are infrequent, typically occurring once every four years. The methodology using cost report data fully accounts for changes in volume and acuity annually, resulting in a more accurate proxy.

[13] Net of productivity adjustment, does not include documentation and coding adjustment.
[14] For example, the labor portion of the market basket update is based on the BLSs' hospital Employment Cost Index.

Market Basket Update – Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be -0.4 percentage points. CMS uses the total factor productivity adjustment as calculated by the BLS. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in multifactor productivity for the period ending September 30, 2023, based on IGI's fourth quarter 2021 forecast.

CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run[15]. CHA appreciates this acknowledgement and agrees that the assumptions underpinning the productivity adjustment are fundamentally flawed. We strongly disagree with the continuation of this punitive policy – particularly during the PHE. The productivity adjustment to the market basket update assumes that hospitals can increase overall productivity — producing more goods with the same or fewer units of labor — at the same rate as productivity increases in the broader economy. However, providing acute care to patients is highly labor intensive, as CMS' projection of the labor related portion of the federal rate — 67.6% — implies in the FFY 2023 proposed rule.

Inpatient hospital care must be provided on-site and has a high "hands-on" component. Therefore, hospitals — particularly in states that have nurse staffing ratios — cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (robotic automation of manufacturing plants) or services (dine-in restaurants that use automated ordering systems to reduce overall staffing count). CMS' own research, conducted prior to the COVID-19 PHE, indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector[16].

CHA notes that during the COVID-19 PHE, productivity fell[17] as a result increased staff turnover and deployment of temporary staffing due to the labor shortage. The use of contract labor substituting for employed staff has also had a negative impact on productivity. As has been widely documented, temporary staff are not accustomed to a specific facility's workflows, which increases the number of hours required to provide care patients.

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified reduction to hospital payments. Further, we ask CMS to use its "exceptions and adjustments" authority under Section 1886(d)(5)(I)(i) of the Act to remove the productivity adjustment for any fiscal year that was covered under PHE determination (e.g., 2020, 2021, and 2022) from the calculation of market basket for FFY 2023 and any year thereafter.

If CMS fails to take the steps described above and provide an adequate market basket update CHA is deeply concerned about access to robust acute care services for Medicare beneficiaries. Given that payment rates for governmental health care programs do not cover the cost to provide care, we believe access could be challenged — particularly in economically disadvantaged areas — for services that are not financially self-sustaining.

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[15] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

[16] ibid

[17] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

Outlier Payments and Threshold

CMS proposes to adopt an outlier threshold for FFY 2023 of $43,214, an increase of 39.5% ($12,266) from the FFY 2022 amount. CMS projects that the proposed outlier threshold for FFY 2023 will result in outlier payments equal to 5.1% of operating diagnosis-related group (DRG) payments and 5.55% of capital payments. Accordingly, CMS is applying a budget neutrality adjustment of 0.949 to the operating standardized amounts and 0.944536 to the capital federal rate.

For FFY 2023, CMS reverts to normal practice and uses the latest year of claims data available (the FFY 2021 Medicare Provider Analysis and Review File (MedPAR) and the most recent cost report data (December 2021 update of the Provider-Specific File (PSF)). Due to abnormally high increases in charges between FFYs 2020 and 2021, CMS will use the increase in charges between FFYs 2018 and 2019 as the charge inflation factor. CMS attributes the abnormal increase in charges between FFY 2020 and 2021 to COVID-19. For the same reason, CMS is also using the cost-to-charge ratio (CCR) adjustment factors based on the 2019 and 2020 updates to the PSF instead of the more recent 2020 and 2021 updates. The proposed rule notes that if CMS did not use alternative charge inflation and CCR update factors the outlier threshold would have been almost double that for FFY 2022 — $58,798.

CHA greatly appreciates CMS' efforts to adjust the outlier threshold calculation so that it better reflects anticipated COVID-19 caseloads. However, given the significant increase in the outlier threshold, we are deeply concerned that CMS has not fully corrected the calculation to account for the decrease in COVID-19 cases and overestimated the outlier threshold. This will result in a further, unwarranted decrease in Medicare payments to hospitals if an artificially high outlier threshold prohibits CMS from paying out its targeted amount of outlier payments due to the outlier budget neutrality adjustment.

CHA strongly encourages CMS to take further steps to appropriately adjust the outlier threshold calculation to reflect the expectation of a decreased COVID-19 caseload in FFY 2023. CHA believes it would be appropriate for CMS to use claims data from prior to the pandemic — similar to what the agency did for FFYs 2021 and 2022 — in the outlier threshold calculation. If CMS believes that approach would understate the COVID-19 caseload in FFY 2023, we strongly encourage the agency to evaluate calculating the outlier threshold using a weighted average charge that is conceptually similar to the methodology used to calculate the Medicare Severity (MS)-DRGs weights. Average charges under this model would be calculated by using one PSF that contains all claims from the FFY 2019 (before the pandemic) and the FFY 2021 PSF.

Medicare Severity (MS) Diagnosis-Related Groups (DRGs)

Basis for Proposed FFY 2023 MS-DRG Updates

CMS analyzed how applying the non-complication or comorbidity (NonCC) subgroup criteria to all MS-DRG currently split into three severity levels would affect the MS-DRG structure for FFY 2023. This analysis used the September 2021 update of the FFY 2021 MedPAR file. CMS found that applying the NonCC subgroup criteria to all MS-DRGs currently split into three severity levels would delete 123 MS-DRGs (41 MS-DRGs x 3 severity levels = 123) and create 75 new MS-DRGs. These updates would also involve a redistribution of cases, which would impact the relative rates and thus the payment rates.

For FFY 2023, CMS proposes not to apply the NonCC subgroup criteria to existing MS-DRGs because of the PHE. CMS intends to address the application of the NonCC subgroup criteria in future rulemaking. **CHA agrees with CMS' concerns about the impact of implementing these changes and strongly supports delaying these changes, if they are implemented at all.** The agency still has not provided the level of transparency — which CHA requested in its comments on the FFY 2022 IPPS proposed rule — necessary for CMS to move forward with a change to the MS-DRG weights of this magnitude.

Given that MS-DRG weights are relative, this policy will impact the weighting of all MS-DRGs — not just the 123 MS-DRGs that are deleted and 75 that are created. Therefore, CHA again respectfully asks that CMS make available for public comment a version of "Table 5" that is calculated under the current policy and a version of "Table 5" that is calculated using the proposed NonCC subgroup criteria before this proposal is implemented. Providing comparative "Table 5s" will allow individual hospitals to understand the impact the proposed methodology will have on their case mixes and payments for inpatient services.

This impact will extend beyond Medicare FFS, given that MS-DRG weights are frequently used as the basis of payment for inpatient services in Medicare Advantage (MA) and commercial health plan contracts. Therefore, the impact of CMS' proposed structural change will be amplified across multiple payer classes. Given this amplification, CHA is specifically concerned that a change to the underlying MS-DRG structure may inadvertently exacerbate payment differentials between different types of hospitals (e.g., urban vs. rural) based on the types of services they provide, which may negatively impact Medicare beneficiary access to some services.

Given the impact of COVID-19 on Medicare utilization, CHA respectfully asks that if CMS moves forward with this policy, the agency delay implementation until at least FFY 2025. This will allow the agency to use claims data from FFY 2023 to model the impact. We anticipate these data will reflect normalized utilization in the future, allowing for comprehensive impact analysis, which can be made available and discussed in the FFY 2025 IPPS proposed rule.

Request for Information on SDOH Diagnosis Codes

CMS solicits comments on how the reporting of diagnosis codes in categories Z55-Z65 may improve its ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs. CMS believes that reporting SDOH Z codes in inpatient claims data could enhance coordination within hospitals across the clinical care continuum and discharge planning teams, including post-acute partners.

CHA appreciates CMS' comments on how a patient adversely impacted by SDOH can increase the resources necessary to provide care to Medicare beneficiaries. CHA supports adjusting payments to account for the increased resources necessary to deliver high-quality care to disadvantaged individuals. However, any payment adjustment should be implemented in a non-budget-neutral manner. Inequitable access to primary and specialist care, at its root, is driven by inadequate payment rates from governmental payers that do not cover the cost to deliver care. CHA asks CMS not to exacerbate existing access issues by implementing a SDOH adjustment for Medicare services in a budget-neutral manner.

CHA notes that starting in January 2023, California will likely require hospitals to screen patients for homelessness, and appropriately report the ICD-10-CM SDOH codes (Z55-Z65) for housing status and any other SDOH condition that is documented in the medical record because of screening. CHA notes

that the 5010 837i can only accommodate 25 ICD-10 codes. We have heard from members it is not uncommon for a Medicare beneficiary's diagnosis to use all 25 diagnosis code fields on the 5010 837i for medical diagnoses. This is particularly true for frail beneficiaries who have been adversely impacted by one or more SDOH.

While CHA is not opposed to reporting Z codes if implementation is undertaken based on the guidance provided below, we are concerned that if reporting becomes mandatory, it may crowd out other medical diagnoses that would impact the assignment of a case to an MS-DRG that carries either a complication or comorbidity or major complication or comorbidity code. Before CMS considers any policy requiring the mandatory reporting of Z codes, we ask the agency to analyze Medicare inpatient hospital claims to determine what percentage uses 20 or more of the diagnosis field locators.

Based on CHA's work helping its members prepare for the requirements discussed above, we recommend that CMS — if it elects to require reporting — makes it optional for at least three years to allow providers and the agency time to gain experience reporting and collecting this data. Additionally, CHA believes that CMS will not only need to know the number of patients experiencing the condition reported, but the number of patients who were screened so the agency can better gauge the scope of the problem within the Medicare population and the extent to which it increases resource utilization within a given population.

CHA strongly encourages CMS to begin only with screening and reporting of homelessness (Z59.00, Z59.01 and Z59.02). Otherwise, we are concerned that use of the more granular codes will introduce a degree of subjectivity that may render the collection of this data meaningless for risk adjustment and other purposes. Before considering expanding to other Z codes related to SDOH, we strongly encourage the agency to engage hospitals and other stakeholders to determine the one or two additional codes that CMS should consider collecting given its potential to impact both resource utilization and patient outcomes.

If CMS elects to allow for voluntary (with an eye to eventual mandatory) screening for homelessness and reporting of Z59.00, Z59.01 and Z59.02, on inpatient claims we strongly encourage the agency to create a stakeholder advisory group. This group's purpose would be to help CMS create the guidance that hospitals and other providers will need to accurately capture this data and report it to CMS in a consistent manner. One example of an issue this group should help CMS resolve is the documentation standards required to support in the chart that a Medicare beneficiary screened positive for homelessness.

Proposed Use of National Drug Codes (NDC) to Identify Cases Involving Use of Therapeutic Agents Approved for New Technology Add-on Payment (NTAP)

CMS currently uses Section "X" New Technology codes to more specifically identify new technologies or procedures that had not historically been captured through ICD-9-CM codes, or to more precisely describe information on a specific procedure or technology than is found in the ICD-10-PCS section. Based on feedback from a wide range of stakeholders the agency is proposing to replace the Section X codes with NDCs to identify therapeutic agents for the administration of the NTAP policy. **CHA strongly supports this policy as we believe it has the potential to reduce unnecessary administrative burden for hospitals.**

CHA notes that hospitals typically capture all NDCs related to a patient stay within their electronic medical record systems. These codes could easily be included with the claim. Therefore, we ask that CMS configure its system to accept all NDC codes, not just those related to products eligible to receive an NTAP. This will significantly reduce administrative burden for hospitals.

Hospital Area Wage Index

CHA appreciates CMS' thorough discussion of hospital area wage index policies proposed for FFY 2023. In general, we are supportive of the agency's efforts to accurately adjust Medicare payments to hospitals, based on audited wage index data, to reflect geographic variation in the cost to deliver care to Medicare beneficiaries. However, we do not support CMS' proposed continuation of its low wage index hospital policy.

Area Wage Index — Low Wage Index Hospital Policy

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. CMS implemented this low wage index hospital policy through a budget neutrality adjustment of -.2% that reduces 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 2023 IPPS 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 its comments on the FFY 2020, FFY 2021, and FFY 2022 IPPS proposed rules. As in these prior years, CHA 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. CHA has long contended that this misguided policy would not only fail to achieve CMS' stated aims of supporting rural hospitals, but the agency lacked legal authority to make the "bottom quartile" adjustment under Medicare statute.

The Low Wage Policy Is Ineffective

CHA again points CMS to the Office of Inspector General's (OIG) December 2020 report that calls the efficacy of the bottom quartile policy into question[18]. The OIG found that only 53% of bottom quartile hospitals are considered rural, and of all bottom quartile hospitals (urban and rural), less than 39% (303) have negative profit margins. Therefore, if the agency's intent is to help rural hospitals, its current policy harms many hospitals it seeks to help. And, instead of helping unprofitable hospitals achieve sustainability, it is reducing the standardized amount for all hospitals — many of which are not profitable — to provide a payment increase to the 61% of bottom quartile hospitals (480) that are already profitable.

The OIG report also questions the assertion that the Medicare wage index is the root cause of bottom quartile hospitals' inability to offer higher wages. The report finds that:

> *"The average hourly wages of hospitals in the same area sometimes varied significantly. (That is, some hospitals already were paying significantly higher wages than other hospitals in the same area prior to the bottom quartile wage index adjustment.)"*

[18] https://oig.hhs.gov/oas/reports/region1/12000502.asp

This finding suggests that Medicare's wage index policy, as it existed before the implementation of the low-wage index policy in FFY 2020, was not an insurmountable barrier in bottom quartile core-based statistical areas preventing hospitals in those markets from paying higher wages.

The Low Wage Policy is Impermissible Under Medicare Statute
In comment letters responding to the FFY 2020, 2021, and 2022 proposed rules, CHA provided a detailed explanation of the ways in which CMS' bottom quartile policy is impermissible under Medicare statute. CHA continues to believe that the bottom quartile policy is impermissible under Medicare statute and refers CMS to those letters for our detailed legal analysis.

On March 2, 2022, the United States District Court for the District of Columbia issued a decision in the case of *Bridgeport Hospital v. Becerra* in favor of hospitals challenging the Medicare program's policy of reducing hospital payments in FFY 2020 to fund increased payments to hospitals in areas with low wages. CHA notes that Judge Nichols' decision in this case turns on many of the same arguments CHA made against the bottom quartile policy in its previous comment letters.

Judge Nichols' decision finds that the plain language of 42 U.S.C. §1395ww(d)(3)(E)[19] undermines the validity of CMS' bottom quartile policy[20]. The statutory language clearly indicates that the U.S. Department of Health and Human Services (HHS) "is required to calculate the relative wage levels of hospitals in different geographic regions as compared to the national average hospital wage level." The low wage index hospital policy, however, is not a calculation of "the" relative wage levels of hospitals in different geographic regions as compared to "the" national average hospital wage level, and it is not "uniformly determined and applied." Instead, the low wage index policy *inflates* the wage index values of the hospitals in the lowest quartile. As a result of this finding, the court invalidated the 0.2% reduction to IPPS rates since it paid for the invalid increase to the wage indexes of the lowest quartile hospitals.

Considering Judge Nichols' decision in the *Bridgeport* case and the clear evidence in the OIG report calling into question the effectiveness of this policy to achieve CMS' goals, CHA strongly encourages the agency not to finalize the bottom quartile adjustment in FFY 2023. Further, CHA asks the agency to eliminate the budget neutrality adjustments for FFYs 2020 (-0.2%), 2021 (-.12%), and 2022 (-0.2%).

Disproportionate Share Hospital and Uncompensated Care Payments

As required by the 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. The remaining 75% (Factor 1) is reduced for decreases in the uninsured population since FFY 2013 (Factor 2) and flows into a separate UCC pool for DSH hospitals. This UCC pool is allocated based on each hospital's share of national UCC costs (Factor 3).

The DSH dollars available to hospitals under the ACA's payment formula decrease by $0.654 billion in FFY 2023 proposed IPPS rule relative to FFY 2022 final IPPS rule. This is due to a decrease in the pool

[19] "[T]he Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) 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. . . . [A]t least every 12 months . . ., the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States."
[20] Bridgeport Hospital, 1:20-cv-01574 at 14–15

from projected DSH payments largely attributable to Factor 1. Further, after reviewing Factor 2, CHA believes that CMS may have significantly underestimated the increase in the uninsured that will occur due to the sunsetting of the various coverage maintenance and expansion mechanisms that Congress implemented in response to the PHE.

Like prior years, for the FFY 2023 IPPS proposed rule CHA has concerns about the proposed calculation of Factor 1 and Factor 2. While we strongly support CMS' rhetoric about efforts to address the conditions that give rise to inequitable health outcomes, we are deeply concerned that cutting payments to safety-net hospitals will hinder, not help, CMS in attaining its goal related to improving outcomes for America's most disadvantaged citizens. Finally, in this rule, CMS proposes changes to the data source used for Factor 3, which CHA strongly supports.

Proposed FFY 2023 Factor 1

In the proposed rule, CMS uses the CMS Office of the Actuary's (OACT) January 2022 Medicare estimate of DSH payments for FFY 2023 as the basis for Factor 1. This amount — $13.266 billion — is reduced by 25% to arrive at a proposed FFY 2023 Factor 1 of $9.949 billion. The proposed Factor 1 for 2023 is about $540 million less than the final Factor 1 for FFY 2022.

The CMS OACT's estimate of Medicare DSH spending uses a baseline year updated to account for projected and actual changes in four component parts that impact DSH expenditures — the IPPS update factor, number of discharges, case mix, and a residual "other" factor to arrive at an estimated DSH amount. Below are tables from the FFY 2022 final and proposed FFY 2023 IPPS rules detailing the specific components of Factor 1 in each rule.

Factors Applied for FFY 2020 through 2023 to Estimate Medicare DSH Expenditures Using FFY 2019 Baseline

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2020	1.031	0.862	1.038	0.989	0.9123	12.598
2021	1.029	0.947	1.029	0.9842	0.9869	12.433
2022	1.025	1.007	0.99	1.0084	1.0304	12.811
2023	1.032	1.01	0.99	1.0035	1.0355	13.266

Source: FFY 2023 IPPS Proposed Rule (87 FR 28384)

Factors Applied for FFY 2019 through 2022 to Estimate Medicare DSH Expenditures Using FFY 2018 Baseline

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2019	1.0185	0.97	1.009	1.0176	1.0144	14.082
2020	1.031	0.857	1.038	0.9912	0.9091	12.802
2021	1.029	1.013	1.029	0.9662	1.0364	13.267
2022	1.025	1.059	0.9675	1.00375	1.0541	13.985

Source: FFY 2022 IPPS Final Rule (85 FR 45228)

The table below compares the changes in the component parts of Factor 1 from the FFY 2023 IPPS proposed rule to the final FFY 2022 IPPS rule for the years in which these components overlap.

UCC DSH Factor 1 Component Comparison:
Proposed FFY 2023 to Final FFY 2022

FY	Update	Discharges	Case Mix	Other	Total	Est DSH Pmt $, Billions
2020	0.000	0.005	0.000	(0.002)	0.003	(0.204)
2021	0.000	(0.066)	0.000	0.018	(0.049)	(0.834)
2022	0.000	(0.052)	0.023	0.005	(0.024)	(1.174)

Sources: 1) CHA Analysis of Factor 1 from FFY 2023 Proposed and FFY 2022 Final Rule

The proposed decrease in Factor 1 is largely driven by a decrease of .066 in FFY 2021 and .052 in FFY 2022 in the discharge component. CHA also notes that projected growth in discharges for FFY 2023 is tepid and case mix is not expected to increase.

In the proposed rule, CMS notes the discharge figure for FFY 2022 is based on preliminary data. While the rule does not specify the exact data set CMS is using, CHA assumes that discharges and case mix for FFY 2022 are based on claims data from the December update of the MedPAR file. This provides less than one-quarter of claims data given the lack of time for "claims run out."

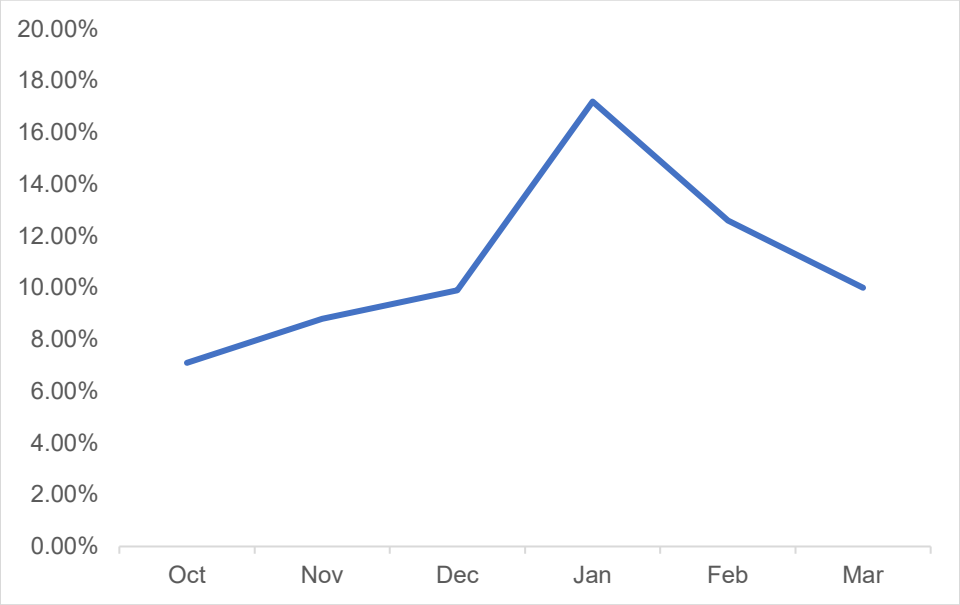
Given the proposed rule uses the OACT's January DSH estimate, CHA is concerned about the accuracy of inpatient utilization and patient acuity assumptions based on less than three complete months of Medicare inpatient claims data for FFY 2022 at a time when utilization is likely aberrant due to high COVID-19 positivity rates in many regions in the country — California in particular[21]. Further, CHA notes that in CMS' Advanced and Final Notice of 2023 MA rates, the agency justifies changes in the normalization factor due to "the expectation that utilization in 2022 will rebound[22,23]." While CHA appreciates that MA and Medicare FFS are separate programs, we note that the trends putting downward pressure on utilization for both programs were the same — the PHE. Therefore, if utilization is going to rebound in MA, it should also hold that utilization will rebound in Medicare FFS. **We ask that when CMS revises its estimate of discharges for the FFY 2023 IPPS final rule, the agency will reflect the same expectation of increased utilization for MA in the IPPS discharges.**

Further, CHA's members anecdotally report that patients — particularly Medicare beneficiaries — requiring inpatient hospital services during Q1 and Q2 of FFY 2022 have been sicker than typical given patients have avoided preventative care and delayed non-emergent procedures at hospitals due to the spike in COVID-19 cases that occurred during Q1 of FFY 2022. This anecdotal experience is confirmed by national data from Kaufman Hall[24,25,26,27,28,29] . The chart below indicates that length of stay — an indicator of patient acuity — has increased for each of the months of the current fiscal relative to the same period during FFY 2020. While CHA realizes this is all-payer data, we note that Medicare beneficiaries make up a significant portion of hospital inpatient discharges. Therefore, if patient acuity — as represented by

[21] https://www.nytimes.com/interactive/2021/us/covid-cases.html
[22] https://www.cms.gov/files/document/2023-advance-notice.pdf
[23] https://www.cms.gov/files/document/2023-announcement.pdf
[24] https://www.kaufmanhall.com/sites/default/files/2022-04/April-2022-National-Hospital-Flash-Report-2.pdf
[25] https://www.kaufmanhall.com/sites/default/files/2022-03/National-Hospital-Flash-Report-March-2022.pdf
[26] https://www.kaufmanhall.com/sites/default/files/2022-02/NationalHospitalFlashReport_Feb2022.pdf
[27] https://www.kaufmanhall.com/sites/default/files/2022-01/National-Hospital-Flash-Report_Jan2022.pdf
[28] https://www.kaufmanhall.com/sites/default/files/2021-12/Dec2021-National-Hospital-Flash-Report.pdf
[29] https://www.kaufmanhall.com/sites/default/files/2021-11/nov.-2021-national-hospital-flash-report_final.pdf

length of stay as a proxy — is increasing, then by definition, Medicare beneficiaries' acuity (e.g., case mix) should also be increasing as well.

Change in Length of Stay:
FFY 2022 Compared to FFY 2020



Given the surge at the end of 2021 that temporarily depressed discharges and the tepid increase in case mix relative to CHA's members' reported experience and national data, we ask CMS to use a more recent vintage of MedPAR claims data when calculating the Factor 1 discharge and case mix index (CMI) components in the FFY 2023 IPPS final rule.

CMS states the discharge figure for FFY 2023 is an assumption based on recent trends recovering back to the long-term trend and assumptions related to how many beneficiaries will be enrolled in MA plans. CHA notes that for FFY 2023 the discharge and CMI components of Factor 1 increase slightly compared to FFY 2022. However, we believe that the increase in both is understated. As discussed above, we believe that discharges in FFY 2023 will increase at a significantly faster rate than CMS currently projects due to pent-up demand. Further, we believe this pent-up demand will also increase CMI, as what would have been relatively low-acuity conditions have increased in complexity as care has been delayed. Further, CHA notes that at a minimum projected CMI should increase by .5% annually given this is the Medicare Trustees' assumption of the increased complexity of Medicare cases from FFY 2023 to 2030[30].

Proposed FFY 2023 Factor 2

Factor 2 adjusts Factor 1 based on the percentage change in the uninsured since implementation of the ACA. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of Congressional Budget Office data as the source of change in the uninsured population. The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who reside in the 50 states or the District of Columbia.

[30] https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf

For FFY 2023, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for CYs 2022 and 2023 is 8.9% and 9.3%, respectively. This results in a proposed Factor 2 of 65.71%[31] yielding a total UCC pool of $6.538 billion[32]. This is approximately $654 million less than the FFY 2022 UCC payment total of about $7.192 billion, resulting in a percentage decrease of 9.1% relative to the FFY 2022.

As illustrated in the table below, the National Health Expenditure Accounts (NHEA)[33] projects a slight increase of 1.5 million individuals in the number of uninsured from 2022 to 2023 causing the projected rate of uninsured to increase by .39%. **CHA believes that CMS' estimate significantly understates the increase in the uninsured rate that will occur during FFY 2023.**

Change in NHEA Uninsured Data from 2022 to 2023

	2022	2023	Difference/ Total
Uninsured	29.5	31	1.5
Total Population	330.9	333.1	
Uninsured Rate	8.92%	9.31%	0.39%
Factor 2 Weighting	25%	75%	
Factor 2	2.23%	6.98%	9.21%

CHA notes that two policies — the Medicaid continuous coverage requirement and the American Rescue Plan (ARP) enhanced premium tax credits — that expanded coverage in response to the COVID-19 PHE will end during FFY 2023. Analysis from the Urban Institute and the CMS Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy suggests that the net loss of coverage resulting from the termination of these programs could increase the number of uninsured by 10 million or more[34,35,36]. **This will result in an uninsured population of over 40 million individuals in 2023, resulting in a Factor 2 of over 80%. This suggests that the UCC DSH pool must increase by over $1.4 billion[37] if it is to be funded adequately to match the actual rate of uninsured projected for FFY 2023.**
There are two significant headwinds to coverage that make scenarios where the number of uninsured increases by as many as 10 million individuals likely between 2022 and 2023. First, it is unlikely that Congress will pass legislation extending the ARP enhanced tax credits[38]. Second, beyond individuals who no longer qualify for Medicaid being disenrolled at the end of the PHE, there is well-documented concern that many individuals who remain eligible for Medicaid benefits will lose coverage. States, due to the termination of the PHE enhanced federal Medicaid match rate, will have a strong economic incentive to quickly process their redeterminations to reduce overall costs to the state[39]. As an example, Ohio's

[31] Proposed Factor 2 = 1-|((0.092-0.14)/0.14)| = 1 - 0.3429 = 0.6571 (65.71%)
[32] UCC Pool = (Factor 1: $9.949 billion) x (Factor 2: 0.6571) = $6.538 billion
[33] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00113
[34] https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf
[35] https://www.urban.org/sites/default/files/2022-04/What%20If%20the%20American%20Rescue%20Plan%20Act%20Premium%20Tax%20Credits%20Expire.pdf
[36] https://aspe.hhs.gov/sites/default/files/documents/1647ad29528ee85a48d6ffa9e7bfbc8f/arp-ptc-sunset-impacts-03-22-22%20Final.pdf
[37] CHA analysis of NHEA data, adjusted for projected increases in uninsurance. Assumes no change in Factor 1.
[38] https://insidehealthpolicy.com/daily-news/pelosi-said-democrats-might-not-extend-obamacare-premium-subsidy-hike
[39] https://insidehealthpolicy.com/daily-news/advocates-alert-some-states-do-quick-medicaid-renewals-post-phe

Legislature has given the state three months to process redeterminations despite concerns raised by the state's Medicaid director[40]. Like other sectors of the economy, state Medicaid agencies are struggling with insufficient staffing as well[41]. However, despite persistent staffing issues, only 30 states plan to hire additional workers to handle the beneficiary outreach and case work associated with a large volume of Medicaid redeterminations[42]. **Considering these concerns, CHA respectfully asks CMS to revise the uninsured estimate used to calculate Factor 2 to more accurately reflect the losses in insurance coverage that are anticipated by groups like the Urban Institute and CMS ASPE Office of Health Policy. We strongly believe successfully addressing the social conditions that result in inequitable health outcomes requires strong safety net providers to ensure that access to care is available to all who need it.**

Proposed Use of Audited FFY 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 the 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 FFYs 2020, 2021, and 2022 CMS used a single year of data from the audited FFY 2015, FFY 2017, FFY 2018 Worksheet S-10 cost report data.

CMS proposes to determine Factor 3 for FFY 2023 using the average of the audited FFY 2018 and FFY 2019 Worksheet S-10 reports instead of basing it on a single year. In addition, CMS proposes for FFY 2024 and subsequent fiscal years to use a three-year average of the UCC data from the three most recent fiscal years for which audited data are available to determine Factor 3.

CHA strongly supports this proposal. As we have stated in prior comment letters, we are deeply concerned about year-to-year volatility in UCC costs found on Worksheet S-10. We believe that using multiple years of S-10 will reduce the impact of this volatility on safety-net hospital finances. CHA thanks CMS for taking this step to provide additional financial certainty for hospitals that take care of at-risk populations.

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,

[40] https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/11/many-medicaid-recipients-could-lose-coverage-as-pandemic-ends
[41] ibid
[42] https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/?utm_campaign=KFF-2022-Medicaid&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz-8D9rW5IJ5HF38ZIvdUx2liNoczOuG4CMJM_0z4yUnvksdvgPB7kkKoEO0h1p8eZEUfydZ2PlFZKtR0aidQ6xH1RZ3UTQ&utm_content=2&utm_source=hs_email

including standard timelines for information submission and acceptable documentation to meet information requirements. We also urge CMS to develop a transparent time frame for the audit, with adequate lead time and communication to providers about expectations, and to establish a process for timely appeals. CHA believes that the Medicare Wage Index audit process could be a model for Worksheet S-10 audits.

1115 Waiver Days in the Medicare DSH Calculation

In the FFY 2023 rule, CMS proposes to modify its regulations to clarify that "regarded as eligible" for Medicaid only includes patients who receive health insurance through a Section 1115 demonstration where state expenditures to provide the insurance may be matched with funds from Medicaid. To conform with this clarified definition of "regarded as eligible" CMS proposes to include only the days of patients "regarded as" eligible for Medicaid who receive health insurance through a Section 1115 demonstration that provides essential health benefits.

CHA strongly opposes this proposal. The days in the numerator of Medicaid fraction are a proxy for the volume (and associated costs) of care provided to low-income individuals. Given this, CHA believes that CMS' existing policy of including these days in the numerator of the Medicaid fraction is the appropriate treatment under statute (as has been confirmed in multiple court rulings) even when the Medicaid payment offsets some portion of the cost of providing UCC instead of providing health insurance coverage to the individual.

CHA is concerned that this policy will negatively impact hospitals beyond those states that have UCC pools funded using Section 1115 waivers. If finalized, this policy will inappropriately reduce the empirical DSH payments to hospitals in waiver states. This in turn will reduce the overall DSH projection that is used to calculate Factor 1 of UCC DSH. Given the financial challenges hospitals continue to face because of the COVID-19 PHE and inflation, we are deeply concerned about any policy that will further reduce payments to safety net providers. This payment reduction will have the unintended consequence of harming access to care for Medicare beneficiaries who live in historically disadvantaged areas. This concern is heightened by the impending increase in the uninsured rate that is not fully accounted for in the proposed Factor 2. **Therefore, CHA strongly opposes CMS' proposed policy related to Section 1115 waiver days.**

Commensurate with continuing to count all Section 1115 Medicaid waiver days in the numerator of the DSH fraction, CMS must take steps to ensure that hospitals in states with UCC pools funded by a Section 1115 waiver do not also include costs associated with these patients in the UCC data used to calculate Factor 3 — thereby "double-dipping." UCC pool payments received from the Medicaid program (such as waiver payments) are reported on line 2 or line 5 of Worksheet S-10, while the costs of providing the care could be recorded as charity care write-offs on line 22 (assuming these patients are covered under the hospital's charity care policy). In this situation the hospital is essentially being paid twice for that care: once under the 1115 waiver and again — if the hospital's charity care policy covers it — because the hospital is reporting it as an uncompensated cost, which entitles the hospital to a bigger share of the limited Medicare DSH UCC pool.

To prevent the situation described above, CHA asks CMS to require hospitals that receive Section 1115 Medicaid UCC pool payments and have a charity care policy that applies to patients who would be covered by the 1115 UCC pool to offset any payments received from the Section 1115 waiver on worksheet S-10 of the Medicare cost report. Given the issues discussed above, CHA believes this

approach strikes the right policy balance. It captures all "regarded as eligible" patient days in the numerator of the Medicaid fraction as required by Congress, allowing for an accurate calculation of the overall DSH projection that is a key component of the Medicare UCC DSH formula. At the same time, it prevents hospitals in states that have UCC pools funded by Section 1115 waiver days from drawing down more Medicare UCC DSH than they are entitled to, thereby "double-dipping."

Low-Volume Hospitals

In FFY 2023 and subsequent years, the criteria for the low-volume hospital adjustment will return to the more restrictive levels as required by statute. To receive a low-volume adjustment, CMS proposes that subsection (d) hospitals must meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (all payer) during the fiscal year.

CHA strongly supports the Rural Hospital Support (RHS) Act introduced by Senators Grassley and Casey. The RHS Act would make the enhanced low-volume adjustment, which is currently scheduled to expire on September 30, 2022, permanent. CHA encourages CMS to work with Congress to pass the RHS Act or other similar legislation that extends the enhanced low-volume adjustment to protect access to acute care services in rural areas.

Medicare Dependent Hospital (MDH) Program

Beginning October 1, 2022, the MDH program will no longer be in effect as the statute does not authorize it beyond September 30, 2022. All hospitals that previously qualified for the MDH program will be paid based on the IPPS federal rate unless they are approved for sole community hospital (SCH) status. **CHA strongly supports the RHS Act, which would also make the MDH program permanent. CHA encourages CMS to work with Congress to pass this act or other similar legislation that extends the MDH program to protect access to acute care services in rural areas.**

Previous policies adopted by CMS allow for an effective date of an approved SCH status to follow the expiration date of the MDH program, as long as the MDH applies for SCH status at least 30 days before the expiration of the MDH program (September 1, 2022) and specifically requests the SCH status to be effective October 1, 2022. **CHA supports the continuation of these policies in the event Congress does not pass an extension of the MDH program.**

Proposed Changes to Graduate Medical Education (GME) Payments Based on *Milton S. Hershey Medical Center, et al. v. Becerra* Litigation

On May 17, 2021, the U.S. District Court for the District of Columbia in *Hershey v. Becerra* found that the proportional reduction methodology improperly modified the weighting factors statutorily assigned to residents beyond the initial residency period. As a resolution to the litigation, CMS proposes to retroactively implement a modified policy applicable to all teaching hospitals, effective for cost reporting periods beginning on or after October 1, 2001. The policy also applies to cost report periods beginning on or after October 1, 2022. This policy will address situations for applying the full-time equivalent (FTE) cap when a hospital's weighted FTE count is greater than its FTE cap, but would not reduce the weighting factor of residents who are beyond their initial residency period to an amount less than 0.5. **CHA appreciates CMS' discussion of this issue in the proposed rule and supports the proposed changes to the weighted FTE count as a result of the decision in *Hershey v. Becerra*.**

Medicare GME Affiliation Agreements and Rural Training Tracks

CMS proposes allowing urban and rural hospitals that participate in the same separately accredited 1-2 family medicine Rural Training Program (RTP) to enter affiliation agreements for the program when certain conditions are met. Eligible hospitals may enter into this proposed agreement effective for the July 1, 2023, academic year. **CHA appreciates and supports CMS' proposal to allow separately accredited 1-2 family medicine RTP participants to enter into an affiliation agreement.** Further, we strongly encourage the agency to allow other RTP participant hospitals to enter into affiliation agreements once the FTE caps for the first cohort of program participants that resulted from the Consolidated Appropriations Act of 2021's expansion of the program are set.

RFI: Payment Adjustments for Domestically Made N95 Respirator Masks

In the FFY 2023 IPPS proposed rule, CMS requests feedback related to a potential additional payment to compensate hospitals for the incremental cost of using wholly domestically produced N95 respirators. The purpose of this payment is to mitigate the supply chain issues experienced by hospitals during the COVID-19 PHE by encouraging the development of a stable, sustainable domestic manufacturing base for N95 respirators. In the preamble, CMS states that it is contemplating only paying for "Medicare's share" of the N95 respirators used by hospitals. It also states that any such additional payment would likely be made in a budget neutral manner for N95s provided in the outpatient setting.

CHA strongly supports CMS' efforts to provide a payment to hospitals to compensate them for the additional, incremental cost of domestically produced PPE. The supply chain issues experienced during the pandemic are just one consequence of the inadequate Medicare payment updates (as discussed above) hospitals have endured for years. In light of the high-labor component of hospital care that cannot be automated or offshored, the inadequate updates have forced hospitals to bind themselves to brittle supply chains in an effort to generate the ever-greater cost savings necessary to ensure financial solvency and continue providing necessary care in their communities. CHA believes that if CMS adopts a broad payment policy that covers hospitals' incremental cost of domestically produced PPE it will improve supply chain resilience and therefore national security. It will also have the effect of reducing carbon emissions in the health care industry by shortening the supply chain. Further, it will move manufacturing from countries that have less stringent environmental protections to the United States.

CHA strongly encourages CMS to expand the items it includes in this policy beyond N95s. First, our members report that during the pandemic they experienced shortages with a broad range of PPE. Common items mentioned include, but are not limited to surgical masks, isolation gowns, surgical gowns, nitrile gloves, bouffant caps, shoe covers and face shields. Second, we are concerned that CMS, by focusing on only N95s, is presuming that the next pandemic will be driven by pathogen whose primary transmission mechanism is respiratory. This may not be the case and if the agency only focuses on N95s, we are concerned that while we may have adequate supplies of N95s during the next pandemic, we will run short of the necessary supplies to protect patients, caregivers, and the general population from further transmission of said pathogen. **Therefore, we ask CMS to apply its policy of reimbursing hospitals for the incremental cost of domestically produced PPE to a broader basket of items that are necessary to respond to any potential PHE.** This will, to the greatest extent possible, ensure a stable, domestic supply of necessary items to protect Medicare beneficiaries, caregivers, and the broader population from the transmission of disease. It will also have the beneficial effect of further reducing the carbon footprint of the health care supply chain, which will positively impact health equity.

In the proposed rule, CMS states that the payment would only be made for "Medicare's share" of the domestically produced PPE consumed by hospitals. CHA notes that Medicare only accounts for 28%[43] of California hospitals' total net revenue. Using this as a proxy for volume, we are concerned that if CMS limits this payment to only the "Medicare share" of PPE consumed by hospitals the demand for domestically produced PPE induced by this additional payment will not be sufficient to support a sustainable manufacturing base in the United States. While the incremental add-on payment will be based in some manner on the amount of PPE consumed by a hospital while providing care to Medicare beneficiaries in the current fiscal year, this is not what CMS is purchasing by making this payment. Instead, this payment is purchasing the option of having a secure, domestic supply of a broad basket of PPE available to protect Medicare beneficiaries when the next PHE occurs. **Therefore, CHA strongly encourages CMS to expand the proposed incremental payment to cover the cost of domestically produced PPE used to care for all patients — not just Medicare patients, — over the course of a hospital's fiscal year. This will create the demand necessary to sustain a domestic manufacturing capability and ensure that PPE will be available for caregivers to protect Medicare beneficiaries during a future pandemic.** If CMS does not have the statutory authority to do this, we ask the agency to work with Congress to embed this flexibility into the Medicare statute.

In the rule, CMS notes that if this payment is made under the outpatient prospective patient system (OPPS), would need to make the payment in a budget-neutral manner and inquires if the IPPS adjustment should also be made in a budget-neutral manner. **CHA believes that making this payment in a budget-neutral manner would be "robbing Peter to pay Paul."**

Similar to limiting the payment to only "Medicare's share" of the covered PPE, CHA's members report that any offset to the standardized IPPS and OPPS amounts would serve as a disincentive to use more expensive domestically produced PPE. It is well established that Medicare does not cover the cost to provide care to beneficiaries. In 2019, hospitals' average Medicare margin for inpatient services was 8.5%[44]. Offsetting the increased cost of domestically manufactured PPE with a rate reduction to all hospitals is counterproductive to CMS' goals and will likely not induce sufficient demand to sustain a domestic manufacturing base. Further, as noted above, systemic underpayment from Medicare has forced hospitals to rely on increasingly fragile supply chains in the first place. **CHA strongly encourages CMS to make the additional payment in a non-budget-neutral manner in both the IPPS and OPPS.** If CMS does not believe it has the statutory flexibility to provide the add-on payment in a non-budget neutral manner under the OPPS, we ask the agency to work with Congress to expand the authority under Section 1833(t) to allow for a non-budget neutral payment that covers the incremental cost of domestically produced PPE.

CHA's members believe that a biweekly interim lump-sum payment to hospitals that is reconciled at cost report settlement is the most appropriate payment mechanism to compensate hospitals for the marginal cost of wholly domestically produced PPE. To the extent that a hospital uses only wholly domestically produced PPE, CHA recommends that CMS survey distributors determine what the monthly price for a specific piece of PPE is that is covered under this policy. CMS can use the monthly price observations to create a weighted annual average for each piece of PPE.

[43] CHA analysis of 2020 California Department of Health Care Access and Information data.
[44] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf

CHA strongly encourages CMS to implement this additional payment in the least administratively burdensome manner possible. Therefore, CHA recommends that CMS only require an invoice (or other similar documentation) from the vendor stating the products were wholly domestically produced. Further, we ask that CMS convene a workgroup of hospital finance/reimbursement experts, supply chain specialists, and Medicare administrative contractors to help draft the specific cost reporting forms and instructions associated with this payment mechanism. As part of this work, they should establish in advance what a reasonable audit protocol to validate the expenses claimed as allowable cost related to domestically produced PPE.

Hospital Readmissions Reduction Program

In the FFY 2022 IPPS final rule, CMS finalized a policy to suppress the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia (PN) Hospitalization measure (National Quality Forum) NQF #0506) (PN Readmission Measure) under the HRRP for FFY 2023. In addition, CMS previously announced technical updates to measure specifications for the remaining five readmission measures to exclude patients with principal or secondary diagnoses of COVID-19 from the measures' denominators.

CMS is further proposing additional technical updates to the HRRP measures to account for the long-term impacts of COVID-19 on readmission rates. Specifically, beginning with FFY 2023, CMS proposes to include a covariate adjustment for patients with a history of COVID-19 in the 12 months prior to admission. This same technical update would be applied to the PN readmission measure beginning with FFY 2024, when CMS intends to resume use of the measure in the HRRP.

CHA appreciates that CMS has continued to analyze the impacts of the COVID-19 PHE on readmissions measures — including the emerging impacts of long-COVID-19 on patient outcomes and readmissions rates — and we support the proposed covariate adjustment to all HRRP measures. However, we encourage the agency to continue to evaluate clinical evidence on the long-term impacts of COVID-19 to ensure a 12-month window is sufficient to address these impacts on HRRP measures. In addition, we urge CMS to refrain from finalizing its proposal to resume use of the PN readmission measure in FFY 2024 and revisit this proposal in future rulemaking. While we agree that revised technical specifications and improved coding practices have allowed the agency to mitigate impacts of COVID-19 on measure performance, the pandemic has continued on an unpredictable trajectory, with hospitalizations of individuals with COVID-19 currently on the rise once again in California. Notably, the state projects COVID-19 hospitalizations will increase by nearly 50% over the next three weeks, growing to an estimated 3,600 per day by July 8, 2022[45]. We urge CMS to make determinations on the FFY 2024 program with the most recent and relevant data available in the next rulemaking cycle.

Potential Future Inclusion of Health Equity Performance in HRRP

CMS seeks comments on how it could encourage hospitals to improve health equity and reduce health care disparities through the HRRP, which could include approaches beyond providing confidential hospital-specific reports of their performance stratified by social risk or demographic data to policies that could impact hospital performance under the program. For example, CMS says it is considering approaches that "would account for a hospital's performance on readmissions for socially at-risk

[45] https://calcat.covid19.ca.gov/cacovidmodels/

beneficiaries compared to other beneficiaries within the hospital, or its performance in treating socially at-risk beneficiaries compared to other beneficiaries, or a combination of these approaches."

CHA strongly cautions CMS against advancing proposals that could ultimately penalize hospitals under the HRRP for social risk factors outside of their control. While we agree hospitals have a unique opportunity to reduce health care disparities, addressing social risk factors and improving health equity will require a long-term, systemic approach with collaboration across all levels of government, community-based organizations, and other institutions.

Hospital Value-Based Purchasing Program

To address ongoing concerns that the COVID-19 PHE has significantly impacted performance on hospital VBP program measures, CMS proposes to suppress several measures using the measure suppression factors as finalized in the FFY 2022 IPPS final rule, along with a special scoring and payment rule to avoid unfairly penalizing hospitals severely impacted by the PHE.

CHA strongly supports CMS' proposals to suppress all the measures in two of the four program domains — the Person and Community Engagement domain (the Hospital Consumer Assessment of Healthcare Providers and Systems measure) and the Safety domain (five Healthcare-Associated Infection (HAI) measures). We agree that performance on these measures has been shown to deviate significantly compared to historical trends, and that the COVID-19 PHE's impact on hospital staffing and resources have contributed to these declines. We also appreciate that CMS will adopt technical specifications to the VBP program mortality measures to include a covariate adjustment to account for patients with a history of a COVID-19 diagnosis within 12 months of admission. As noted in our comments on the HRRP, we urge CMS to continue to assess its risk adjustment to determine if a 12-month period fully accounts for the impacts of long COVID-19 on these mortality measures.

CHA also supports CMS' proposal to adopt a special scoring and payment rule — similar to its policy for FFY 2022 — under which CMS would not calculate a total performance score under the VBP program and return to each hospital a value-based incentive payment equal to the statutory 2% VBP withhold. We agree that it would be inappropriate to apply VBP penalties based only on the unsuppressed measures of the clinical outcomes and efficiency domains. As the pandemic continues to impact different regions in waves, we urge CMS to continue to carefully review the impact of COVID-19 and revised technical specifications on measure performance prior to establishing a policy for VBP payment adjustments in future years.

Hospital-Acquired Conditions Reduction Program

In response to concerns that HAC Reduction Program payments may become inequitable due to COVID-19 impacts, CMS proposes to suppress measure data for all HAC Reduction Program measures — the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) HAI measures and Patient Safety Indicators (PSI)-90 — from the calculation of measure scores and the Total HAC score, and as such, would not apply HAC penalties to any hospitals for FFY 2023. **CHA strongly supports this proposal as it recognizes the significant deviation in national performance across all program measures due to the COVID-19 PHE.**

CHA also supports proposed technical adjustments to the PSI-90 measure's risk adjustment model beginning with FFY 2024. We also appreciate that CMS will suppress NHSN HAI measure data from 2021 for the FFY 2024 program year. However, we urge CMS to carefully review performance on the

newly risk-adjusted PSI-90 measure, along with NHSN HAI measure data from 2022 prior to finalizing a policy to reinstitute HAC penalties in FFY 2024.

Hospital Inpatient Quality Reporting Program

CMS proposes significant changes to the hospital IQR program, including the addition of 10 new measures to the program. While CHA supports many of CMS' priorities — including advancing health equity and improving outcomes for maternal care — we are concerned that hospitals will be challenged in putting so many changes into operation while continuing to face the significant workforce and financial impacts of the PHE. We urge CMS to prioritize fewer new measures and continue to provide hospitals with flexibility in eCQM reporting. Our comments on specific proposed measures are provided below.

Proposed Hospital Commitment to Health Equity Measure

CMS proposes the addition of a structural measure — Hospital Commitment to Health Equity — beginning with the CY 2023 reporting period/FFY 2025 payment determination and for subsequent years. The measure is intended to assess a hospital's commitment to health equity across five domains (e.g., Data Collection), each of which includes multiple elements (e.g., the collection of demographic information and/or SDOH information; training of staff in culturally sensitive collection of demographic and/or SDOH information; and input of demographic and/or SDOH data into structured, interoperable data elements using certified electronic health record (EHR) technology). Hospitals must attest affirmatively to each of the elements within a domain to receive a point for the domain — no partial credit is awarded for attesting to specific elements within a domain. As proposed, CMS would publicly report the hospitals score up to a maximum of five points, one for each domain.

California hospitals are deeply committed to improving health equity and we share CMS' goals of reducing health care disparities for historically discriminated-against and underserved communities. As our members are working to achieve their hospital-specific equity goals, we believe the attestations and domains included in the proposed measure align with many of these ongoing efforts and we generally support this attestation-based measure. However, we are concerned that the proposed scoring methodology and public reporting proposals may result in misleading views of hospitals' health equity strategies, particularly due to the all-or-nothing nature of how points are awarded in each domain.

For example, Domain 1 — Equity is a Strategic Priority — includes four elements that require hospitals' strategic plans have identified priority populations who currently experience health disparities, identify specific goals and discrete actions to achieving those goals, outline the specific resources dedicated to achieving those goals, and describe the hospital's approach to engaging key stakeholders, such as community-based organizations. Under the proposed scoring methodology, a hospital early in its efforts to address health equity would receive no credit if it has worked to identify equity goals and determined how it will use hospital resources to achieve those goals but has not yet engaged community-based organizations, which could take more time and may be somewhat out of the hospital's control. Under the current scoring and public reporting proposal, the public may be misled to believe the hospital has not made a commitment to reducing health care disparities in its strategic plans, though it has achieved three out of four elements in the domain.

We urge CMS to reconsider its proposal and score hospitals based on how many elements within each domain can be attested to for a total possible score of 11. We believe this would be more transparent and representative of ongoing hospital efforts to achieve health equity goals. Further, as currently proposed, each domain is weighted equally, with each domain representing 20% of the total score. Because certain domains have fewer elements than others, CMS seems to be weighing certain

actions that make up the entirety of a domain — like hospital participation in local, regional, or national quality improvement activities focused on reducing health disparities — higher than other actions, such as the three elements within the Data Collection domain. However, it is not clear in the proposed rule that this is the intent of the agency. As hospitals begin to establish and work toward achieving their health equity goals, we believe awarding credit for each potential element provides CMS and the public a more holistic and transparent view of this ongoing work.

Proposed Adoption of Two Social Drivers of Health Screening Measures

CMS proposes to adopt two measures to the IQR program related to screening for health-related social needs (HRSNs). CMS proposes to begin reporting for both measures on a voluntary basis beginning with the CY 2023 reporting period, with mandatory reporting required beginning in CY 2024 for the FFY 2026 payment determination, and subsequent years. The first proposed measure is a structural process measure, Screening for Social Drivers of Health. The measure would assess the percentage of patients admitted to the hospital who are 18 years or older at the time of admission and are screened for five domains of HRSNs: food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety.

CHA supports the addition of this measure to the IQR program, and we appreciate that CMS will allow for one year of voluntary reporting prior to requiring the measure by CY 2024. The collection of comprehensive and accurate data on HRSNs is essential to understanding how the social needs of patients contribute to disparities in our health care system. Screening patients for this information is an important step that will allow hospitals to shape their strategic health equity goals. In addition, we appreciate that CMS will allow hospitals the flexibility to choose the screening tool and modes of data collection most appropriate to their organization, which will reduce burden for those who are already conducting these screenings. Finally, we urge CMS to submit this measure for NQF-endorsement prior to mandatory reporting.

However, CHA has concerns with the second proposed measure — Screen Positive Rate for Social Drivers of Health — and we urge CMS not to adopt it at this time. This measure would assess the proportion of patients who screened positive on the date of hospital admission for one or more of the five HRSNs listed previously, and would require hospitals to report five separate rates for each of the HRSN domains. As an IQR program measure, the positive screening rates for each of the HRSN domains would be publicly reported. CHA questions the value of publicly reporting these rates and cautions the agency against unintended consequences that could occur from this reporting. For example, we are concerned that the public will view hospital quality negatively based on factors outside the control of the hospital — such as high levels of housing instability more reflective of housing shortages and economic circumstances within a community — incentivizing those with the most resources to seek care from other hospitals with lower rates of positive HRSN screening rates. These effects could be most challenging for safety-net hospitals, where high rates of HRSNs among the patient population are reflective of numerous societal and economic factors, rather than the quality of care provided by the hospital.

CHA agrees that information gleaned from HRSN screening could be useful to hospitals in understanding the unmet needs of their patient population and could help to inform community benefit programs and strategic health equity goals. However, this information will already be provided to hospitals by conducting the HRSN screening — as proposed in the first measure — and as such, we do not believe it is necessary to publicly report the screen positive rates.

Finally, we urge CMS to revisit its measure exclusions for both screening measures, should they be finalized as mandatory measures. Specifically, CMS proposes to exclude patients who opt out of screening and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf. Due to the sensitive nature of the screening domains — including interpersonal safety — we urge CMS to remove "and lack a guardian or caregiver available to do so on the patient's behalf," and limit the exclusion to patients who opt out of screening or are unable to complete the screening. There may be patients who have a caregiver or guardian available but are not able to answer screening questions honestly in their presence due to abuse or other circumstances.

Proposed Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

CMS proposes to add a PRO-PM that would assess patient functional improvement following elective hip and knee replacement procedures. This PRO-PM is based on a measure developed for and used as a voluntary measure in the Comprehensive Care for Joint Replacement (CJR) model. Hospitals would be required to utilize standardized, validated survey instruments completed within three months pre-, and at about one year post-operatively to assess patient-perceived pain and function and submit that patient-reported data to CMS. CMS would combine these PRO data with Medicare claims, Medicare beneficiary and enrollment database and U.S. Census Bureau Survey data to risk-adjust and calculate hospital performance. Initially, the measure would be available for voluntary reporting, with mandatory reporting proposed to begin with the FFY 2028 payment determination. Under this proposal, mandatory PRO data collection would begin July 1, 2025.

While CHA agrees there is promise in PRO-PMs — and we appreciate that CMS has proposed an incremental approach to mandatory reporting — we are concerned with the significant burden in reporting this measure and question its value in the IQR program as the volume of elective joint replacement procedures increasingly shift toward the outpatient setting. Notably, CHA members who have participated in the CJR model report that the data collection burden for the voluntary measure was significant, and that measure results were not useful for evaluation data due to high levels of missing PRO data. In particular, CHA hospitals report that it will be incredibly challenging to get completed post-operative survey data from patients, as many patients travel to a specific hospital for their elective surgeries — often from significant distances — and complete follow-up care back in their home communities under the care of other providers.

We urge CMS to reconsider the use of this measure in the IQR program, and work with stakeholders to develop more appropriate — and less burdensome — PRO-PM measures. Notably, CMS is currently engaged in a two-year project with the National Quality Forum on *Building a Roadmap From Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures*[46]. The culmination of this project at the end of 2022 is likely to provide CMS with additional insights on the development of high-quality PRO-PMs, and this work could inform future rulemaking. However, should CMS finalize the use of the proposed measure, we encourage the agency to consider a longer period of voluntary reporting, followed by significant analysis of the voluntarily reported data, before finalizing a date certain for mandatory reporting

Proposed Electronic Clinical Quality Measures and Reporting Requirements

CMS proposes the addition of four new eCQMs — two of which would be mandatory and two which would be available for self-selection — as well as increasing the number of eCQMs that must be reported. Specifically, CMS proposes that beginning with the CY 2024 reporting year hospitals would be required

[46] https://www.qualityforum.org/ProjectDescription.aspx?projectID=93898

to report six total eCQMs: three self-selected, the Safe Use of Opioids eCQM (as previously finalized), and the newly proposed Cesarean Birth and Severe Obstetric Complications eCQMs.

CHA is concerned with this increase in reporting, particularly as hospitals will be reporting full-calendar years of eCQM data by 2024. In addition, we continue to believe that allowing hospitals to self-select the measures most appropriate to achieve their quality improvement goals is the best approach to increase the electronic reporting of quality measures. As such, we caution the agency from requiring too many specific eCQMs, and rather, to finalize new eCQMs as an option for the available menu of measures a hospital can self-select. **We urge CMS to maintain the current reporting requirements of four eCQMs and allow hospitals to self-select the measures most suited to their quality improvement needs.**

In addition, CHA provides the following comments on specific proposed eCQMs:

Cesarean Birth eCQM

CMS proposes to include this eCQM as a voluntary option available for self-selection in the 2023 reporting year, and as a mandatory measure beginning with CY 2024 reporting. The measure assesses the rate of nulliparous, term, singleton, vertex (NTSV) live-born deliveries via Cesarean section (C-section) at greater than 37 weeks gestation, and is similar to a chart-abstracted version that many hospitals report to other programs. In the proposed rule, CMS says the measure is intended to ultimately reduce the occurrence of non-medically indicated C-sections**. Because the measure does not make a distinction between medically necessary and non-medically necessary C-sections, we question the measure's value in achieving that goal, and as such, we do not support its inclusion as a mandatory measure. However, we agree that encouraging hospitals to track the rate of low-risk C-sections could increase adherence to recommended clinical guidelines and improve maternal health outcomes, and we support the measure an option for self-selection.**

Severe Obstetric Complications eCQM

CMS proposes to include this eCQM as a voluntary option available for self-selection in the 2023 reporting year, and as a mandatory measure beginning with CY 2024 reporting. The measure assesses the proportion of patients with severe obstetric complications that occur during inpatient delivery hospitalizations and is reported as two separate rates per 10,000 deliveries: the total rate of severe complications, and the rate of complications excluding instances where blood transfusion is the only complication. The proposed measure would exclude patients with a confirmed diagnosis of COVID-19 and related respiratory illnesses and is risk-adjusted for variables such as patient age, certain preexisting conditions and pregnancy characteristics, lab tests and vital signs upon hospital arrival, long-term anticoagulant medication use, and social risk indicated by the presence of economic and housing instability.

CHA agrees that addressing severe obstetric complications is a key priority for hospitals in addressing both maternal outcomes and health equity. While we appreciate that the measure is risk-adjusted to account for so many variables, we are concerned that the measure as constructed will assess such small numbers of cases that reliability and validity will be challenged. We are encouraged that CMS has included social risk factors in its risk adjustment; however, this is a new concept that should be tested thoroughly before inclusion in federal quality reporting programs. As CMS notes in the proposed rule, the measure was submitted for NQF endorsement in January 2022. The measure is currently under review by the Perinatal and Women's Health Standing Committee for the spring 2022 cycle. **CHA urges CMS to allow the measure to undergo additional testing and receive NQF endorsement prior to finalizing it as an available eCQM for self-selection.**

Hospital Harm — Opioid-Related Adverse Events eCQM (NQF #3501e)

CMS proposes to add this measure as an option available for self-selection beginning with the CY 2024 reporting period. The proposed measure would assess the proportion of inpatient encounters where patients have been administered an opioid followed by administration of naloxone within 12 hours, which is intended to serve as a marker for adverse events — most of which are avoidable — triggered by opioid administration to inpatients. A similar version of this measure was proposed in the FFY 2020 IPPS proposed rule, but ultimately was not finalized due to stakeholder concerns. **CHA appreciates the steps that CMS and the measure developer have taken to improve the measure since its earlier proposal, such as limiting the window for the administration of naloxone to 12 hours after the administration of an opioid and excluding the use of naloxone in the operating room. We support this measure as an option available for hospital self-selection.**

Proposed Establishment of a Publicly Reported Hospital Designation to Capture the Quality and Safety of Maternity Care and RFI on Additional Activities to Advance Maternal Health Equity

As first announced by Vice President Kamala Harris — and in support of the Biden administration's priorities to reduce disparities in maternal health outcomes across race, ethnicity, and geographic area — CMS proposes to establish a hospital designation reflecting the quality and safety of maternal care. This designation would be publicly reported on a CMS website beginning in the fall 2023, and initially would be awarded to hospitals that report "Yes" to both questions embedded in the Maternal Morbidity Structural measure of the hospital IQR Program, as finalized in the FFY 2022 IPPS final rule. The questions in this measure assess whether a hospital participates in a structured state or national Perinatal Quality Improvement (QI) Collaborative, and whether participating hospitals are implementing the safety practices or bundles embedded in these QI initiatives.

CHA supports the establishment of this designation and shares the administration's goals of improving maternal care and reducing disparities in maternal health outcomes. As noted in our comments on the Maternal Morbidity Structural measure, more than 200 hospitals in California — the vast majority of hospitals that provide inpatient labor and delivery services — participate in the California Maternal Quality Care Collaborative (CMQCC). It has been national leader in reducing maternal mortality and morbidity rates in California since its inception in 2006, despite simultaneous increases in the national rates. Also in California, Cherished Futures for Black Moms & Babies — a joint initiative of Communities Lifting Communities, the Public Health Alliance of Southern California, and the Hospital Association of Southern California — is currently conducting research centered on the lived experiences and preferences of Black women regarding a birth equity hospital designation and to identify areas where the CMS hospital designation can be improved.

As CMS considers future indicators to include in the criteria for achieving this designation, we urge the agency to focus on including valid, reliable, and NQF-endorsed measures. CHA also urges CMS to collaborate with leaders in this space, like CMQCC and other hospital-based QI collaboratives that are led by and center those most impacted by national and statewide maternal health disparities, such as Cherished Futures for Black Moms & Babies.

In addition, CMS seeks comments on policy approaches to advancing maternal health equity, which could include revisions to the Medicare and Medicaid Conditions of Participation (CoPs) and quality reporting programs. **CHA urges CMS to focus its efforts on improving maternal health equity in its quality programs, rather than as an update to the CoPs.**

The CoPs set forth broad requirements that hospitals must meet to participate in and receive reimbursement from the Medicare and Medicaid programs. Failure to comply with the CoPs could result in potential termination from the programs and would jeopardize the financial and operational viability of most hospitals. As such, CHA believes the CoPs should be limited to those requirements that are most specifically linked to patient life and safety, and which apply as broadly as possible to all hospitals. We are concerned that maternal-health specific CoPs could have unintended consequences of reducing access to labor and delivery services, particularly in rural areas where compliance with additional CoPs could be a barrier to maintaining or expanding these services.

Rather, we urge CMS to leverage its quality and value-based programs to improve maternal outcomes and reduce disparities. CMS could further incentivize participation in Perinatal QI Collaboratives by requiring hospitals to demonstrate data on how their participation has led to improvements in maternal health outcomes. As an example, in California, the Hospital Quality Institute recently completed a two-year collaborative with 147 birthing hospitals focusing on perinatal mental health[47]. Participating hospitals represented 84% of all births; 84% of all Medi-Cal (Medicaid in California) births; and 90% of all Black births in California in 2020. Participating hospitals' rates of screening women for mental health disorders in the perinatal period increased from 82% to 98%; and hospitals' reliable tracking of whether patients have received education about perinatal mental health disorders grew from 47% to 83% over the course of two years.

CMS could also work with Perinatal QI collaboratives to understand how existing data is stratified to identify disparities. Hospitals that participate in CMQCC can stratify the data they provide through the collaborative by race, ethnicity, and other variables. We urge CMS to leverage existing efforts, rather than establishing duplicative reporting requirements.

CMS also seeks information on what best practices exist for ensuring systemic racism and biases, including implicit bias is not perpetuated in maternity care. In California, state law (SB 464[48]) requires hospitals that provide perinatal care to implement an evidence-based implicit bias program. Many hospitals in California utilize a free course developed by the California Health Care Foundation[49], while others have developed internal implicit bias training programs.

RFI: Measuring Health Care Quality Disparities Across CMS Quality Programs

In follow up to its FFY 2022 IPPS proposed rule RFI on leveraging Medicare quality programs to close the health equity gap, CMS provides its overarching principles — and seeks comments on — measuring health care quality disparities across the quality programs. **CHA applauds CMS' ongoing commitment to addressing health equity and we appreciate the agency's thoughtful approach to measuring disparities as described in the RFI.**

CHA agrees that providing information to hospitals and other health care providers on disparities in their quality data — including providing measure reports stratified by race, ethnicity, dually eligible status, or other factors — will be helpful in identifying where hospitals should focus their health equity improvement strategies. We also agree that both "within-provider" and "across-provider" reports are necessary to provide hospitals with the full picture of where health equity gaps within their facility and the broader community exist.

[47] https://www.hqinstitute.org/post/perinatal-mental-health-learning-community
[48] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB464
[49] https://www.diversityscience.org/evidence-based-capacity-building/equal-perinatal-care/

We also appreciate that CMS intends to prioritize existing clinical quality measures with sufficient sample size and evidence of underlying disparities in treatment or outcomes for stratified measure reporting. While stratified measure reporting is useful, it may not be appropriate for every measure given the very small cell sizes that can result, and CMS has outlined a set of principles that will help to ensure hospitals can focus their disparity reduction strategies in areas where they have the most quality improvement experience.

As CMS further considers its principles for social risk factor and demographic data, we urge the agency to consider how it can support hospitals and other providers in improving the collection of patient self-reported social risk and demographic data. Within this proposed rule, CMS includes several proposals and RFIs that could inform these efforts, including screening patients for HRSNs, and improving reporting of ICD-10 SDOH codes. We urge CMS to carefully review comments on these topics and continue to work closely with stakeholders to understand and promote best practices for the collection of self-reported patient demographic and social risk information.

Finally, as CMS works with stakeholders to improve and standardize demographic data collection, we urge the agency to focus on providing confidential, hospital-specific reports. While there may be a place for public reporting in the future, we believe the significant work needed to address the lack of standardized and reliable data should be completed prior to public reporting of disparities data. In particular, we would oppose public reporting of disparities reports using imputed sources of data, which could unintentionally introduce measurement bias.

RFI: Current Assessment of Climate Change Impacts on Outcomes, Care and Health Equity

As CMS notes in the proposed rule, climate change is increasingly understood as a serious threat to the health of our communities. In California, rising temperatures have led to more frequent extreme heat events resulting in heat related illnesses such as dehydration, heat stroke, and worsening cardiovascular and kidney diseases. Frequent drought coupled with these warming temperatures has increased the frequency, size, and intensity of wildfires — which in addition to displacing vulnerable populations — has contributed to poor air quality throughout the state, increasing and worsening respiratory diseases like asthma.

It is also clear that climate change is exacerbating health disparities, as its impacts worsen existing health and economic burdens, particularly for the most vulnerable among us, including children, low-income communities, and people of color. Some of these disproportionate impacts are due to the lack of resources available to these communities to mitigate climate change, such as low-income households that cannot afford to run air conditioning during heat waves or cannot purchase expensive air filtration systems for wildfire smoke. Other factors include systemic, historically discriminatory policies — such as redlining — which segregated communities of color to neighborhoods most likely to be impacted by climate disasters or industrial pollution.

Hospitals and health systems have also been directly and indirectly impacted by climate change. As patient health is increasingly impacted by the changing climate, hospitals and health system see increased demand for primary and specialty care services, along with increased emergency department demand during periods of acute crises. Facility operations have also been impacted by climate change. For example, humidity controls — which are necessary to meet standards in operating rooms — were not designed to handle increasing levels of humidity that have accompanied changes in temperature, requiring hospitals to invest in expensive system upgrades or mitigation strategies.

In California, hospitals are most often directly impacted by wildfires and public safety power shutoff (PSPS) events intended to prevent wildfires. In several cases, wildfires have caused evacuations of facilities and nearby communities. In addition to the challenges associated with evacuating patients from the hospital or skilled-nursing facility, community evacuations can impact patient health, especially for those who rely on medical devices. Wildfire evacuations and displacements have also exacerbated workforce challenges, as hospital staff evacuate with their families or relocate to areas less prone to fires. In 2018, the Camp Fire completely devastated the town of Paradise, destroying the hospital and multiple nursing homes, therefore increasing pressure on the health systems of nearby communities for years.

During PSPS events — under which utility companies shut off power to certain areas during times of high winds, extreme heat, or other high fire risks — hospitals are required to rely on backup generator power. Under current CMS emergency preparedness requirements, hospital backup generators meet certain National Fire Protection Association (NFPA) requirements. As allowed under 2010 NFPA 110, the power sources for these generators must be gas, diesel, propane, or natural gas. Though natural gas is lower in emissions than diesel generators, hospitals in California must rely on diesel due to the potential for natural gas lines to be disrupted during an earthquake.

Some hospitals have explored the use of microgrid technologies to reduce or eliminate the need for backup diesel generation. A microgrid is a self-sufficient energy system, typically with multiple kinds of energy (e.g., solar panels, wind turbines) and energy storage (e.g., batteries). These technologies are intended not only deployed during emergencies, but to be used more broadly to increase the use of renewable energy for hospital operations. However, current state and federal regulations do not allow hospitals to use microgrids for backup power, and maintaining parallel diesel generators while investing in new microgrid technology is cost-prohibitive for most hospitals.

Hospitals understand that the U.S. health care sector accounts for a significant portion of overall U.S. greenhouse gas emissions and have been working for years to reduce their carbon footprint. These steps include improving energy performance within facilities and investing in cleaner sources of energy, employing water-conservation strategies, and integrating emissions reduction goals into their strategic priorities. One way that hospitals track progress on these goals is under the American Society for Health Care Engineering's Energy to Care program, which provides hospitals with information and tools to assess, track, and reduce energy consumption in their buildings. Currently, 178 California hospitals participate in the Energy to Care program.

However, while hospitals understand their important role in reducing greenhouse gas emissions, it is important to note that the U.S. medical device and pharmaceutical supply chains remain the health care sector's largest contributors to carbon emissions. As CMS looks to future policies that would incentivize further emissions reductions in the health care sector, it is critical to understand that hospitals alone cannot address these challenges. Further, we urge CMS to recognize health systems who have already begun the work to conserve energy and reduce emissions as it considers future policymaking.

Medicare Promoting Interoperability Program (PIP)

CMS proposes several changes to the Medicare PIP, including making a voluntary measure mandatory, adding two new measures — one optional under the Health Information Exchange objective, and one required under the Public Health and Clinical Data Exchange objective — as well as proposed updates to the scoring methodology beginning with CY 2023 reporting and public reporting of total PIP scores.

CHA continues to support efforts to increase the interoperability of health information, and we support long-term goals of improving public health and clinical data reporting. However, as hospitals

continue to face financial and workforce challenges — including health information technology staff shortages — exacerbated by the PHE, we are concerned that hospitals will be unable to implement new requirements without diverting significant resources from direct patient care, and other regulatory requirements like the COVID-19 data reporting CoPs. We generally caution CMS against implementing significant changes to the PIP during the PHE, and provide comments on specific proposals below.

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

CMS proposes to require reporting of the Query of PDMP measure under the e-Prescribing objective, and to expand the measure to include Schedule III and IV drugs beginning with CY 2023. Currently, the measure is voluntary and only applies to Schedule II drugs. Under the proposal, hospitals would report a "yes/no" response to the measure description, which would read as: "For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using certified electronic health record technology (CEHRT) during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a PDMP for prescription drug history." Hospitals that report yes on the measure would receive 10 points under the objective.

CHA supports CMS' proposal to expand the measure to include schedule III and IV drugs. Under California law (California Health & Safety Code section 11165), health care practitioners authorized to prescribe, order, administer, or furnish a controlled substance must consult the state's prescription drug monitoring program (PDMP) (CURES database) to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time, and at least once every six months thereafter if the substance remains part of the treatment of the patient.

In recent years, California has taken steps to improve the electronic interface with the CURES database and we support CMS' proposal to require the Query of PDMP measure as a "yes/no" attestation-based measure. However, California hospitals continue to face challenges with electronic access to the PDMP, with the most significant being identity management and patient matching. Further, the state does not participate in cross-state data sharing and many patients travel often between western states. As such, we would caution CMS against requiring the reporting of the measure using a numerator/denominator structure in the future.

Public Health and Clinical Data Exchange Objective Proposals

CMS proposes several changes under the Public Health and Clinical Data Exchange Objective, including a new required measure, modifications to level of engagement requirements, and an overall increase from 10 to 25 points available to achieve. While CHA is strongly supportive of improving public health and clinical data reporting, we remain concerned that the overall lack of public health reporting infrastructure presents significant challenges to hospitals in meeting requirements due to circumstances outside of the control of the hospital. CHA continues to advocate with the state and county public health systems to improve this infrastructure and provides specific comments below in that context.

Proposed Antimicrobial Use and Resistance (AUR) Surveillance Measure

CMS proposes to require a new AUR measure that would reflect whether hospitals are in active engagement with the CDC's NHSN to submit AUR data and receives a report from NHSN indicating their successful submission of AUR data, beginning with CY 2023 reporting. To report this measure, eligible hospitals and CAHs would have to use technology certified to the criterion at 45 CFR 170.315(f)(6), "Transmission to public health agencies — antimicrobial use and resistance reporting." Hospitals would report a "yes" response or an exclusion for which they are eligible. A "no" response or the failure to report a response would result in no credit for the measure and thus failure to meet the

objective, forfeiting 25 points from the total PIP score. The measure would be calculated by reviewing all patient records, not just those whose records are maintained using CEHRT.

CHA urges CMS to delay required reporting of the AUR measure, and instead first include it as a voluntary measure available for bonus points. According to the California Department of Public Health[50], among 399 California hospitals, 132 (33.1%) are currently submitting data into the NHSN Antimicrobial Use option and only 66 (16.5%) are submitting data into the Antimicrobial Resistance option. We urge CMS to allow hospitals more time to implement reporting to the NHSN AUR module prior to mandatory reporting, particularly considering the objective's all-or-nothing scoring methodology and the significant increase in scoring weight the objective will now be assigned.

Levels of Active Engagement for Measures in Public Health and Clinical Data Exchange Objective
Previously, CMS established three options to demonstrate active engagement under the objective, in the hope that eligible hospitals would get to option three: (1) Complete registration to submit data, (2) Test and validate electronic submission of data, (3) Complete testing and validation of the electronic submission and electronically submit production data to the Public Health Authority or clinical data registry. In this rule, CMS proposes to consolidate current options 1 and 2 into one option beginning with the EHR reporting period in CY 2023. CMS also proposes to require that hospitals submit their level of active engagement (Pre-production and Validation or Validated Data Production) for each measure they report.

Further, CMS would require that — beginning with CY 2023 — hospitals spend only one EHR reporting period at the Pre-production and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level for the next EHR reporting period for which they report a particular measure. **CHA opposes this proposal due to the lack of available technical capabilities across many California county public health departments. In California, the public health system is decentralized and managed at the county level and many counties simply do not have the capability to provide documentation to demonstrate Validated Data Production. This requirement would put California hospitals at a significant disadvantage under the PIP and we urge CMS to withdraw it.**

Condition of Participation: Reporting COVID-19 and Influenza Infections

During the PHE, CMS has required hospitals and CAHs to report specific information about COVID-19, such as the number of staffed beds in a hospital and the number of those that are occupied; information about its supplies; a count of patients currently hospitalized who have laboratory-confirmed COVID-19; current inventory supplies of any COVID-19-related therapeutics that have been distributed and delivered to the hospital (or CAH) under the authority and direction of the Secretary; and the hospital's (or the CAH's) current usage rate for these COVID-19-related therapeutics. Under current regulatory language, these reporting requirements will no longer be required through the CoPs once the PHE declaration ends.

CMS is proposing that beginning at the conclusion of the current PHE declaration, and continuing until April 30, 2024, a hospital or a CAH must electronically report information about COVID-19 and seasonal influenza in a standardized format specified by the Secretary, noting that the Secretary could establish an earlier sunset date. **CHA strongly encourages CMS to sunset the data collection as early as possible to reduce the administrative burden associated with this requirement.**

[50] https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/NHSN_AUR_OptionImplementationToolkit.aspx

We also urge CMS to continue to allow COVID-19 data reporting under the current Teletracking system, rather than transitioning to a new CDC NHSN-based system from the end of the PHE until the sunset date in 2024. CMS notes that if the PHE is ongoing when the FFY 2023 IPPS final rule goes into effect, its proposals would not be implemented until the PHE concludes and guidance has been issued to indicate a transition. However, CHA questions why there is a need for a transition when hospitals already have established processes for daily reporting to HHS via the Teletracking system. Should CMS finalize its proposal to extend COVID-19 reporting requirements beyond the PHE, allowing for consistency within the reporting mechanisms and processes would be the least burdensome option.

However, should CMS move forward with requiring reporting via an NHSN COVID-19 reporting module, CHA strongly encourages CMS to allow for a significant transition period, and ensure education is made available to hospitals in advance of the transition. Given that this is a new, different COVID-19 reporting module, hospitals will need to familiarize themselves with it to ensure they understand how the various data points are to be reported. Further, CHA notes that in California, COVID-19 data reported to the state could also be reported to the Teletracking system, avoiding duplicative reporting requirements. CHA's members found this support incredibly beneficial. If the NHSN system is used instead, CHA asks CMS to ensure that states still have the ability to report on hospitals' behalf if the hospital so desires.

CHA recognizes the need and supports reporting the data necessary to the CDC, CMS, and other governmental agencies necessary to help federal entities effectively protect the American people during a PHE. **However, CHA strongly encourages CMS and other federal agencies to weigh the value of any data that hospitals are required to report against the administrative burden imposed on hospitals and their staff at a time when these organizations face significant workforce shortages that have been exacerbated by the pandemic.** As discussed in detail below, experience with mandatory reporting during the PHE has shown that many of the more detailed reporting requirements pull clinical staff away from patient care at a time when all capable hands were needed at the bedside to deliver patient care. Beyond removing caregivers from the bedside, these requirements have the deleterious effect of increasing staff workload and reducing days off to meet reporting requirements, which has contributed to the epidemic of clinician burnout facing hospitals. **With an eye to these unintended consequences, we strongly encourage the agency to focus only on the fields that are crucial to coordaining the federal response to a PHE.**

For COVID-19 reporting between the end of the PHE and April 30, 2024, hospitals and CAHs would be required to report:

- Suspected and confirmed COVID-19 infections among patients and staff
- Total COVID-19 deaths among patients and staff
- PPE and testing supplies in the facility
- Ventilator use, capacity, and supplies in the facility
- Total hospital bed and intensive care unit bed census and capacity
- Staffing shortages
- COVID-19 vaccine administration data of patients and staff
- Relevant therapeutic inventories and/or usage

CHA is concerned the COVID-19 data items requested — as discussed below — are administratively burdensome and unnecessary.

1) *Suspected COVID-19 Cases*: CHA notes that reporting suspected cases at the beginning of the pandemic was necessary due to limited access to testing — even for medical facilities. However, testing is now readily available, there are few, if any, suspected cases. **Therefore, we question the need to report suspected cases and ask CMS not to require reporting of suspected COVID-19 cases unless there is a severe testing shortage.**

2) *Patient/Staff COVID-19 Count Frequency*: CHA notes that hospitals typically report counts for COVID-19 cases and deaths for patients and staff at different frequencies. Patient counts are reported daily, while staff counts are reported weekly. **CHA strongly encourages CMS to provide the flexibility to allow this continued reporting cadence.**

3) *PPE Counts*: The requirement to provide specific counts of certain supplies is incredibly time-consuming. Instead of spending time providing needed care to patients, reporting these granular data elements requires caregivers to dedicate considerable time on to an administrative task that is of questionable value — particularly as the shortages of many types of PPE have been resolved. Further, given the many different size categories for some of these items, a specific count reported may not be particularly accurate representation of the PPE that is available in the facility for use by staff. **Therefore, CHA strongly encourages CMS to only require PPE reporting if there is an active shortage of a specific type of PPE.**

For seasonal influenza, hospitals and CAHs would be required to report:

- Confirmed influenza infections among patients and staff
- Total influenza deaths among patients and staff
- Confirmed co-morbid influenza and COVID-19 infections among patients and staff.

CHA notes that the current COVID-19 reporting framework does not require hospitals to submit data related to influenza for staff. Given the federal government has successfully steered its COVID-19 response without most of these data for over two years, we question its value in light of the additional administrative burden.

To respond to future crises more effectively, CMS proposes to require hospitals and CAHs to report specific data elements to the NHSN, or other CDC-supported surveillance systems, as determined by the Secretary. The proposed requirements would apply to local, state, and national PHEs. **CHA strongly encourages the agency to ensure that the data it is collecting from hospitals during future PHEs are shared with states and localities. Doing so can reduce duplicate reporting requests and pressure on the clinical staff who are responsive to these requirements.**

While CHA appreciates the flexibility inherent in adding measures on an "as-needed basis" we are concerned about both the administrative burden and the potential for incomplete data reporting as a result of inadequate hospital education on the requirements. During the PHE, new fields were added based on CDC or HHS data monitoring needs. However, these changes were frequently not well communicated both in terms of their timing and the specifications of the newly added/modified measures. As a result, hospital staff — frequently clinicians — were burdened by the need to quickly change the way patients were counted to meet the requirements of the new field. This created data

integrity issues for weeks after the changes were made that potentially negated the usefulness of the new measure. Additionally, very few fields were actually removed as case counts fell or the measure became irrelevant. Given the ongoing national health care workforce shortage, it's critically important that CMS move quickly to reduce or eliminate reporting when case counts are low or measures are no longer relevant.

CHA strongly encourages CMS to make more measured changes to the reporting requirements. We ask that when changes are made there is a timely and effective education effort in advance of the changes to ensure that staff reporting these data elements understand the current requirements. Effective communication and education are the surest ways to minimize administrative burden on hospitals, allow for clinical staff to spend more of their time where they belong — providing patient care, and allow for the accurate reporting of data necessary to facilitate an effective federal response to a future PHE. To that end, CMS must communicate very clearly with hospitals about what fields will be activated and deactivated prior to updates. The latest COVID-19 reporting updates, which made fields optional immediately, as opposed to deleting them immediately, allowed hospitals an opportunity to adapt over time instead of overnight.

Relevant to a declared future PHE, CMS proposes requiring reporting of the following items on a daily basis to NHSN or other CDC-supported surveillance systems:

- Suspected and confirmed infections of the relevant infectious disease pathogen among patients and staff
- Total deaths attributed to the relevant infectious disease pathogen among patients and staff
- PPE and other relevant supplies in the facility
- Capacity and supplies in the facility relevant to the immediate and long-term treatment of the relevant infectious disease pathogen, such as ventilator and dialysis/continuous renal replacement therapy capacity and supplies
- Total hospital bed and intensive care unit bed census, capacity, and capability
- Staffing shortages
- Vaccine administration status of patients and staff for conditions monitored under this section and where a specific vaccine is applicable
- Relevant therapeutic inventories and/or usage
- Isolation capacity, including airborne isolation capacity
- Key co-morbidities and/or exposure risk factors of patients being treated for the pathogen or disease of interest that are captured with interoperable data standards and elements
- Person-level information such as medical record identifier, race, ethnicity, age, sex, county of residence and ZIP code, and relevant comorbidities for affected patients

The proposed list represents a significant expansion in data elements compared to what hospitals are currently required to report. In particular, CHA questions the value of the following newly added measures relative to their administrative burden:

- Dialysis/continuous renal replacement therapy capacity and supplies
- Isolation capacity, including airborne isolation capacity

- Key co-morbidities and/or exposure risk factors of patients being treated for the pathogen or disease of interest in this section that are captured with interoperable data standards and elements

CHA is deeply concerned that any expansion of the list that includes non-essential measures will reduce the supply of clinicians (both immediately and long-term through burnout) available to deliver lifesaving patient care. Therefore, we ask the agency to eliminate these measures from the standing reporting requirements. If the specific nature of a future PHE requires these data points to inform the federal government's decision-making, CMS can add them to the reporting requirements as needed.

Further, CHA believes CMS needs to provide additional clarity related to "key co-morbidities and/or exposure risk factors …" First, we are concerned that without additional guidance from CMS or the CDC, hospitals may not know what is considered a "key co-morbidity." In absence of this guidance, hospitals will likely report all available diagnosis codes captured on the hospital inpatient claims form which could be as many as 25 individual diagnoses. Second, it is unclear how hospitals will document and report "exposure risk factors." Based on feedback from our members, we believe this is beyond the realm of medical judgment and is more appropriately tracked outside of the hospital through contract tracing and other public health efforts. **Given the challenges with this item, we strongly encourage CMS not to require it under any circumstance.**

In the rule, CMS proposes to require infection and vaccination data to be reported in a format that provides person-level information. This includes a medical record identifier, race, ethnicity, age, sex, county of residence/ZIP code, and relevant comorbidities. The rule states these elements are necessary to address issues of health equity and response management. Further, the pandemic identified the inability to follow patients with COVID-19 through the health care system, especially the important transfers that often occur between acute and long-term care facilities. **CHA notes that in California, hospitals were not used as public vaccination sites. As a result, any vaccine data reported would be of questionable accuracy and therefore limited use.**

Requiring patient-level reporting of any data — particularly on a daily basis — is incredibly burdensome and will pull even more clinicians away from patient care. While we appreciate the need to monitor this data to identify issues of health equity that may arise in the pandemic response, we are concerned the strain on staffing created by this requirement will reduce access to care. This reduced access, will, unfortunately, most likely negatively impact those at greatest risk of inequitable outcomes as they have the least ability to utilize an alternative site of care where access may be more available.

Further, the proposed addition of patient-level data runs counter to the proposal to limit personally identifiable data. CHA is deeply concerned the combined use of medical record identifiers, race, ethnicity, age, sex, and ZIP code might potentially expose the identity of patients. This risk of inadvertent identification is particularly acute in smaller and more rural hospitals. **Beyond normal patient privacy protection, CHA is concerned that during a future PHE patients may be less likely to seek care if they believe doing so will identify them as carriers of a particular pathogen.** This concern is informed and heightened by the degree to which various forms of disinformation have inhibited our members' COVID-19 response and federal vaccination efforts. **Therefore, given these issues, CHA strongly encourages CMS not to require patient-level data reporting.**

Specific to the proposed requirement that hospitals report a medical record identifier, CMS states that this will allow for the tracking of transfers between facilities and provide greater insight into outcomes and health care facility capacity. **CHA strongly questions the usefulness of a patient's medical record identifier in achieving this goal.** First, we note there is no federal universal patient identifier. For over 20 years, Congress has included language in the Labor, Health and Human Services, and Education and Related Agencies Appropriations bill blocking the development of such an identifier. In the absence of a standard federal patient identifier, each medical record number is unique to each hospital that treats the patient. If a patient is transferred to an unaffiliated hospital or post-acute care provider, the new facility will assign its own unique patient identifier. **Given the inability to track a patient across the care continuum using each hospital/post-acute provider's unique medical record number, we strongly recommend that CMS not require hospitals to report this data element that has limited to no value and could potentially be used to identify a specific patient.**

Allogeneic Stem Cell Acquisition

Section 108 of the Further Consolidated Appropriations Act (FCA), 2020 (Pub. L. 116-94) made changes to how Medicare pays for the acquisition of hematopoietic stem cell for the purpose of an allogeneic hematopoietic stem cell transplant by removing them from the definition of operating costs and reimbursing them on a reasonable cost basis. This change was effective for cost-reporting periods beginning on or after October 1, 2020. While CHA strongly supports this change, we note that CMS has yet to release updated cost-reporting instructions. Until CMS releases these instructions, any hospital that provides stem cell transplants with a fiscal year that began on or after October 1, 2020, and ends before the updated instructions are released will need to file an amended cost report that accounts for the changes stem cell acquisition reimbursement by Section 108 of the FCA. This creates additional administrative burden for both hospitals and the Medicare Administrative Contractors, which are both experiencing staffing shortages. It is also contrary to CMS' efforts — through "Project Groundwater" — to audit and finalize cost reports that have only been tentatively settled. **Therefore, CHA asks CMS to expedite the release of updated cost report instructions that include the changes to organ acquisition worksheets as required by Section 108 of the FCA.**

CHA appreciates the opportunity to comment on the FFY 2023 IPPS proposed rule. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy