

June 17, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Room 445-G  
Washington, DC 20201

***RE: 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: Proposed Rule (Vol. 87, No. 90), May 10, 2022.***

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2023. We are submitting separate comments on the agency's proposed changes to the long-term care hospital PPS.

**We support a number of the inpatient PPS (IPPS) proposed rule's provisions, such as those related to the full-time equivalent cap calculation in the graduate medical education (GME) program and the cap on area wage index decreases. We also support several aspects of CMS's quality-related proposals, including additional steps to recognize the ongoing impact of the COVID-19 pandemic on its programs, and important steps to advance health equity.**



**At the same time, we have strong concerns about the proposed payment updates, which, together with the rule's policy changes, would result in a net *decrease* in payments to IPPS hospitals in FY 2023 compared to FY 2022.**

**In particular, we are deeply concerned about the inadequacy of the proposed market basket update given the extreme inflationary environment in which we continue to operate. As such, we strongly urge CMS to utilize its authority to provide a market basket adjustment to account for the unexpected and persistent increase in inflation. We also are concerned about the agency's proposed cuts to disproportionate share hospital (DSH) payments and the lack of transparency in the underlying calculations. Additionally, we are concerned about the dramatic increase in the proposed high-cost outlier threshold. Finally, we have concerns about several of the agency's quality-related proposals. A summary of our key recommendations follows.**

### **IPPS Payment Update**

CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, combined with the FY 2022 payment update hospitals received last year for IPPS, are woefully inadequate and do not capture the unprecedented inflationary environment hospitals and health systems are experiencing. Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update is essential to ensure that Medicare payments for acute care services accurately reflect the cost of providing hospital care. Therefore, **we urge CMS to use its "special exceptions and adjustments" authority to make a retrospective adjustment to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022. We also urge the agency to use the same authority to eliminate the productivity cut for FY 2023.**

### **Disproportionate Share Hospital (DSH) Payments**

The AHA continues to be concerned about the agency's lack of transparency with regard to how it is calculating DSH payments. **Specifically, we disagree with the agency's estimates of both the inpatient discharge volume for FY 2023 and the number of uninsured.** For instance, signs of volume recovery are emerging and it is clear that a large *increase* in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions being to unwind. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate.**

## High-cost Outlier Threshold

We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven an increase in the high-cost outlier threshold. However, we remain concerned about the dramatic scale of the proposed change — a 39% increase from the FY 2022 threshold. **We ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.**

## Hospital Quality and Value-based Programs

Consistent with hospitals and health systems' steadfast commitment to advancing health equity, the AHA is pleased to support the addition of health equity-related measures to the inpatient quality reporting (IQR) program. At the same time, we offer several recommendations to ensure the measures are meaningful, feasible, and accurate and achieve their critically important objectives. This includes providing more specific implementation guidance on and revising the scoring methodology of the Hospital Commitment to Equity Measure. We also ask that CMS adopt its proposed health related social needs screening measures for voluntary reporting for now, and revisit a date for mandatory reporting after it has assessed the first year of voluntary reporting.

The AHA also thanks CMS for recognizing the continued disruption posed by the COVID-19 public health emergency (PHE) on its quality measurement and value programs, and support CMS's proposals not to penalize hospitals under the Hospital Value-Based Purchasing and the Hospital-Acquired Condition Reduction Program for FY 2023. However, the AHA has significant concerns about several of CMS's proposed new quality measures, and urges CMS to reconsider their implementation. In addition, we object to the heavy-handed proposed use of Conditions of Participation to compel data reporting for COVID-19 and future PHEs, and instead urge CMS to work with hospitals to obtain needed data in a more collaborative and sustainable fashion.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA senior associate director for policy, at (202) 626-2963 or [swu@aha.org](mailto:swu@aha.org).

Sincerely,

/s/

Stacey Hughes  
Executive Vice President

**American Hospital Association (AHA)  
Detailed Comments on the Inpatient Prospective Payment System (PPS)  
Proposed Rule for Fiscal Year (FY) 2023**

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## IPPS PAYMENT UPDATE

For FY 2023, CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the unprecedented inflationary environment hospitals and health systems are experiencing. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. **When historical data vastly underestimate future inflation, the market basket becomes inadequate. Similarly, when data incorrectly predict gains in productivity, the productivity adjustment is substantially overstated. This is essentially what occurred in the forecasting of the FY 2022 and 2023 market basket and productivity adjustments.** Indeed, recent data<sup>1</sup> shows that the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year. Additionally, the latest data from the U.S. Bureau of Labor Statistics actually indicate *decreases* in productivity, not gains.<sup>2</sup> **As such, we urge CMS to use its "special exceptions and adjustments" authority to 1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023, as we detail below.**

Context of the Inflationary Economy. The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems. Health care providers remain on the front lines fighting this powerful virus, while at the same time struggling with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic. **We urge CMS to consider the changing health care system dynamics, including those described below, and their effects on hospitals. Taken together, these shifts in the health care environment are putting enormous strain on hospitals and health systems, which will continue in FY 2023 and beyond.**

Historic inflation has continued and heightened the severe economic instability that the pandemic wrought on hospitals and health systems. Specifically, high inflation began to take hold in the second half of calendar year 2021, with the consumer price index (CPI), a measure of general inflation, ultimately hitting a 12-month high in May 2022 at 8.6%.<sup>3</sup>

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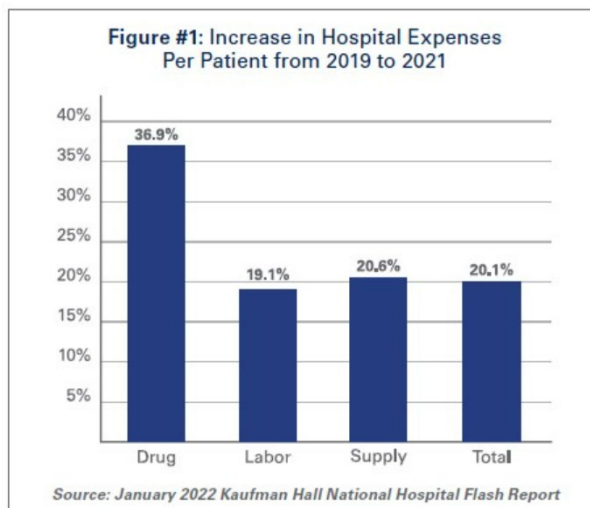
<sup>1</sup> IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>

<sup>2</sup> U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. <https://www.bls.gov/news.release/pdf/prod2.pdf>.

<sup>3</sup> U.S. Bureau of Labor Statistics. (June 10, 2022). Consumer Price Index Summary Results. <https://www.bls.gov/news.release/cpi.nr0.htm>; Statista. (June 13, 2022). Monthly 12-month Inflation Rate in the United States from May 2021 to May 2022. <https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/>

Fannie Mae forecasts that inflation will remain elevated through at least the end of 2022, averaging 5.5% in the fourth quarter of the calendar year.<sup>4</sup> Because this high rate of inflation is not projected to abate in the near term, it is critical to account for it when considering hospital and health system financial stability in FY 2023 and beyond. As described in a report by FTI Consulting, which is attached to this letter, more recent inflationary pressures are also likely to work their way into wage expectations, particularly in industry sectors such as health care where labor is in short supply, thus driving up labor costs even further.

Indeed, the financial pressures providers are experiencing are massive. Expenses continue to rise across the board, with hospitals face increasing costs for labor, drugs, purchased services, personal protective equipment (PPE), and other medical and safety supplies needed to care for patients. Specifically, an April 2022 [report](#) by the AHA highlights the significant cost growth in hospital expenses across labor, drugs, and supplies (as shown in the reproduced chart below), as well as the impact that rising inflation is having on hospital prices. By the end of calendar year 2021, total hospital expenses per adjusted discharge were up 20.1% compared to pre-pandemic levels in 2019.



**Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.** Indeed, Medicare only pays 84% of hospital costs on average according to

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<sup>4</sup> Fannie Mae. April 19, 2022. Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'. <https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing>

our latest analysis.<sup>5</sup> In 2020, two-thirds of hospitals received Medicare payments less than cost and Medicare margins fell to *negative* 12.6% without COVID relief funds.<sup>6</sup> Inadequate payment updates that do not account for inflation will cause this underpayment to be even more pronounced. Moreover, hospitals' median change in operating margin dropped nearly 76% compared to April 2021 and gross operating revenue declined over 50% in the same time period.<sup>7</sup> These data reveal the adverse impact of higher costs and a change in the mix of resources needed to respond to the current environment.

Market Basket. CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2% for FY 2023. These estimates were produced using historical data through the third quarter of calendar year 2021, forecast into the future. In a steady-state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. The rationale for using historical data as the basis for a forecast is reasonable in a typical economic environment. However, we are not in a typical economic environment. **The end of calendar year 2021 into calendar year 2022 should not, in any sense, be considered a steady-state economic environment that is a continuance of past trends. And, as a result, the market basket updates for FY 2022 and FY 2023 are resulting in woefully inadequate reimbursements for hospitals and health systems.** This is, in large part, because the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs faced by the healthcare industry beginning in late 2021.

Specifically, for FY 2022 (Oct. 1, 2021 through Oct 1, 2022), CMS finalized a market basket of 2.7%. To do so, it used estimates from historical data through the first quarter of calendar year 2021, forecast into the future.<sup>8</sup> Because this market basket was a forecast of what was *expected* to occur, it missed the *unexpected* trends that actually did occur. For example, the inflation rate in March 2021 was 2.6%, but by December 2021 it had skyrocketed to 7%.<sup>9</sup> Clearly, the FY 2022 market basket was unable to capture the extraordinarily high inflationary spikes that occurred towards the latter half of calendar year 2021.

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<sup>5</sup> American Hospital Association (February 2022). Underpayment by Medicare and Medicaid Fact Sheet. <https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf>

<sup>6</sup> MedPAC. (2022). March 2022 Report to the Congress: Medicare Payment Policy. Chapter 3 – Hospital inpatient and outpatient services. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)

<sup>7</sup> Kaufman Hall (May 2022). National Hospital Flash Report. <https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-05-2022-May.pdf>

<sup>8</sup> 86 Fed. Reg. 45214 (August 13, 2021).

<sup>9</sup> Statista. (June 13, 2022). Monthly 12-month Inflation Rate in the United States from May 2021 to May 2022. <https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/>



The FY 2022 market basket was also unable to capture large increases in labor and wage costs, which also occurred towards the latter half of calendar year 2021. Indeed, when we examine preliminary labor costs reported on the Medicare cost report, we find that contract labor costs increased by 55% and total labor expenses increased by nearly 8% for those cost reports ending April 2021–December 2021 compared to the year prior (cost reports ending April 2020–March 2021).<sup>10</sup> Indeed, the FY 2022 market basket in the final rule missed these unexpected turns reflected in the data. Specifically, as more recent data becomes available beyond those used to forecast the FY 2022 market basket<sup>11</sup>, that market basket is trending toward 4.0%, well above the 2.7% CMS actually implemented.

In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction dulls the impact of any unexpected spikes that occur. For instance, the market basket uses three price proxies to measure price changes over time — the Employment Cost Index (ECI), which measures changes in compensation costs; the Consumer Price Index (CPI), which measures changes in prices paid by consumers; and the Producer Price Index (PPI), which measures changes in price experienced by producers. The graph below, reproduced from the FTI Consulting report attached at the end of this letter, shows the three components that make up the market basket. In particular, CPI has a significantly steeper upward trend than is reflected in the market basket for inpatient hospital services. This suggests that when the market basket captures shocks, it is much more muted than what hospitals and health systems actually experience in those shocks because it is a time-lagged rolling average estimate. Again, in a steady-state economy with small and stable changes in inflation and costs, this may be a reasonable approach. However, in an atypical environment, such as the one we are currently in, payment updates must adequately account for these dynamic changes.

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<sup>10</sup> AHA analysis of hospital Medicare cost reports reported to the Healthcare Cost Report Information System (HCRIS) March 31, 2022 Update.

<sup>11</sup> IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>



**Figure 3: Price Index, Cost Index, and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)**



**Given these extreme and uncontrollable circumstances occurring in FY 2022, we strongly urge CMS to use its "special exceptions and adjustments" authority to implement, for FY 2023, a retrospective adjustment to account for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022. While this difference is currently 1.3% (4.0% minus 2.7%, as mentioned above), we ask CMS to use the most recent data available to calculate this adjustment and implement it in the final rule.**

Productivity. Under the Affordable Care Act (ACA), the IPPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).<sup>12</sup> This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2023, CMS proposes a productivity cut of 0.4 percentage points.

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. **Thus, this measure effectively assumes the hospital sector can mirror productivity gains across the private nonfarm business sector. However, in an economy marked by great uncertainty due to inflation, and demand and supply shocks, this assumption generates significant departures from economic reality.**

**In fact, CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run. Specifically,**

<sup>12</sup> Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf>

research indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.<sup>13</sup> Thus, using the private nonfarm business sector TFP to adjust the market basket exacerbates Medicare underpayments to hospitals — particularly in a period of record inflation. Indeed, Medicare margins in 2020 were already *negative* 8.5% when COVID-19 relief funds are accounted for, and *negative* 12.6% without those funds.<sup>14</sup>

The use of an adjustment that is a 10-year moving average also negates year-to-year fluctuations. For example, over the last decade, there have been four quarters of productivity decreases. Two of these quarters occurred during the past 12 months — a 0.4 percent decline in the third quarter of 2021 and a 0.6 percent decline in the first quarter of 2022.<sup>15</sup> Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. Although the productivity adjustment uses a 10-year moving average, two quarter declines in 12 months in this metric is also noteworthy enough that it should be considered when deciding upon the appropriate productivity adjustment to implement for FY 2023.

In addition, whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services. Generally, hospital services have not recovered to pre-pandemic levels,<sup>16</sup> and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the proposed FY 2023 payment update. Specifically, Bureau of Labor Statistics data show that hospital employment levels have decreased by approximately 100,000 from pre-pandemic levels.<sup>17</sup> Additionally, the combination of employee burnout and fewer available staff have forced hospitals to heavily rely on contract staff, especially contract nurses. The loss of established employees and the reliance on contract staffing firms to help address staffing shortages all echo our members' experiences related to declines in productivity during the pandemic, not gains. Indeed, an October 2021 survey conducted by Kaufman Hall found

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<sup>13</sup> Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf>

<sup>14</sup> MedPAC. (2022). March 2022 Report to the Congress: Medicare Payment Policy. Chapter 3 – Hospital inpatient and outpatient services. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)

<sup>15</sup> U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. <https://www.bls.gov/news.release/pdf/prod2.pdf>, <https://www.bls.gov/opub/ted/2022/nonfarm-business-labor-productivity-down-0-6-percent-from-first-quarter-2021-to-first-quarter-2022.htm>.

<sup>16</sup> Kaufman Hall (May 2022). National Hospital Flash Report. <https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-05-2022-May.pdf>

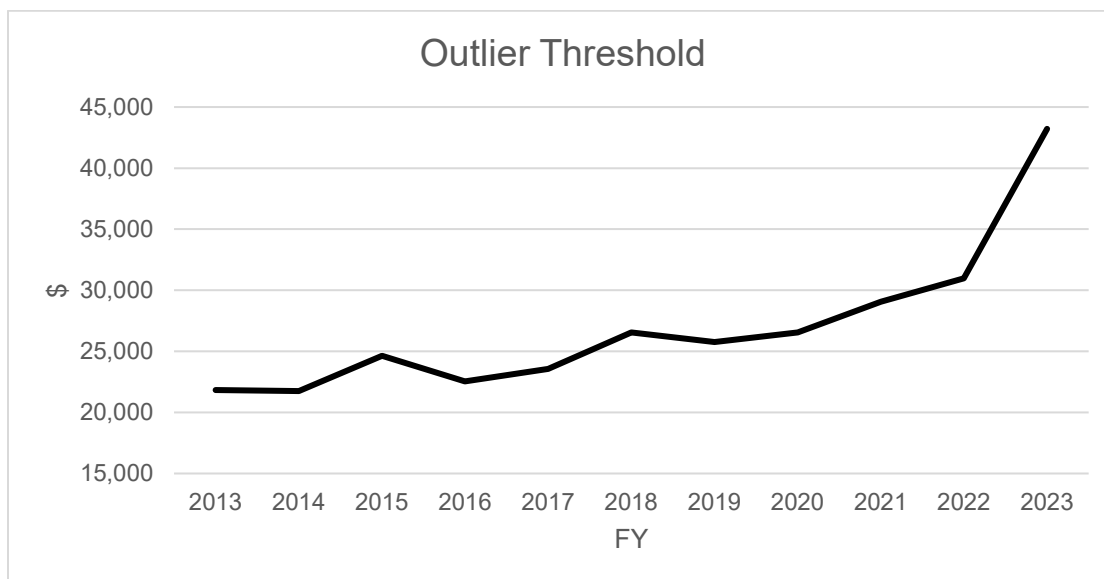
<sup>17</sup> American Hospital Association. (April 2022). Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems. <https://www.aha.org/costsofcaring>

that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.<sup>18</sup>

**The AHA has deep concerns about the proposed productivity cut, given the extreme and uncontrollable circumstances in which hospitals and health systems are currently operating. As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2023.** It is clear that significant uncertainty will continue to persist regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions and the war in Ukraine) continue to affect productivity. This uncertainty, as well as the continued divergence in hospital productivity from overall private nonfarm business sector productivity, should be accounted for in the FY 2023 payment update.

### HIGH-COST OUTLIER THRESHOLD

The AHA is concerned about the dramatic scale of the proposed increase in the high-cost outlier threshold — a 39% increase from the FY 2022 threshold — that would significantly decrease the number of cases that qualify for an outlier payment. The agency states that its proposed increase from \$30,988 in FY 2022 to \$43,214 in FY 2023 seeks to align total FY 2023 outlier payments with its target of 5.1% of total IPPS payments. However, we urge the agency to explain in more detail the factors driving this significant increase in IPPS high-cost outlier threshold. The chart below details the dramatic increase in the outlier threshold for FY 2023 compared to the past decade.



FY 2013–2022 outlier thresholds in the published final rule.

<sup>18</sup> Kaufman Hall. (October 18, 2021). 2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment. <https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates>

Source: AHA analysis of outlier threshold published in final and proposed rules.

**We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven the increase, but which will likely not continue fully in FY 2023.** Specifically, CMS states that the FY 2023 outlier threshold would be even higher at \$58,798, if certain policy adjustments were not applied. **However, we ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.** Using data from the proposed rule, we find that different assumptions about the impact of COVID cases in FY 2023 lowers the threshold. As additional data come in for the final rule, we urge CMS to consider these temporary changes to lower the threshold further. For example, rather than using a 50/50 blend of COVID-19 and non-COVID-19 cases to determine the outlier threshold, a blend of 2019 and 2021 data may more accurately reflect the impact of the pandemic in FY 2023 on the outlier threshold. Another alternative may be to use the 50/50 blend proposed by CMS to determine the relative weight but to remove COVID-19 cases to determine payments. These alternatives all acknowledge that COVID-19 cases will have continued effects in FY 2023 but the impact may be dulled compared to previous years.

## **MS-DRG RELATIVE WEIGHT SETTING**

CMS proposes to use FY 2021 claims and FY 2020 cost report data for FY 2023 rate-setting purposes. However, anticipating Medicare inpatient hospitalizations for COVID-19 will continue in FY 2023, the agency is proposing several modifications to the usual rate-setting methodology to account for the continued effects of the pandemic. Specifically, CMS is proposing modifications to determine the MS-DRG weights for FY 2023 by averaging the relative weights as calculated with and without COVID-19 cases. For example, 50% of the relative weight calculation would come from all applicable cases and 50% would come from cases without COVID-19. CMS believes that this approach would reduce, but not entirely remove, the effect of COVID-19 cases. Additionally, CMS is also proposing a permanent 10% cap on the reduction in a MS-DRG relative weight for a given fiscal year, which would be applied in a budget neutral manner. **We support the proposed 10% cap on MS-DRG relative weight decreases but urge CMS to apply this policy in a non-budget neutral way.**

## **MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT**

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

Transparency related to DSH calculation. The AHA continues to be concerned about the agency’s lack of transparency with regard to how CMS and the Office of the Actuary

(OACT) are calculating DSH payments. This is particularly troubling because Congress has generally foreclosed subsequent review, making the adequacy and completeness of notice-and-comment rulemaking that much more important from a constitutional due process perspective. We highlight below some examples of improvements that should be made to promote transparency related to the DSH calculation; however, this list is not all-encompassing, and **we urge CMS to provide all additional information required for stakeholders to replicate and validate this complex calculation.**

Factor 1. Factor 1 is the estimate of what total DSH payments would have been under the former statutory formula. CMS includes in the rule a table explaining the factors it applied for FYs 2020 through 2023 to estimate Factor 1. In this table, the agency includes a “Discharges” column that shows the changes in the number of Medicare fee-for-service inpatient hospital discharges. CMS proposes a decrease of \$176 million in Factor 1.

In estimating Factor 1, CMS used a variety of data sources, including historical discharge numbers. Specifically, the agency states that the “discharge figures for FY 2020 to FY 2023 reflect the actual impact and estimated future impact of the COVID-19 pandemic.” In this year’s rule, CMS has revised its estimate of FY 2022 discharges substantially downward; this, combined with its small forecasted growth of 1% in discharges for FY 2023, yielded the proposed decrease in Factor 1. **We disagree with these estimates. While total discharge volume remains low compared to pre-pandemic levels, signs of volume recovery are emerging and we believe discharges will increase more than 0.7% in FY 2022 and 1% in FY 2023.** For example, according to a Kaufman Hall study, adjusted national patient volume has increased by 18% from February 2022 to March 2022 alone.<sup>19</sup> Additionally, surgery volumes continue to increase as patients return after delaying many non-urgent procedures,<sup>20</sup> and adjusted patient volumes are up more than 64% compared to 2020.<sup>21</sup> Indeed, our analysis also shows that non-COVID-19 inpatient hospital discharge volume increased 22% from February to March 2022.<sup>22</sup> Although it appears likely that FY 2022 volumes will remain lower than historic, pre-pandemic levels, the trends indicate that FY 2022 and 2023 volumes will continue to increase substantially.

CMS is using preliminary claims data to estimate the “Discharges” factor that is used to arrive at Factor 1 for FY 2023. Therefore, it is critically important that these data be updated to reflect the latest information available and ensure that hospitals are accurately paid for their uncompensated care costs. The rule indicates that “OACT intends to use more recent data that may become available for purposes of projecting the final Factor 1

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<sup>19</sup> Kaufman Hall (April 2022). National Hospital Flash Report.

<https://www.kaufmanhall.com/sites/default/files/2022-04/April-2022-National-Hospital-Flash-Report-2.pdf>

<sup>20</sup> Kaufman Hall (April 2022). National Hospital Flash Report.

<https://www.kaufmanhall.com/sites/default/files/2022-04/April-2022-National-Hospital-Flash-Report-2.pdf>

<sup>21</sup> Kaufman Hall (May 2022). National Hospital Flash Report.

<https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-05-2022-May.pdf>

<sup>22</sup> Analysis based on Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, <https://www2.ccwdata.org/web/guest/home>.

estimates for the FY 2023 IPPS/LTCH PPS final rule.”<sup>23</sup> **Indeed, we urge OACT to carefully monitor changes in discharge volume and to update its estimate of the Medicare DSH amount in the final rule to more accurately reflect discharge volume.**

**We also request that CMS publish a detailed methodology on the calculation of Factor 1. In fact, we ask that this information be provided to the hospital field in advance of publication of the final rule and in the inpatient PPS proposed rule each year going forward. The absence of CMS’s methodology severely limits the AHA’s ability to comment sufficiently on this issue.**

Factor 2. CMS establishes Factor 2 in the calculation of the uncompensated care payment as 1 minus the percent change in the percent of individuals who are uninsured, determined by comparing the percent of the individuals who were uninsured in 2013 and the percent of individuals who were uninsured in the most recent period for which data is available. In the FY 2022 final rule, CMS determined that the most recent uninsured rate was 9.6%; for FY 2023, CMS proposes that the uninsured rate would decrease to 9.2%. **We strongly disagree with this estimate. Indeed, it is expected that health coverage for millions of people will end after the PHE expires, as the Medicaid continuous coverage requirement and the Marketplace enhanced premium tax credits will unwind. As such, we will see a large *increase* in the number of the uninsured, not a decrease, in FY 2023.**

To determine FY 2023 uninsured rates, OACT uses projections from the latest National Health Expenditure Accounts (NHEA) historical data, which accounts for expected changes in enrollment across several categories of insurance coverage, including Medicaid. NHEA projects that in 2023, Medicaid enrollment will drop by 2.6 million as states are expected to trim enrollments with the assumed end to the PHE.<sup>24</sup> However, we disagree with the magnitude of this estimate. For example, Kaiser Family Foundation finds that between 5.3 million and 14.2 million people could lose Medicaid coverage following the end of the PHE.<sup>25</sup> This is magnitudes different than the 2.6 million that NHEA estimates. Similarly, the Urban Institute finds that the longer the PHE lasts, the greater the potential number of people that will lose Medicaid coverage. It estimates that 15.8 million people will lose Medicaid if the PHE expires after the third quarter of 2022.<sup>26</sup> This is over six times higher than NHEA’s estimate. While some people who lose Medicaid coverage

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<sup>23</sup> 87 Fed. Reg. 28383 (May 10, 2022).

<sup>24</sup> Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2021 – 2030. <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>

<sup>25</sup> Kaiser Family Foundation. (May 10, 2022). KFF Analysts Find that Between 5.3 Million and 14.2 Million People Could Lose Medicaid Coverage Following the End of the Public Health Emergency and Continuous Enrollment Requirement. <https://www.kff.org/medicaid/press-release/kff-analysts-find-that-between-5-3-million-and-14-2-million-people-could-lose-medicaid-coverage-following-the-end-of-the-public-health-emergency-and-continuous-enrollment-requirement-with-an-unknown/>

<sup>26</sup> Urban Institute. (March 2022). What Will Happen to Medicaid Enrollees’ Health Coverage after the Public Health Emergency? [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](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)

may be eligible for other subsidized health insurance coverage, many people losing coverage become uninsured. For example, the Urban Institute estimates that only one third of adults who would lose Medicaid at the end of the PHE would be eligible for Marketplace subsidies. **CMS has stated that it may consider the use of more recent data to estimate the uninsured rate and, given these trends, we urge the agency to do so. This would yield figures that more accurately reflect changes in health insurance coverage and losses.**

Use of Worksheet S-10 Data. CMS proposes to utilize the average of audited FY 2018 and audited FY 2019 data to determine the distribution of uncompensated care payments in FY 2023. Additionally, CMS is proposing to use three years of audited data to determine uncompensated care payments beginning in FY 2024. Specifically, the agency proposes to use the three-year average of the uncompensated care data from the three most recent fiscal years for which audited data are available.

**The AHA has a longstanding position supporting the use of audited S-10 data in order to promote accuracy and consistency. We continue to believe that audited data and, by extension, ongoing refinements to the audit process, result in data that are more appropriate for use in Medicare DSH payments. We, therefore, support the use of FY 2018 and 2019 S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2023.**

**Additionally, we appreciate and support CMS's proposal to use more than one year of data to determine uncompensated care payments, which would address concerns from stakeholders regarding substantial year-to-year fluctuations in uncompensated care payments.** As we have commented previously, utilizing a single year of S-10 data may increase the potential for anomalies and instability in uncompensated care payments — especially when hospitals experience unforeseen circumstances such as a pandemic.

Interim Uncompensated Care Payments. In making DSH payments, CMS calculates an interim amount per discharge for each DSH hospital, based on the hospital's estimated DSH total uncompensated care payment (UCP) divided by the hospital's most recently available three-year average number of discharges. For FY 2023, CMS is proposing to exclude FY 2020 data and instead use FY 2018, 2019, and 2021 data to calculate a three-year average. **We urge CMS to utilize data it normally would have used — FY 2019, 2020 and 2021 — to determine the interim UCP per discharge. Using FY 2018 data would inflate the discharge volume too high. While volume recovery is occurring, achieving discharge volume to pre-pandemic levels may not be possible with the continued impacts of the PHE in FY 2023.**

Puerto Rico, Indian Health Service (IHS) and Tribal Hospitals. Previously, CMS has used a low-income patient proxy, rather than Worksheet S-10 data, to determine the share of uncompensated care provided by Puerto Rico, IHS and Tribal hospitals. For FY 2023, CMS is proposing to discontinue the use of the low-income insured days proxy for these



hospitals and to instead use the same data as for other hospitals. However, CMS recognizes that the proposal to discontinue the use of the low-income insured days proxy and to rely solely on Worksheet S-10 data could result in significant financial disruptions for these hospitals. Therefore, it also proposes to establish a new supplemental payment for Puerto Rico, IHS and Tribal hospitals under its exceptions and adjustments authority beginning in FY 2023. **We support these proposals.**

**We also support the following DSH proposals:**

- Newly Merged Hospitals. CMS proposes to continue its policy that interim uncompensated care payments for newly merged hospitals would be based only on the data available at the time of the development of the final rule for the surviving hospital's CMS Certification Number (CCN). For FY 2023, this would be the FY 2018 and FY 2019 cost reports for the surviving hospital's CCN. Per the policy described above, CMS would then determine the final DSH payment for the newly merged hospital based on the FY 2023 during cost report settlement.
- "New Hospitals." CMS proposes to continue its policy for "new hospitals" finalized in FY 2020. Specifically, for those hospitals with a CCN established on or after Oct. 1, 2019, the hospital's Medicare Administrative Contractor (MAC) would make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement based on its FY 2023 cost report.

**COUNTING DAYS ASSOCIATED WITH SECTION 1115 DEMONSTRATION PROJECTS IN THE MEDICAID FRACTION**

**The AHA opposes CMS's proposal to limit the inclusion of patient days for patients who are regarded as eligible for Medicaid benefits under a Section 1115 demonstration project for purposes of the Medicare DSH calculation.** The agency has chosen to renew its FY 2022 proposal to exclude the counting of days of patients associated with uncompensated care pools from the Medicaid fraction of the Medicare DSH patient percentage. In addition, the agency proposes to modify its previous recommendation to limit the counting of premium assistance patient days to only days of patients that purchased health insurance that provides essential health benefits (EHB) equal to 90% of the cost of health insurance. CMS bases both of these proposed changes on its interpretation of the Medicare statute as it relates to what types of 1115 demonstration project patients days count for purposes of the Medicaid fraction. **However, the agency's interpretation is contrary to unambiguous statutory language.**

States have long relied on the authority of Social Security Act Section 1115(a) to enable more individuals to receive Medicaid benefits without satisfying all statutory Medicaid requirements. To ensure these benefit opportunities, states can request Secretary of Health and Human Services' (HHS) approval to waive certain statutory Medicaid requirements for demonstration projects that will promote the objectives of the Medicaid program. Because a component of the Medicare DSH patient percentage includes Medicaid patient days (i.e., the Medicaid fraction), questions have been raised over the

years about whether patients provided medical services through a Medicaid 1115 demonstration project could be included in the Medicaid fraction of the Medicare DSH patient percentage. And, Congress answered those questions in 2005 through a provision of the Deficit Reduction Act:

“In determining [the Medicaid fraction,] the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [Medicaid], the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.”<sup>27</sup>

A plain reading of the statutory phrase “...include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI,” suggests that Congress intended that patients receiving benefits under a Medicaid 1115 demonstration be counted in the Medicaid fraction.

This reading is supported by opinions from several federal courts.<sup>28</sup> For example, in *Forrest General Hospital v. Azar*, the United States Court of Appeals for the Fifth Circuit held: “The governing provisions unambiguously require HHS to include such patient days. By excluding instead of including, HHS committed a fraction infraction—and flouted the law’s plain language.”<sup>29</sup> It explained: “Once the Secretary authorizes a demonstration project, no take-backs. The statutory discretion isn’t discretion to exclude populations that the Secretary has already authorized and approved for a given period; it’s discretion to authorize the inclusion of those populations in the first place.”<sup>30</sup>

CMS’s current proposal flouts the plain language of the law. The agency proposes to only include those patient days in the Medicare DSH calculation where the patients “receive health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance provided by a section 1115 demonstration” and state expenditures are matched by Title 19 Medicaid funds.<sup>31</sup> CMS justifies these proposals based on its belief that statute does not grant the Secretary such authority to count days of patients who are “not so eligible but who are regarded as such.” It explains:

“We do not believe that the DRA gave the Secretary blanket authority to count in the Medicaid fraction any patient who is in any way related to a section 1115 demonstration. Rather, our authority under section 1886(d)(5)(F)(vi) of the Act

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<sup>27</sup> Deficit Reduction Act 2005 PUBLIC LAW 109–171, Sec. 5002

<sup>28</sup> *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020).

<sup>29</sup> *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019) (emphasis added).

<sup>30</sup> *Id.*

<sup>31</sup> 87 Fed. Reg. 28699, 28400 (May 10, 2022)

remains limited to including the days of expansion groups—those for whom a state seeks Federal Medicaid matching funds in order to provide health insurance to individuals through a demonstration that is comparable to Medicaid state plan benefits—that is, patients who “are regarded as” eligible for medical assistance under a State plan approved under title XIX.”<sup>32</sup>

But this reading cannot be squared with the text of the statute. As the Fifth Circuit explained: “The statute means that patients who aren’t actually Medicaid-eligible still count towards the Medicaid fraction’s numerator if they’re considered or accounted to be capable of receiving a demonstration project’s helpful or useful effects by reason of a demonstration project’s authority. There’s only one plausible way to read this.”<sup>33</sup>

Despite the unambiguous language of the statute, CMS argues that it will exercise its purported discretion in interpreting the statute to include only those patient days for purposes of the Medicaid fraction for patients that purchased health insurance providing EHBs equal to 90% of the cost of health insurance. The proposed rule explains that EHBs are benefits established by Medicaid regulation for the Alternative Benefit Plan<sup>34</sup> and this new threshold test is more consistent with benefits provided individuals eligible under Medicaid state plans. The agency acknowledges that the proposal in the FY 2023 IPPS regulation differs from the FY 2022 version and is based on public comment (the substance of which the agency does not elucidate). The agency further states that in creating this new threshold test for premium assistance programs they rely on the statute’s “regarded as eligible” language.

But, again, *Forrest General* and other decisions hold otherwise. The Secretary cannot exclude patient days attributable to 1115 demonstration projects for purposes of the Medicare DSH patient percentage once the Secretary approved the same demonstration project for purposes of the Medicaid program. The agency’s artificial add-on of the EHB standard for purposes of counting patient days — what the Fifth Circuit might colorfully call a “take-back”<sup>35</sup> — has no basis in the text of the statute. And no matter how much the agency wishes its novel policy is the one Congress enacted, it was not. CMS therefore has no power to “tailor” legislation to bureaucratic policy goals by rewriting unambiguous statutory terms.<sup>36</sup>

Finally, CMS’ proposal is fatally flawed because it fails to consider the impact of policy on hospitals. It states that it cannot estimate the impact because it does not have information

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<sup>32</sup> 87 Fed. Reg. 28400 (May 10, 2022).

<sup>33</sup> *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); see also *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020) (“the demonstration project enabled the patient to receive inpatient services, regardless whether the project gave the patient a *right* to these services or allowed the patient to enroll in an insurance plan that provided the services”).

<sup>34</sup> 42 CFR part 440, subpart C

<sup>35</sup> *Forrest General Hospital v. Azar*, 926 F.3d 221.

<sup>36</sup> *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 325 (2014).

on 1115 demonstration days by hospital.<sup>37</sup> But in reality, the impacts would be devastating to many states. For example, “Florida can receive up to \$1.5 billion in funding for its uncompensated care pool every year . . . , and Texas can receive up to \$3.87 billion.”<sup>38</sup> On June 8<sup>th</sup>, CMS notified the state of Texas that it has agreed to increase the uncompensated care pool to \$4.51 billion.<sup>39</sup> Even absent precise information on demonstration days, it is safe to presume that hundreds of millions of dollars of funding for hospitals in these two states alone — and thus hundreds of millions of dollars of care — is at risk. In addition, the agency bases its policy changes on the federal fiscal year and not according to a hospital’s cost reporting year, making such changes administratively challenging for hospitals. And lastly, the agency overlooks another consequence of its actions and that is on 340B hospitals whose eligibility is dependent on meeting the various Medicaid DSH patient percentages prescribe in federal law. 340B hospitals in 1115 demonstration project states would pay the added penalty of potentially losing their access to drug discounts that allow these very hospitals to stretch the funding they have available to meet the needs of their patients in vulnerable communities.<sup>40</sup> The loss of access to drug discounts provided by the 340B program will only put added pressure on these hospitals as they continue to struggle through the COVID-19 PHE. CMS should not move forward with these proposed policy changes.

## **GRADUATE MEDICAL EDUCATION (GME)**

Medicare direct GME funding is critical to educating the physician workforce and sustaining access to care. Yet, current funding is insufficient and limitations on the number of residents for which each teaching hospital is eligible to receive GME reimbursement are a major barrier to reducing the nation’s significant physician shortage. CMS proposes several modifications that would affect Medicare direct GME payments to teaching hospitals.

Direct GME Payment (DGME) — Adjusted Weighted Full-Time Equivalent (FTE) Count Calculation. CMS provides payments to teaching hospitals for the direct costs of approved GME programs. In part, Medicare direct GME payments are determined using the number of FTE residents, while certain weighting factors are applied to adjust this count of FTE residents. For example, residents are counted at 1.0 FTE for their initial residency periods (IRP), or the minimum number of training years for board eligibility, and at 0.5 FTEs when outside their IRP. Under the law, for the direct GME payment, for cost reporting periods beginning on or after October 1, 1997, a hospital’s weighted FTE count of residents may not exceed the hospital’s unweighted FTE count in 1996 (known as the FTE cap). Thus, CMS established a method to bring each teaching hospital’s weighted FTE count within its unweighted FTE cap.

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<sup>37</sup> 87 Fed. Reg. 28400 (May 10, 2022).

<sup>38</sup> Goldman, Maya. Modern Healthcare. (May 12, 2022).

<https://www.modernhealthcare.com/medicare/wonky-medicare-proposal-worrying-safety-net-hospitals>

<sup>39</sup> June 8, 2022 letter from Lisa Marunycz, CMS Director, Division of System Reform Demonstrations to Stephanie Stephens, Texas State Medicaid Director

<sup>40</sup> H. Rep. 102-384 (II), 102d Cong., at 12 (1992).

However, a U.S. District Court ruling held that CMS's proportional reduction method improperly modified the weighting factors statutorily assigned to residents and fellows when the weighted FTE count exceeded the FTE cap. Specifically, it was found that the CMS method effectively reduced the weighting factors below the statutorily mandated weights.

Accordingly, CMS proposes specific revisions to Worksheet E-4, line 9 on the cost report (for the periods beginning on or after October 1, 2001) to address situations for applying the FTE cap when a hospital's weighted FTE count is greater than its FTE cap. If a teaching hospital's weighted FTE count is greater than its FTE cap then its payment for DGME will be based on its FTE cap. If a teaching hospital's weighted FTE count is at or below the FTE cap then its DGME payment will be based on the weighted FTE count. **We support these proposals, which ensure that CMS would preserve the statutorily mandated weighting factors for all hospitals.**<sup>41</sup>

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<sup>41</sup> While the AHA wholeheartedly supports the policy proposals here, it questions whether it is necessary or appropriate to use retroactive rulemaking to accomplish those important policy goals. Historically, CMS has made policy changes to comport with clear statutory standards *without* claiming the need to invoke retroactive rulemaking. See *generally* Letter from Stephanie A. Webster, Ropes & Gray, to Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services, Re: Comment on Proposed Rule, CMS-1771-P (June 9, 2022). To take just one example, in December 2020, without any rulemaking, CMS instructed Medicare contractors to restore Part C GME funding to affected hospitals that CMS had improperly reduced going back nearly two decades, and applied the change not only to hospital cost years under appeal, but more broadly to "each and every" affected cost year that was within the reopening window at the time. See CMS Pub. 100-20, Transmittal No. 10520 (Dec. 14, 2020).

This approach is particularly appropriate where, as here, CMS will be acquiescing to an adverse court decision. Again, CMS has routinely *not* sought retroactive rulemaking in these circumstances. For instance, CMS entered into a settlement agreement with affected hospitals following a decision against the agency regarding the treatment of Section 1115 waiver days in the DSH calculation. See *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); see also Clerk's Orders Granting Extensions To Accommodate Pending Mediation, dated March 26, 2019, April 18, 2019, and June 13, 2019, *HealthAlliance Hosps., Inc. v. Azar*, No. 18-5372 (D.C. Cir.); Joint Stipulation of Dismissal dated August 29, 2019, *HealthAlliance Hosps., Inc. v. Azar*, No. 18-5372 (D.C. Cir.).

In fact, the existence of a binding adverse court decision — which CMS notably chose *not* to appeal — undermines one of the agency's stated rationale for why it is permitted to engage in retroactive rulemaking under 42 U.S.C. § 1395hh(e)(1)(A) ("failure to apply the change retroactively would be contrary to the public interest"). Here, CMS claims that a retroactive rule is in the public interest "because it will permit interested stakeholders to comment on the proposed approach and allow the agency to have the benefit of those comments in the development of a final rule." 87 Fed. Reg. at 28,411. But there is no need for public comment where a court decision requires the agency to comply with the statute and act in a particular way. Put another way, no public comment would allow the agency to act otherwise given the binding effect of the district court decision.

Taken together, expanding the statutory exception to the general bar against retroactive rulemaking as proposed 1) implicitly contradicts the decision in *Milton S. Hershey Medical Center, et al. v. Becerra*, No. 19-2680, 2021 WL 1966572, (D.D.C. May 17, 2021), *appeal dismissed*, No. 21-5169, 2021 WL 4057675 (D.C.

Medicare GME Affiliation within Certain Rural Track Program (RTPs). CMS is proposing, for the first time, to allow hospitals that established an ACGME 1-2 family medicine program prior to October 1, 2022, to create Rural Track Medicare GME Affiliation Agreements. These affiliation agreements would allow hospitals to share FTE caps for agreed upon academic years and provide flexibility to hospitals to match resident rotation schedules where needed. **We support this proposal and encourage CMS to engage in future rulemaking that will allow *any* rural track program, not just those in family medicine, that were established prior to October 1, 2022 to also engage in affiliation agreements following the conclusion of the cap-building period.**

### **AREA WAGE INDEX (AWI)**

Permanent Cap on Wage Index Decreases. In the FY 2020 final rule, CMS adopted a transitional policy that placed a 5% cap on any decrease in a hospital's wage index due to the combined effects of policy changes in FY 2020. In FY 2021, CMS again adopted a 5% cap on any decrease in a hospital's final wage index due to its adoption of updates from Office of Management and Budget (OMB) bulletin 18-04. Given the PHE, CMS continued the policy in FY 2022 but it only applied to hospitals that were affected by the OMB bulletin.

For FY 2023, CMS now is proposing to permanently adopt a 5% cap on all wage index decreases each year, regardless of the reason, in a budget neutral manner. **The AHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control. This proposed policy would increase the predictability of IPPS payments for hospitals and we are pleased the agency would make it permanent, as we urged last year. That said, we continue to urge CMS to apply this policy in a non-budget neutral way.**

Low-wage Hospital Policy. CMS previously finalized a policy to increase wage index values for low-wage hospitals, beginning in FY 2020 and effective for at least four years. As such, CMS proposes to continue this policy in FY 2023. Specifically, for hospitals with a wage index value below the 25th percentile, the agency would continue to increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. The agency proposes to continue to make this policy budget neutral by adjusting the national standardized amount for all hospitals.

As we have stated previously, hospitals have repeatedly expressed concern that the wage index is greatly flawed in many respects, including its accuracy, volatility, circularity and substantial reclassifications and exceptions. Members of Congress and Medicare officials also have voiced concerns with the present system. To date, a consensus solution to the

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Cir. Aug. 23, 2021), and 2) is unnecessary because CMS can achieve the same laudable policy ends in a variety of other ways.

wage index's shortcomings has yet to be developed. **The AHA appreciates CMS' recognition of the wage index's shortcomings and supports continuing to improve the wage index values for low-wage hospitals. However, we maintain that budget neutrality is not a requirement of the statute that provides CMS the authority to implement this policy.**

In addition to statutory permissibility, the AHA continues to believe there is strong policy rationale for making the low-wage hospital policy non-budget neutral. As we have previously stated, Medicare consistently reimburses IPPS hospitals less than the cost of care. For example, the Medicare Payment Advisory Commission (MedPAC) found that hospitals' aggregate Medicare margins were *negative* 8.5% in 2020, even including COVID-19 relief funds. Aggregate Medicare margins excluding these relief funds were a staggering *negative* 12.6%. Unfortunately, these figures are a continuance of a longstanding trend of substantially negative Medicare margins.<sup>42</sup> Taken together, these observations strongly suggest that there is a need to *add* funds into the system, such as by implementing this policy in a non-budget-neutral manner.

**Wage index increases for low-wage hospitals provide these facilities with sorely needed funds that will begin to address chronic Medicare underfunding. However, CMS is not bound by statute to make such increases budget neutral; indeed, reducing the standardized amount for all PPS hospitals intensifies historical Medicare underpayment. As such, the AHA urges CMS to implement the low-wage hospital policy in a non-budget neutral manner.**

Rural Floor Calculation. Per statute, the area wage index value of any urban hospital may not be less than the area wage index applicable to hospitals located in rural areas in the same state — this is known as the “rural floor” policy. CMS proposes to continue to exclude the wage data of urban hospitals that reclassify to rural areas when calculating the rural floor. **We support this proposal.**

Imputed Rural Floor Calculation. As required by law, CMS proposes to continue the reinstatement of its minimum area wage index for hospitals in all-urban states, known as an “imputed rural floor” for FY 2023. This policy applies to states that have no rural hospitals or no rural areas to set a rural floor wage index for those states. Also as required by law, CMS proposes apply this policy in a non-budget-neutral manner. **We support this proposal.**

## **RURAL HOSPITAL PROVISIONS**

The rule discusses several proposals with specific impact on rural hospitals.

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<sup>42</sup> MedPAC. (2022). March 2022 Report to the Congress: Medicare Payment Policy. Chapter 3 – Hospital inpatient and outpatient services. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)



Low-volume Adjustment Program. Section 406 of the Medicare Modernization Act (MMA) created a payment adjustment under the IPPS to account for the higher costs per-case of low-volume hospitals. Several laws have since provided for enhanced low-volume adjustment payments. However, beginning in FY 2023, the low-volume hospital qualifying criteria and adjustment will revert to MMA requirements. **The AHA supports Congressional action on H.R.1887/S.4009, which extend the enhanced low-volume adjustment for FY 2023 and beyond so that hospitals can continue to qualify for and be paid under the current enhanced method.**

In the meantime, CMS proposes that a low-volume hospital would be defined as one that is located more than 25 road miles from another subsection (d) hospital and has fewer than 800 total discharges. In addition, it proposes the same payment adjustment that was effective from FY 2005 through 2011. Specifically, the agency would apply a 25% low-volume adjustment to all qualifying hospitals with less than 200 discharges, but hospitals with between 200 and 799 discharges would not receive any adjustment. The agency states that this method is most consistent with the statutory requirement to provide relief to low-volume hospitals where empirical evidence shows higher incremental costs are associated with low numbers of total discharges. **The AHA is concerned that CMS is ignoring congressional intent and denying a group of hospitals — those with 200 to 799 discharges — access to this critical payment adjustment. Therefore, we urge CMS to apply the 25% payment adjustment to all hospitals with fewer than 800 total discharges, as is specified under the law. That is, we urge CMS to apply the 25% payment adjustment not only to hospitals with less than 200 discharges, but also to hospitals with 200 to 799 discharges.** This would extend the adjustment to approximately 136 additional rural hospitals. Two thirds of these hospitals have payment-to-cost ratios that are less than one.<sup>43</sup> These small and isolated hospitals desperately need this additional support to cover the cost of caring for their patients.

The intent of the low-volume adjustment program is to support low-volume and isolated hospitals that lacked economies of scale and thus have higher standardized costs per stay. CMS's proposal to only extend the benefits of this program to hospitals with less than 200 discharges would severely undermine the financial stability of rural providers at a time when substantial additional funding, not less, is needed to bolster care in these communities. For example, while approximately 600 hospitals currently are eligible for the low-volume adjustment under the enhanced criteria, only 24 hospitals would receive the adjustment under CMS's proposal in FY 2023. Thus, if CMS's proposal were to go into

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<sup>43</sup> AHA analysis of the Medicare Provider Analysis and Review (MedPAR) File, December 2021 Update; FY 2021 Inpatient PPS Final Rule with Correction Notice Impact File; FY 2023 Inpatient PPS Proposed Rule Impact File and Other Public Use Files; CMS Provider Specific File (PSF), April 2022 Update; Medicare Hospital Cost Reports (CMS-2552-10), Healthcare Cost Report Information System (HCRIS), March 31, 2022 Update. Costs and payments were estimated for FY 2021. Costs were estimated using covered charges in MedPAR and the operating and capital cost-to-charge ratios in the FY 2021 inpatient PPS impact file. For purposes of modeling FY 2021 payments used to calculate the payment-to-cost ratios, we assume payments do not contain low-volume adjustments and add-ons (20% MS-DRG, New COVID-19 treatment add-on payments, or Medicare-dependent hospital add-on), but would contain sequestration.

effect, it would mean that nearly all rural hospitals currently eligible for the adjustment would lose it, cutting nearly \$428 million in critical funding from rural health care. Further, this cut would occur at a time when rural hospitals face unprecedented challenges as a result of the COVID-19 pandemic. **We urge CMS to support policies that help rural communities maintain their access to care. As such, it should utilize its authority to make low-volume payment adjustments to rural hospitals to the fullest extent of the law.**

Medicare Dependent Hospital (MDH) Program. Under current law, the MDH program is set to expire Sept. 30, 2022. Providers under the MDH program serve rural Americans and are more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment. **The AHA supports making the MDH program permanent through H.R.1887/S.4009. Additionally, we also support the additional base year that hospitals may choose for calculating MDH payments to provide more flexibility for these hospitals to provide care for their patients.**

In the proposed rule, CMS reiterated its policy that allows MDHs to apply for Sole Community Hospital (SCH) status and be paid as such under certain conditions, following the expiration of the MDH program. Hospitals wishing to apply for SCH status must apply at least 30 days before the end of the MDH program, or by September 1, 2022, in order for SCH status to be effective upon expiration of the MDH program. **The AHA supports this policy.**

However, the possibility remains that Congress may extend the MDH program retroactively, after it expires on October 1, 2022. To account for this distinct possibility, we ask that CMS provide hospitals with the ability to, in turn, rescind their new SCH status retroactively and reinstate their MDH status in a seamless manner, if a retroactive extension to the MDH program is made. Such an allowance would be extremely helpful for these hospitals, which are facing an unreasonably uncertain future of Medicare inpatient payments.

Hospitals Applying for Rural Referral Center (RRC) Status. One way in which a hospital can qualify for RRC status is based on a combination of discharge volume and case-mix criteria, in comparison to other providers in the hospital's region. CMS proposes to use FY 2021 data to calculate case-mix criteria and FY 2020 cost report data to calculate discharge volume. **We support this proposal.**

Sole Community Hospitals. CMS has discretion to require Medicare Administrative Contractors (MACs) to issue interim settlements for volume decrease adjustments (VDA) for Sole Community Hospitals. Many Sole Community Hospitals experienced substantial volume declines during the pandemic and will be eligible for VDA adjustments. However,

some MACs are pointing to CMS guidance stating MACs have discretion on issuing interim VDA adjustments. Getting these dollars to rural providers sooner, rather than waiting until final cost report settlement three to four years later, will help with workforce and inflation challenges. **We urge CMS to support policies that can help rural providers during this unprecedented time.**

## **CHANGES TO MS-DRG CLASSIFICATIONS**

**In general, the AHA supports CMS' proposed changes contained within the MS-DRG classifications. These proposed changes seem reasonable given the data, the ICD-10-CM/PCS codes, and information provided, with the exceptions noted below.**

FY 2023 MS-DRG Updates. CMS uses the criteria established in FY 2008 (72 FR 47169) to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG is warranted. In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58448), CMS finalized the proposal to expand existing criteria to create a new CC or MCC subgroup within a base MS-DRG. Specifically, CMS finalized the expansion of the criteria to include the non-CC subgroup for a three-way severity level split. CMS believed that this would better reflect resource stratification and promote stability in the relative weights by avoiding low volume counts for the non-CC level MS-DRGs.

CMS' analysis applying the non-CC subgroup criteria to all FY 2021 MS-DRGs split into three severity levels found that, for FY 2022, it would have deleted 96 MS-DRGs (32 MS-DRGs x 3 severity levels = 96) and created 58 new MS-DRGs. These updates would have also involved a redistribution of cases, which would have impacted the relative rates and thus the payment rates.

We appreciate CMS' recognition of the burden hospitals continue to bear because of the PHE and we agree with CMS with regards to the impact of implementing these MS-DRG changes. We also agree with CMS' ultimate decision to delay the application of the non-CC subgroup criteria for FY 2022.

For the FY 2023 IPPS/LTCH PPS proposed rule, CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2021 update of the FY 2021 MedPAR file, which contains hospital bills received from Oct. 1, 2020, through Sept. 30, 2021, for discharges occurring through Sept. 30, 2021. CMS' analysis of applying the non-CC subgroup criteria to the FY 2023 MS-DRGs split into three severity levels would delete 123 MS-DRGs and create 75 new MS-DRGs. These updates would also involve a redistribution of cases, which would impact the relative weights, and, thus, the payment rates proposed for particular types of cases.

**We again appreciate CMS' recognition of the ongoing PHE and the acknowledgement of the concerns around the impact of implementing this volume of MS-DRG changes at this time. We strongly agree with CMS' proposal to delay the**

**application of the non-CC subgroup criteria to existing MS-DRGs to maintain more stability in the current MS-DRG structure. Specifically, we agree with CMS' proposal to maintain the current structure of the 41 MS-DRGs that currently have a three-way severity level split (total of 123 MS-DRGs) that would otherwise be subject to these criteria for FY 2023.**

**In response to CMS' comment that it intends to address the application of the non-CC subgroup criteria to existing MS-DRGs with a three-way severity level split in future rulemaking, we continue to urge CMS to delay the change due to the lack of data transparency and operational considerations listed below.**

We respectfully recommend CMS consider the following timeline:

- Publish the data on the proposed weights and volume of cases affected in the FY 2023 final rule or the FY 2024 proposed rule if it is not possible to include in the FY 2023 final rule.
- Comparing the FY 2022 and FY 2023 proposals regarding the deletion change from 96 to 123 MS-DRGs and the change from 58 to 75 new MS-DRGs, consider that the data may be too dynamic to implement this type of change.
- Typically, CMS has required two years of good data to reassign MS-DRGs for new codes. The AHA believes CMS should also consider 1-2 years of good data be available for analysis prior to implementing a change of this degree. For example, consider a run out period through the end of FY 2024 for the MedPAR file to use for a FY 2026 rule. Allowing hospitals 1-2 years for stable data to analyze the implications of the changes to their own patient population and case mix would provide the opportunity for more meaningful and useful public comment specific to these proposed changes.

Data Transparency Issues. Hospitals have not had the opportunity or the possibility to closely analyze the operational or financial impact of the proposed change due to the lack of data transparency. Neither the FY 2021 final rule, the FY 2022 proposed or final rule, nor the FY 2023 proposed rule provided the specific data required for such an analysis. For example, the data needed would include anticipated redistribution of cases, volumes by MS-DRG that supports the current FY 2023 proposal to reduce the 123 MS-DRGs (especially since there are some MS-DRGs that are moving to single tiers), and proposed relative weights.

There were several more MS-DRG changes proposed in the FY 2023 proposed rule compared to the FY 2022 proposed rule. For example, the MS-DRGs proposed for deletion went from 96 to 123, while the proposed new MS-DRGs went from 58 to 75. In

Table 6P.1c - List of the 96 MS-DRGs that would be subject to deletion and list of 58 new MS-DRGs that would be proposed for creation for FY 2022

List of 96 MS-DRGs		List of 58 MS-DRGs	
MS-DRG	Description	MS-DRG	Description
283	Acute Myocardial Infarction Expired with MCC	XXX	Acute Myocardial Infarction Expired
284	Acute Myocardial Infarction Expired with CC		
285	Acute Myocardial Infarction Expired without CC/MCC		

comparing the FY 2023 tables to FY 2022, some of the MS-DRGs on the deleted list this FY were not on the deleted list last FY. Additionally, there are new proposed MS-DRGs this FY that were proposed for deletion last FY. It did not appear there was any explanation as to why these changes in proposals occurred. For illustration purposes referencing table 6P.1c, MS-DRGs 283-285 were on list for deletion for FY 2022 and not on the list for deletion FY 2023.

Additionally, for MS-DRGs 411-413, these are on the list for deletion for FY 2023. However, these are the same MS-DRGs in which CMS is also asking for comment on related to re-structuring of these MS-DRGs, along with MS-DRGs 417-419, by Oct. 20, 2022, as noted in the FY 2023 proposed rule.

Table 6P.1b - List of the 123 MS-DRGs that would be subject to deletion and list of 75 new MS-DRGs that would be proposed for creation for FY 2023			
List of 123 MS-DRGs		List of 75 MS-DRGs	
MS-DRG	Description	MS-DRG	Description
411	Cholecystectomy with C.D.E. with MCC	XXX	Cholecystectomy with C.D.E.
412	Cholecystectomy with C.D.E. with CC		
413	Cholecystectomy with C.D.E. without CC/MCC		

**We respectfully request that CMS consider obtaining data from different databases where more of those volumes could potentially be realized. For example, the below Obstetric MS-DRGs were listed in table 6P.1b as being subject to deletion, flattening these to 1 MS-DRG in each of these categories. We urge CMS to consider using Medicaid and/or State databases to obtain volumes for the Obstetric related MS-DRGs. The Medicare database often portrays low volumes for these MS-DRGs since they are not indicative of the typical Medicare population. Having the insight from other databases may better inform decision making related to deletion of MS-DRGs, particularly Obstetric MS-DRGs. Additionally, we request that CMS consider the potential impact from the maternal health quality initiatives, maternity hospital designation as well as the FY 2023 CMS solicitation for comments for conditions represented by low volumes within MS-DRG Structure.**

Table 6P.1b - List of the 123 MS-DRGs that would be subject to deletion and list of 75 new MS-DRGs that would be proposed for creation for FY 2023			
List of 123 MS-DRGs		List of 75 MS-DRGs	
MS-DRG	Description	MS-DRG	Description
783	Cesarean Section with Sterilization with MCC	XXX	Cesarean Section with Sterilization
784	Cesarean Section with Sterilization with CC		
785	Cesarean Section with Sterilization without CC/MCC		
796	Vaginal Delivery with Sterilization and/or D&C with MCC	XXX	Vaginal Delivery with Sterilization and/or D&C
797	Vaginal Delivery with Sterilization and/or D&C with CC		
798	Vaginal Delivery with Sterilization and/or D&C without CC/MCC		
817	Other Antepartum Diagnoses with O.R. Procedures with MCC	XXX	Other Antepartum Diagnoses with O.R. Procedures
818	Other Antepartum Diagnoses with O.R. Procedures with CC		
819	Other Antepartum Diagnoses with O.R. Procedures without CC/MCC		
831	Other Antepartum Diagnoses without O.R. Procedures with MCC	XXX	Other Antepartum Diagnoses without O.R. Procedures
832	Other Antepartum Diagnoses without O.R. Procedures with CC		
833	Other Antepartum Diagnoses without O.R. Procedures without CC/MCC		

The above noted examples are just a few supporting reasons for the data that is needed that includes the anticipated redistribution of cases and volumes by MS-DRG related to the proposal to delete the currently proposed FY 2023 123 MS-DRGs.

Without this crucial information, hospitals cannot analyze the potential payment rates and how they will affect their case mix, their annual budgets, specific bottom lines and future projections.

Operational and Financial Impact Considerations. To re-state from previous comments, the impact on community hospitals could be significant as their case mix may be more significantly affected because they do not perform as many of the more complex surgeries. For such hospitals, significant changes in the MS-DRG structure could result in large financial losses if the MS-DRG redistribution is across all MS-DRGs rather than within related MS-DRG clusters. We urge CMS to perform additional analysis for the explanatory power of predicting resource use. The change in the case mix index could potentially adversely affect the ability of some hospitals to participate in academic programs or attract medical residents.

As an additional unintended consequence consideration, commercial payers and Medicare Advantage programs may rely on the MS-DRG groupings to calculate payment or negotiate annual contracts. Without the ability to perform a detailed financial analysis, hospitals will be unable, or at a disadvantage, when renegotiating such MS-DRG based managed care contracts.

Pre-MDC: MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies. We acknowledge that there were no requests or proposals for new procedure codes to describe the administration of a CAR T-cell or another type of gene or cellular therapy discussed at the September 14-15, 2021, ICD-10 Coordination and Maintenance Committee meeting. For the March 8-9, 2022, ICD-10 Coordination and Maintenance Committee meeting, there were topics on the agenda that included proposals for new procedure codes to describe the administration of a CAR T-cell or another type of gene or cellular therapy product.

We acknowledge that CMS noted that the diagnosis and procedure code proposals that are presented at the March meeting for an October 1 implementation (upcoming FY) are not finalized in time to include in Table 6A. – New Diagnosis Codes and Table 6B. – New Procedure Codes in association with the proposed rule, as noted in prior rulemaking, and that CMS uses the established process to examine the MS-DRG assignment for the predecessor codes to determine the most appropriate MS-DRG assignment.

We appreciate CMS' recognition that the predecessor code and MS-DRG assignment most closely associated with the new procedure code, in the absence of claims data, is considered with other factors that may be relevant to the MS-DRG assignment, including the severity of illness, treatment difficulty, complexity of service and the resources utilized in the diagnosis or treatment of the condition. We appreciate CMS' continued consideration when determining the MS-DRG assignment and resulting reimbursement of CAR T-cell technology, including recommendations to ensure that reimbursement adequately reflects both patient care and product costs.

MDC 7 Hepatobiliary System and Pancreas. CMS stated in the FY 2023 IPPS proposed rule an opportunity to further refine the below MS-DRGs. CMS' intent for this refinement would be to reflect cases where only a laparoscopic cholecystectomy is performed without a common bile duct exploration procedure, and, to determine if severity levels are also supported according to existing criteria.

- 411-413; (Cholecystectomy with C.D.E. with MCC, with CC, and without CC/MCC, respectively)
- 414-416 (Cholecystectomy Except by Laparoscope without C.D.E. with MCC, with CC and without CC/MCC, respectively)
- 417-419 (Laparoscopic Cholecystectomy without C.D.E with MCC, with CC and without CC/MCC respectively)

We acknowledge that CMS is requesting feedback on alternative recommendations or options to further refine these MS-DRGs. Additionally, we acknowledge that CMS also stated that additional analysis would be performed for consideration in future rulemaking.

**We look forward to the opportunity to review and provide comment on the additional analysis that CMS completes. The insight gained from this analysis will better inform comment development should the analysis develop into a future proposal.**

Operating Room (O.R.) and Non-O.R. Issues. In the FY 2020 IPPS/LTCH PPS proposed rule, CMS announced that given the long period of time that has elapsed since the original O.R. (extensive and non-extensive) and non-O.R. designations were established, incremental changes that have occurred to these O.R. and non-O.R. procedure code lists, and changes in the way inpatient care is delivered, CMS planned to conduct a comprehensive, systematic review of the ICD-10-PCS procedure codes. CMS noted that this will be a multi-year project during which they will also review the process for determining when a procedure is considered an O.R. procedure.

We continue to acknowledge O.R. and non-O.R. designation determinations are a substantial undertaking that may significantly restructure many MS-DRGs. In this FY 2023 IPPS Proposed Rule, CMS noted that in consideration of the ongoing PHE, they continue to believe it may be appropriate to allow additional time for the claims data to stabilize prior to selecting the timeframe to analyze for this review. Additional time was also stated as necessary as CMS continues to develop their process and methodology. **We agree with CMS on the decision to allow for additional time for the claims data to stabilize prior to selecting the timeframe to evaluate for this review. We look forward to CMS providing more detail on this analysis and the advanced notice for comment in future rulemaking regarding the proposed methodology for conducting this review.**

Comprehensive CC/MCC Analysis. In the FY 2018 IPPS final rule, CMS provided public notice of their plans to conduct a comprehensive review of the CC and MCC lists for FY



2019. For FY 2020, CMS proposed but did not finalize a change in the severity level designation for 1,492 ICD-10-CM diagnosis codes.

For FY 2021, CMS finalized nine guiding principles that, when applied, could assist in determining whether the presence of the specified secondary diagnosis would lead to increased hospital resource use in most instances. CMS plans to use a combination of mathematical analysis of claims data and the application of these guiding principles, to continue a comprehensive CC/MCC analysis and present the findings in future rulemaking.

In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25175 through 25180), as another interval step in the comprehensive review of the severity designations of ICD-10-CM diagnosis codes, CMS requested public comments on a potential change to the severity level designations for “unspecified” ICD-10-CM diagnosis codes that they were considering adopting for FY 2022. Specifically, CMS noted they were considering changing the severity level designation of “unspecified” diagnosis codes to a non-CC where there are other codes available in that code subcategory that further specify the anatomic site.

As summarized in the FY 2022 IPPS/LTCH PPS final rule, many commenters expressed concern with the potential severity level designation changes overall and recommended that CMS delay any possible change to the designation of these codes to give hospitals and their physicians time to prepare. After consideration of the public comments CMS received, for FY 2022, CMS ultimately decided to maintain the severity level designation of the “unspecified” diagnosis codes currently designated as a CC or MCC where there are other codes available in that code subcategory that further specify the anatomic site. However, instead for FY 2022, CMS finalized a new Medicare Code Editor (MCE) code edit for “unspecified” diagnoses effective with discharges on or after April 1, 2022.

In the current FY 2022 proposed rule, CMS acknowledged this new edit was just recently effective beginning with discharges on and after April 1, 2022. Therefore, its clinical advisors believed it would not be appropriate to propose to change the designation of any ICD-10-CM diagnosis codes, including the unspecified codes that are subject to the “unspecified code” edit, as the comprehensive CC/MCC analysis continues thereby allowing stakeholders the time to adjust to this edit. CMS stated that it continues to solicit feedback regarding the nine guiding principles, as well as other ways they can incorporate meaningful indicators of clinical severity.

**We appreciate and agree with CMS’ decision not to propose any further changes to the designation of any ICD-10-CM diagnosis codes, including the unspecified codes, at this time. With the new MCE recently implemented April 1, 2022, we urge CMS to allow 1-2 full years of data availability before proposing any additional changes. Having 1-2 full years of data will afford more meaningful analysis in future rulemaking considerations as part of the *Comprehensive CC/MCC Analysis*.**

Request for Information on Social Determinants of Health Diagnosis (SDOH) Codes. For this FY 2023 IPPS/LTCH PPS proposed rule, we acknowledge that CMS is soliciting public comment on how the reporting of diagnosis codes in categories Z55-Z65 may improve the ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRGs. Additionally, we recognize that CMS also is interested in receiving feedback on how it might foster the documentation and reporting of the diagnosis codes describing social and economic circumstances. The intent is to reflect each health care encounter more accurately, and, to improve the reliability and validity of the coded data in support of efforts to advance health equity.

As noted, there are 96 ICD-10-CM diagnosis codes describing SDOH in categories Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances). These codes describe a range of issues related to education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, and occupational exposure to toxic agents, dust, or radiation and other aspects as applicable. CMS acknowledges in this proposed rule that Section I.B.14 of the FY 2022 *ICD-10-CM Official Guidelines for Coding and Reporting* was updated, effective October 1, 2021. This updated guidance provided clarification of the term “clinician” in reporting codes related to SDOH and clarified the documentation that can be utilized to assign SDOH codes when documented in the official medical record.

As CMS notes, reporting SDOH Z codes on inpatient claims data could enhance quality improvement and that more routine collection of these codes could impact and enhance coordination of care activities across all points of contact. CMS also noted that reporting of these codes may also better determine the resource utilization for treating patients experiencing these circumstances. In turn, this data could help inform whether a change to the severity designation of these codes would be clinically warranted as the *Comprehensive CC/MCC Analysis* continues through CMS assessment.

We appreciate CMS acknowledging in this rule some of the main concerns previously shared by stakeholders as to the reasons why there may not be ideal documentation and reporting of these specific codes. Some of these, as presented in this rule include:

- Z codes are not required to be reported by inpatient hospitals and generally do not affect MS-DRG assignment. If reported, they are typically voluntarily reported.
- Many of the circumstances captured through SDOH Z codes are dependent on the willingness of patients to discuss and provide information related to these conditions/circumstances, making it difficult to reliably document.
- Providers also expressed concern regarding considerable time pressures and lack of access to comprehensive care and coordination teams that may be better equipped to address SDOH.

In this FY2023 IPPS proposed rule, CMS seeks comment specifically on the questions outlined below. We have provided comment on each of these aspects to follow:

**How the reporting of certain Z codes — and if so, which Z codes — may improve its ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs?**

It is important to reflect on CMS' comments in this FY 2023 rule that prior to FY 2022, homelessness was one of the more frequently reported codes that describe social determinants of health. CMS also reviewed the data on the impact on resource use for diagnosis code Z59.0 (Homelessness) when reported as a secondary diagnosis.

In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19243 through 19244), as part of CMS' proposal to change the severity level designations for 1,492 ICD-10-CM diagnosis codes, CMS proposed to change the severity level designation of code Z59.0 (Homelessness) from a non-CC to a CC. CMS stated that because the C1 value (C1 = 1.5964) in the table was generally close to 2, the data suggested that when reported as a secondary diagnosis, the resources involved in caring for a patient experiencing homelessness supported increasing the severity level from a non-CC to a CC. In the FY 2020 IPPS/LTCH PPS proposed rule, CMS also stated their clinical advisors reviewed the data and believed the resources involved in caring for these patients are more aligned with a CC.

As reflected in the data, the data supports that homelessness in general is more commonly captured as per ICD-10-CM code assignment, and, that resources involved in caring for those patients are more aligned with a CC. We respectfully ask that CMS revisit the Z code category for homelessness (Z59.0) to consider the CC designation for this code category. Currently, only 25 diagnoses are captured on the 837i claim (UB04 electronic claim form) due to space. All conditions and diagnoses that represent a CC, MCC, Hierarchical Condition Category (HCC), Hospital Acquired Conditions (HAC), etc. are captured in the MS-DRG logic prior to ICD-10-CM diagnosis codes that do not have any type of designation.

**Whether CMS should require the reporting of certain Z codes — and if so, which ones — to be reported on hospital inpatient claims to strengthen data analysis?**

Prior to any type of requirement to report certain Z codes, we respectfully request that CMS consider the following: ICD-10-CM *Official Guidelines for Coding and Reporting* changes and *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* have been published, as well as new ICD-10-CM codes created, that have helped provide direction on the application of these codes. As noted earlier in this section, the recent coding guideline update to Section I.B.14 of the FY 2022 *ICD-10-CM Official Guidelines* effective October 1, 2021, now allows for documentation of these conditions to be provided by other healthcare professionals, not only the patient's provider. **Although we would not currently support the "requirement" to report these codes for reasons stated, we would support CMS' consideration to provide additional education to health care**

**teams.** This education could be focused on the *Official Coding Guideline* that now allows source documentation for SDOH codes to be based on non-provider documentation and may help promote and encourage the reporting of the SDOH codes.

We acknowledge the continued work of the Gravity Project where definitions for some of the SDOH Z codes have been collaboratively developed. However, we are not aware of any nationally accepted and published “definitions” for the diagnoses and conditions represented by the SDOH Z codes. Without nationally accepted definitions, it could present challenges to encourage, and especially require, the consistent capture of these codes across all health care systems. Additionally, without such standard definitions, variances in medical record documentation and reporting of these codes could result. **We recommend that CMS consider collaborating with applicable sources to develop standard, nationally accepted definitions that could promote more consistent application and data capture of the SDOH Z codes.**

As stated previously in this section, the institutional claim forms are limited in data fields and currently can only capture 25 ICD-10-CM diagnoses on the 837i (electronic claim) and 19 ICD-10-CM diagnoses on the paper claim form. **We recommend that CMS consider reprioritizing the MS-DRG logic to help ensure capture of these diagnoses on the claim when reported.** All conditions and diagnoses that represent a CC, MCC, HCC, HAC, etc. are captured in the MS-DRG logic prior to ICD-10-CM diagnosis codes that do not have any type of designation. There are likely many instances where insufficient data fields on the institutional claim form could be an issue, especially for those more complex care patients where many diagnoses and conditions are reported on the claim.

We acknowledge that CMS has included health equity as a high priority and topic in many aspects of the FY 2023 IPPS proposed rule. We encourage CMS to continue considering an approach for health equity data capture that encompasses a combination of eMeasures, abstracted measures, ICD-10-CM SDOH Z codes and other avenues as applicable, supporting where this data would be most meaningfully and appropriately captured.

**We respectfully ask that CMS consider the potential impact that ICD-10-CM SDOH Z codes may have, or have potential to lead to, reportable patient safety indicator (PSI) or HAC conditions due to the complexity/severity of the cases involved. We recommend that CMS consider a study to determine potential impact to cases when there is an ICD-10-CM Z code for homelessness captured along with a HAC diagnosis such as decubitus.** This outcome of the study may provide insight to help assess whether or not any of the SDOH codes meet exclusion criteria.

There have been instances reported by some of our stakeholders that payers are denying claims with a Z code for homelessness in conjunction with a physical address

also reported on the institutional claim form. While the provided address may be for mail only, a family member's address or even a false address, we encourage CMS' consideration in providing specific direction to the MACs regarding claim rejection or denial in these instances.

**The additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries.**

From a burden perspective, as we noted previously in this section, institutional claim forms are limited in data fields and are limited to 25 ICD-10-CM diagnoses on the 837i (electronic claim) and 19 ICD-10-CM diagnoses on the paper claim form. Instances where this data is collected on a claim may create re-work by the hospital coding and billing teams. For example, if there are ICD-10-CM SDOH Z codes that are not listed in one of the 25 positions due to the volume of codes reported on specific claims, this could create manual re-work to ensure that the SDOH codes are included on the claim for reporting purposes. For this reason, and as we stated previously, **we recommend that CMS consider re-prioritizing the MS-DRG logic to help ensure capture of these diagnoses on the claim when reported.**

From a potential benefits perspective of reporting SDOH related data, we again acknowledge and agree with CMS' comments that reporting SDOH Z codes on inpatient claims data could enhance quality improvement, enhance coordination of care activities across all points of contact and may also better determine the resource utilization for treating patients experiencing these circumstances.

**Whether codes in category Z59 (Homelessness) have been underreported and if so, why? CMS is interested in hearing the perspectives of large urban hospitals, rural hospitals, and other hospital types in regard to their experience. CMS also seeks comments on how factors such as hospital size and type might impact a hospital's ability to develop standardized consistent protocols to better screen, document, and report homelessness.**

It is possible that codes in the SDOH Z code category, including Z59, are being underreported. Some of the main driving factors, but not limited to, likely contributing to underreporting are due to reasons provided previously in this section and are noted below. Although it could vary, these factors would likely apply regardless of hospital size and type. Additionally, CMS may want to consider requesting data on how often insufficient data fields are a major driving factor in a reason for underreporting, i.e., any of the SDOH Z codes not making it on the institutional claim form.

- Lack of standard, nationally accepted definitions for the diagnoses and conditions represented by the SDOH Z codes;
- Insufficient data fields on the institutional claim forms;

- Delay in adoption, delay in health care team education, and/or not enough time has elapsed to be realized in the data that reflects the Oct. 1, 2021, coding guidance change noted above.

Possible Mechanisms to Address Rare Diseases and Conditions Represented by Low Volumes within the MS-DRG Structure. We acknowledge that within this FY 2023 IPPS proposed rule, CMS requests comments related to aspects that could assist with policy development to reduce health disparities. As part of that effort, CMS requests comments to explore possible mechanisms through which they can address rare diseases and conditions that are represented by low volumes in their claims data.

CMS stated that as discussed in prior rulemaking, the MS-DRGs are a classification system intended to group together diagnoses and procedures with similar clinical characteristics and utilization of resources. CMS also acknowledges that rare diseases and conditions that are represented by low volumes pose a unique challenge to this methodology as these conditions by definition affect small subsets of the population. For these reasons, CMS noted the challenge to identify other potential existing MS-DRGs or creating new MS-DRGs for rare conditions represented by low data volumes.

CMS seeks to identify sufficiently large sets of claims data with a resource/cost similarity and clinical similarity in developing diagnostic-related groups rather than smaller subsets. CMS stated concerns with basing MS-DRG reclassification decisions on small numbers of cases, indicating it could lead to complexities in establishing the relative payment weights for the MS-DRGs because several expensive cases could impact the overall relative payment weight.

Based on internal review and interpretation as well as input from external stakeholders, we viewed this as potentially two separate aspects to address, i.e., rare diseases vs. conditions represented by low volumes. Both of which could have different and unique challenges and solutions. Conditions with low volumes may represent an opportunity to obtain data that could be outside of the MedPAR data. While the rare diseases category may have another database; however, by nature of being in the rare disease category, rare diseases may also be low in volume.

We acknowledge the impact that rare disease and low volume data can have on the MS-DRG classification system. **Recognizing that there is the potential to dilute the core population when attempting to adjust for low volumes or rare disease, we recommend that CMS consider exploring databases that are outside of the traditional databases used to obtain claims data for inclusion in data analysis.**

In terms of low volume MS-DRGs within the Medicare claims data, accessing other databases that represent MDC 14 and MDC 15 (Obstetrical and Newborns) as a start could provide additional insight. Potential databases to consider could include Healthcare Cost and Utilization Project (H-CUP), state databases, etc. The information from these

additional databases used along with the MedPAR data could potentially provide valuable data for MS-DRG development within MDCs 14 and 15.

Although the rare disease category presents a similar challenge in terms of low volume, these conditions may or may not have additional databases to consider unless there are specific registries where this data could be obtained. However, rare diseases and conditions often present an additional challenge in that they typically involve long term symptom assessment with extensive diagnostic and therapeutic work up prior to establishing a definitive diagnosis and care plan. We suggest a couple of potential options for consideration:

- Explore the potential of creating a process that is similar to cost outliers for rare diagnosis outliers;
- Explore the potential of creating a process or methodology similar to add-on payments for new services and technologies (NTAP) for rare diseases.

Proposed Use of National Drug Codes (NDCs) to Identify Cases Involving Use of Therapeutic Agents Approved for New Technology Add-on Payment. We acknowledge that CMS is proposing to use NDCs to identify cases involving the use of therapeutic agents approved for new technology add-on payment. In this FY 2023 proposed rule, CMS noted that they anticipate that this proposal would reduce work for hospital coding professionals in becoming familiar with newly created ICD-10-PCS Section X codes to describe the administration of therapeutic agents and in searching for these codes within the documentation and within the classification in what may be non-intuitive locations. CMS also stated that this proposal would address concerns regarding the creation of duplicative codes within the ICD-10-PCS procedure coding system to describe the administration of therapeutic agents, which would also reduce the need for vendors to incorporate additional procedure codes into their coding products; for educators to provide training on these codes; and for programmers to maintain codes that may be seldom reported on inpatient claims but for the purposes of the new technology add-on payment in their databases. It would also reduce efforts associated with determining the disposition of procedure codes describing therapeutic agents that have reached the end of their three-year new technology add-on payment timeframe.

CMS noted additionally in this proposed rule that they also believe that NDCs are a viable alternative to Section X codes for the administration of the new technology add-on payment for therapeutic agents. CMS indicated that their understanding is that inpatient hospital staff are familiar with using NDCs and are familiar with having previously utilized NDCs to administer the new technology add-on payment, i.e., FY 2013 IPPS/LTCH PPS final rule regarding DIFICID® and the FY 2019 IPPS/LTCH PPS final rule regarding VABOMERE®.

We acknowledge that CMS is proposing a transitional period for FY 2023 to allow for adequate time to implement this regular usage of NDCs with the new technology add-on



payment for health care providers and hospital coding professionals. During this transitional period, CMS stated they would utilize NDCs to identify the administration of therapeutic agents for new technology add-on payment purposes. However, CMS would also utilize ICD-10-PCS Section X codes, including codes newly created for FY 2023, for therapeutic agents during the FY 2023 new technology add-on payment application cycle. Beginning with the FY 2024 new technology add on payment application cycle, CMS proposes to utilize only NDCs to identify claims involving the administration of therapeutic agents approved for the new technology add-on payment, except for claims involving therapeutic agents that are not assigned an NDC by the Food and Drug Administration (FDA) (for example, blood, blood products, etc.) and are approved for the new technology add-on payment.

We appreciate the rationale CMS presented regarding the proposal for the use of NDC numbers to identify new technology add-on payments for claims involving the administration of therapeutic agents. We also acknowledge that CMS has continued to receive comments from stakeholders, including the AHA and representatives from hospital associations, software vendors, professional societies, and coding professionals, opposing the continued creation of new ICD-10-PCS (for example, Section X) procedure codes for the purpose of administering the new technology add-on payment for drugs and biologics, especially when new codes were created, but the NTAP was not. Specifically, public comments from the ICD-10 Coordination and Maintenance Committee Meetings have stated that the ICD-10-PCS classification system was not intended to represent unique drugs/ therapeutic agents and is not an appropriate code set for this purpose.

Given that these discussions and comments shared have occurred over time historically and systems and technologies have evolved, it is important to provide insight on current items of consideration that have been brought to our attention from external stakeholders regarding this proposal. We specifically provide the following, as shared from some of our stakeholders, for CMS to consider regarding this proposal:

- **Complexity of Information Transfer.** Drug manufacturers include the 10-digit NDC number format on the drug product package and/or in the barcode. The 5010 HIPAA transaction standard states that the “11-digit NDC number format is used for billing on the claim.” The conversion from 10 to 11 digits can be complex and NDC numbers have three segments. Converting NDCs from a 10-digit to an 11-digit format requires placing the zero in the correct location based on the 10-digit format.
  - For a 10-digit NDC in the 4-4-2 format, a “0” would need to be added in the 1st position.
  - For a 10-digit NDC in the 5-3-2 format, a “0” would need to be added in the 6th position.
  - For a 10-digit NDC in the 5-4-1 format, a “0” would need to be added in the 10th position.

Complexities in converting the 10-to-11-digit NDCs appear to make the use of the NDC number for new technology add-on payment challenging. Since a zero can be a valid digit in the NDC, this could potentially lead to confusion when trying to reconstitute the NDC back to its FDA standard. Example: 12345-0678-09 (11 digits) could be 12345-678-09 or 12345-0678-9 depending on the configuration required.

- **Multiple NDC Numbers for One Drug Product Dose.** If multiple NDCs are applicable and used due to different drug strengths being administered, would all NDC numbers need to be reported on the claim? If so, this could present operational and reporting challenges for NTAP capture on the institutional claim form.
- **Form locator 43 (FL43) on the institutional claim form may not be unique to only the NDC number.** The proposed usage of this field appears that it would not be allowed under existing rules for that field. FL43 allows for the reporting of NDC codes for the purpose of Medicaid drug rebates, but not for the NTAP purpose.

## PROMOTING INTEROPERABILITY PROGRAM

In the proposed rule, CMS has laid out a vision for continuing to advance the use of information technology in health care such that in the future, communication and sharing of relevant patient information among those providers caring for an individual is easy because all of it can be transferred among providers electronically while still protecting patient confidentiality. CMS has offered up provisions that it believes would promote interoperability by aligning all providers around the Trusted Exchange Framework and Common Agreement (TEFCA) and by requiring further steps to ensure that hospital and health system electronic health records (EHRs) and other data are in systems that are interoperable with the systems used by public health, physicians and other providers of care. The Office of the National Coordinator for Health Information Technology (ONC) was established in 2009 through the Health Information Technology for Economic and Clinical Health (HITECH) act. Since then, the office has been working to promote interoperability, often in collaboration with CMS.

The Medicare Promoting Interoperability Program. **AHA urges CMS to allow flexibility for hospitals in areas where the prescription drug monitoring programs (PDMPs) have not yet improved.** The proposed rule would expand the requirement to query the PDMPs to include schedule II, III and IV drugs. Yet, over the past few years, we have heard many reports from our members that accessing their state PDMPs is time consuming for clinicians, often requiring that they exit the hospital's medical record and then spend several minutes trying to connect with and query the PDMP because the state's technology is outdated. This was highly frustrating at any time for busy clinicians, and especially now as we see the increased stress clinicians have experienced during the pandemic and continue to experience with the ongoing shortage of doctors, nurses and other clinicians. We urge CMS to recognize that this is not the time to put more burden on

clinicians, even for the important task of consulting the PDMPs, and provide for enforcement discretion or a waiver until the state has improved its technology to enable easy inquiries.

**Further, AHA urges CMS to coordinate its revisions to the scoring of the Public Health and Clinical Information Data Exchange objective with CDC's efforts to ensure the public health agencies are capable of receiving the data.** In the proposed rule, CMS plans to change from three different levels of active engagement to just two levels of engagement in exchanging data with public health entities. This is one of the four scored objectives of interoperability, which are electronic prescribing, health information exchange, provider to patient exchange of information, and public health and clinical data exchange beginning with the calendar year 2023 EHR reporting. Interoperability is truly an activity that requires two or more willing and capable partners. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided funding to CDC to disseminate to public health agencies to improve their technology systems ability to receive significant public health data from hospitals and other providers of care. We believe CDC is in the process of disseminating that bolus of funds to state and local public health departments to update their critical information systems and become capable of receiving hospitals' information, but it will take time. We urge CMS to consult with CDC around this funding and the anticipated implementation schedule, and to delay updating categories of scoring until every hospital has the opportunity to work with a public health agency that is able to receive their data.

Expansion of TEFCA Compliance Options. **AHA supports this proposal, which expands how hospitals can demonstrate fulfillment of the requirement. However, we note that the objectives of TEFCA are being achieved in many new ways now. Many of our members are confused by what is and is not allowed to demonstrate the capacity to exchange information with others efficiently and effectively.** TEFCA is the tool created to enable the exchange of information, but other tools and many health information exchanges (HIEs) and other mechanisms for this information exchange have emerged over the last decade. Hospitals participating in these activities that can rapidly and securely exchange information with other providers, with public health and with other authorized users wonder what the additional value of TEFCA is.

AHA requests that CMS at the very least provide additional education on the benefits of TEFCA and why it remains essential when they are already able to accomplish the real objective of exchanging information. This effort by CMS should include an opportunity for hospitals and health systems to request information regarding their hospital-specific structure to justify additional investments for their boards and communities for TEFCA compliance. If they are in a network that is connected through the eHealth Exchange that is supported by the Sequoia Project, what benefit does TEFCA compliance provide?

## **HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)**

The HRRP imposes penalties of up to 3% of base IPPS payments for having “excess” readmission rates for selected conditions when compared to expected rates. CMS uses six Medicare claims-based readmission measures to assess performance in the program. As required by the 21<sup>st</sup> Century Cures Act, CMS implemented a sociodemographic adjustment approach beginning with the FY 2019 HRRP in which CMS places hospitals into one of five peer groups based on the proportion of patients dually eligible for Medicare and Medicaid that they treat. In this rule, CMS proposes several changes to account for the impact of the COVID-19 PHE.

**Resumption of Pneumonia (PN) Readmissions Measure for FY 2024. The AHA urges CMS not to finalize its proposal to reintroduce the pneumonia readmission measure for FY 2024. Instead, we urge CMS to conduct further analysis to ensure it has minimized the overlap between this measure and COVID-19-related pneumonia.**

In last year’s inpatient PPS final rule, CMS adopted a COVID-19 measure suppression policy across its quality measure programs that permits the agency to not use quality measure data the agency believes have been affected by the pandemic and would result in distorted hospital performance. CMS used this policy to suppress the use of the PN readmissions measure from the FY 2023 HRRP because of data showing a substantial proportion of the measure cohort included admissions with a COVID-19 diagnosis. As a result, the measure’s “clinical proximity” to COVID-19 was close enough to affect performance.

CMS now believes its proposed technical changes to the measure are sufficient to minimize the overlap with COVID-19-related pneumonia. Specifically, CMS would remove patients with COVID-19 as a principle or secondary diagnosis from both index admissions and readmissions. CMS also believes the ICD-10-CM code it adopted in January 2021 that captures pneumonia due to COVID-19 as a secondary diagnosis (J12.82) is now sufficiently well-known and used by hospitals that patients with a COVID-19 diagnosis now make up a small portion of PN admissions.

The AHA agrees that these specification changes are directionally appropriate, and we appreciate that the proposed rule includes data showing the impact of these changes. Indeed, the percentage of pneumonia patients with COVID-19 present on admission dropped from 9.8% in January 2021 to 0.7% in July 2021. However, it is notable that there were upticks in these percentages in August and September 2021, rising to 3.5% of patients. We recommend CMS run the same data for the entirety of 2021 to ensure these increases are anomalies — rather than trends — before re-introducing the PN readmission measure into the HRRP. This would enable agencies and the hospitals to determine whether additional education on the new codes is necessary, or if further measure specification tweaks may be required.

**History of COVID-19 as a Risk Adjustment Co-variate. The AHA supports the concept of CMS’s proposal to include patient history of COVID-19 diagnosis in the 12 months**

**prior to the index hospitalization as a co-variate in the HRRP measures' risk adjustment models. However, we urge CMS to conduct further analysis before finalizing this proposal to ensure prior COVID-19 is captured across hospitals in a complete, consistent and equitable way.** We greatly appreciate CMS's recognition of the potentially long-lasting impacts of a COVID-19 diagnosis on patient risk for readmission. To ensure a level playing field in the HRRP over the long run, CMS must improve measure methodologies to recognize COVID-19's potential impacts.

While we believe CMS's approach likely is the appropriate starting point for accounting for COVID-19 risk, the methodology also raises important questions that we would encourage CMS to address before finalizing its proposal. First, we urge CMS to examine and share publicly any data on variation in how prior COVID-19 is being captured in claims data. COVID-19 can be diagnosed in the course of either inpatient or outpatient care. It would be helpful to know what percentages of COVID-19 diagnoses are captured as part of the index hospitalization, a prior hospitalization in the 12 months before the index admission, or in the course of ambulatory care. It would also be helpful to know if there are any variations by geography and hospital type, and whether those patterns shifted over time. Indeed, especially during 2020, testing supplies were often constrained, which could potentially lead to differences in how consistently COVID-19 was diagnosed. While we agree that capturing prior COVID-19 likely is the right approach for risk adjustment, we also want to ensure the implementation of this approach is equitable.

Second, we encourage CMS to explore to what extent its codes are capturing COVID-19 self-testing that patients may perform at home, and how frequently those codes are being used. We are concerned by the potential for leaving out a substantial portion of patients that may have had COVID-19, but did not get tested in an inpatient or ambulatory setting in the prior 12 months. To the extent that positive home tests can be captured in a consistent way, it should improve the validity and equity of the risk adjustment.

Lastly, over the long run, CMS should continue to monitor the evolving evidence around post-COVID conditions to determine whether the 12 month timeframe should be lengthened or shortened. As the field continues to learn more about the ways in which "long COVID" manifests itself, and the duration of its impacts, CMS's current approach may need to change.

Potential Future Inclusion of Health Equity Performance in HRRP. The proposed rule includes a request for information on how CMS could encourage hospitals to improve health equity and reduce health care disparities through the HRRP. CMS is considering approaches that go beyond providing hospitals with confidential reports of their performance stratified by particular demographic or social risk data and that could potentially impact hospitals performance — and therefore, financial penalties — in the program. For example, CMS is considering approaches that "would account for a hospital's performance on readmissions for socially at-risk 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.”

The AHA shares CMS’s strong commitment to advancing health equity. Hospitals and health systems are working hard to identify and address health disparities, and to close remaining gaps in quality performance across patient populations. We appreciate that CMS has provided hospitals with HRRP feedback reports that could help hospitals identify potential variation in readmission performance across demographic and social risk categories. These reports can help inform hospital efforts to remove any inappropriate variation in their own care and target any supportive resources that can help reduce readmissions risk to patients that could benefit from them. While these feedback reports have largely been limited to using dual-eligible status as the stratification variable so far, we would welcome additional feedback reports that provide stratified results on a wider range of demographic and social risk data, including race/ethnicity, language and other social determinants of health.

**However, we strongly urge CMS not to tie HRRP penalties to either within or between provider disparities in readmission rates. Such an approach would not only be counterproductive, but also would be inconsistent with the HRRP scoring methodology prescribed by statute.** Over a decade’s worth of peer-reviewed research has repeatedly underscored that 30-day hospital readmissions rates are significantly affected by social needs that hospitals alone do not control. These social needs include access to primary care, home health and rehabilitation services in the community, transportation options that enable patients to go to follow up appointments and adequate access to nutritious foods. Many other studies have also underscored the wide variation in the availability of such resources across communities. In response to this evidence, Congress appropriately amended the HRRP statute to require CMS to account for social risk factors in calculating readmissions performance and penalties. Since FY 2019, CMS has placed hospitals into quintile peer groups based on their proportion of dual-eligible patients.

Yet, tying hospital HRRP penalties to disparities in readmission rates would effectively treat readmission rates as solely the responsibility of the hospital. Hospitals across the country are working hard with other providers and community-based partners to develop approaches to keep patients out of the hospital. Yet, there are limits to what these efforts can achieve, and the reality is that some hospitals provide care in communities with significant resource limitations. As a result, we fear that penalties tied to readmission rate disparities would lead to disproportionate readmission penalties for hospitals serving the communities with the greatest social needs. This could create a vicious cycle that further reduces the resources available to those hospitals to work with their communities to address readmissions specifically, and health equity more broadly. In short, this approach may not only fail to advance health equity, but it may actually inadvertently worsen it.

This approach also would be incongruous with the broader approach to scoring hospitals on readmissions. CMS scores hospitals on readmission rates that are risk adjusted for clinical factors because the agency knows readmission risk is affected by a range of factors beyond hospitals' control. Yet, CMS does not choose to isolate a clinical risk factor and score hospitals on their within or between provider performance on those factors. For example, iron deficiency is a risk variable for AMI readmissions. But CMS likely would not adopt a scoring methodology in which hospital penalties are tied to the within or between provider differences in readmission rates for patients with iron deficiency.

**In fact, the AHA believes the HRRP statute would not permit CMS to incorporate disparity rates into hospital performance and penalty calculations.** To calculate hospital performance, section 1886(q)(4)(C) of the Social Security Act requires CMS to calculate an excess readmissions ratio of actual to expected readmissions using readmissions measures endorsed by the National Quality Forum (NQF). To our knowledge, none of the readmission measures used in the HRRP includes an approach for calculating either actual or expected readmissions in a way that summarizes between or within provider disparities into a single number. Furthermore, it is unclear how CMS could calculate a single ratio for each hospital that would appropriately account for either within or between hospital disparities in performance. For the reasons articulated above, we are skeptical that such a number would be a meaningful or appropriate way to assess hospital performance.

## **HOSPITAL VALUE-BASED PURCHASING (HVBP)**

The ACA mandated that CMS implement the HVBP program, which ties a portion of hospital payment to selected measures of the quality, safety and cost of hospital care. CMS funds the program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance. Hospitals may earn back some, all or more than the 2% withhold based on their measure performance. By statute, the program must be budget neutral — that is, the entire pool of dollars must be paid back to hospitals, and CMS may not hold back any portion of it to achieve savings to the Medicare program.

CMS proposes several significant changes to the HVBP program for FY 2023 and beyond to account for the continued impact of the COVID-19 PHE.

**FY 2023 MeasureSuppressions and Neutral Payment Adjustments. The AHA supports CMS's proposals to suppress most of the HVBP program's measures for FY 2023, and to apply neutral payment adjustments to all hospitals for FY 2023.** We appreciate the agency engaging with hospitals to gauge the impact of COVID-19 on individual measures and programs, and using a data-driven approach to inform its proposals. We agree that hospital performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and healthcare associated infection (HAI) measures are likely non-representative because of the pandemic.

Furthermore, we believe it is both appropriate and well within CMS's statutory discretion to apply neutral HVBP payment adjustments for FY 2023. Indeed, it would have been problematic to apply any positive or negative HVBP payment adjustments because CMS would only have sufficient data for only two of the HVBP's performance domains. Furthermore, the HVBP program's budget neutral design means that the program does not result in costs or savings to the Medicare program.

**We urge CMS to continue analyzing data from both 2021 and 2022 to determine whether further suppressions — and even neutral HVBP payment adjustments — may be necessary in future fiscal years.** For the most part, the measure performance periods for the FY 2023 HVBP included data from 2021. Yet, the pandemic has unfortunately continued into 2022, and many parts of the country saw significant surges of COVID-19 cases and hospitalizations during quarter four of 2021 and quarter one of 2022. As a result, the baseline and performance periods that include 2020 and 2021 data likely will be affected by the COVID-19 PHE. We would be pleased to continue working with the agency to help it assess the continued impact of COVID-19 on its measures and program.

In this proposed suppression, we understand that CMS intends to suppress the use of the data in its value based payment programs, such as the readmissions reduction program, but not to withhold the data from publication. While we support this approach, we also believe it is important for transparency that the agency include information on its Care Compare website explaining this decision so that others, who might intend to use the data for other purposes also can consider whether their intended use needs to be adjusted or suppressed for a time period due to COVID-19 impacts.

Resumption of PN Mortality Measure for FY 2024. **The AHA urges CMS not to finalize its proposal to re-introduce the pneumonia mortality measure for FY 2024. Instead, we urge CMS to conduct further analysis to ensure it has minimized the overlap between this measure and COVID-19-related pneumonia.** CMS proposal for the pneumonia mortality measure is similar to that of the HRRP's pneumonia readmission measure, and we refer the agency to our comments in the HRRP section of this letter.

History of COVID-19 as a Risk Adjustment Co-variate. Similar to its proposal for the HRRP's readmission measures, CMS proposes to include patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models for its HVBP mortality and complication measures starting in FY 2023. **The AHA supports the concept of this proposal, but urges CMS to conduct further analysis before finalizing this proposal to ensure prior COVID-19 is captured across hospitals in a complete, consistent and equitable way.** We refer CMS to our discussion of a nearly identical proposal in the HRRP section of this letter.

Revised Baseline Periods for FY 2024. **The AHA supports CMS's proposals to alter the FY 2025 baseline periods for some HVBP measures in order to account for the COVID-19 PHE.** Specifically, for the HCAHPS and HAI measures, CMS proposes to use



CY 2019 as the baseline period instead of CY 2021. This would allow CMS to use data unaffected by the COVID-19 pandemic, while permitting CMS to use a full year of data to compare to the CY 2023 performance period.

## **HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM**

The HAC Reduction Program imposes a 1% reduction on all Medicare inpatient payments for hospitals in the top (lowest-performing) quartile of certain risk-adjusted national HAC rates. The HAC Reduction Program's basic scoring methodology and measure set are unchanged. However, CMS proposes to apply several COVID-19 measure suppressions to the program in FYs 2023 and 2024.

FY 2023 Measure Suppressions and Payment Adjustments. **The AHA supports CMS's proposal to suppress all six HAC Reduction Program measures for FY 2023, thereby resulting in no penalties for hospitals for FY 2023.** As the agency appropriately notes, the COVID-19 PHE has continued to have a profound impact on hospital performance on the measures included in the program. Factors such as sicker patients, longer hospital stays, higher volumes, staffing challenges, supply constraints and other factors have all impacted hospitals at various times during the pandemic, including during the performance period for the FY 2023 HAC Reduction Program. Importantly, these impacts were not all felt at the same time, and were not uniform with respect to geography or intensity. Given that CMS cannot account for these factors in the risk adjustment models for the measures in the program, we agree that suppressing their use in determining HAC penalties is the fairest approach to hospitals.

**The AHA also supports CMS's balanced, data-driven approach to maintaining transparency in the HAC Reduction Program.** CMS would continue to report hospital HAI measure performance in confidential preview reports and on its *Care Compare* website. While we are not entirely confident that the HAI measure data will be fully representative of hospital performance because of the pandemic's impacts, we also understand the potential value of continuing to report these measures. Given recent analyses suggesting increases in some HAI rates during the first year of the pandemic, and preliminary data in the proposed rule from 2021 indicating the same, tracking HAI trends in the aggregate and by hospital type could continue to provide the field with important insights.

**We also support CMS's proposal not to publicly report PSI 90 data for FY 2023.** As CMS notes, several vital components of the measure — including individual measure weights and parts of the risk and reliability adjustment models — were set using pre-pandemic data that do not account for the pandemic's impact. Specifically, the reference period for the current version of the software used to calculate PSI 90 is Jul. 31, 2018–Dec. 31, 2019. Yet, the PSI 90 performance period for FY 2023 HAC Reduction Program — Jul. 1–Dec. 31, 2019 and Jan. 1–Jun. 30, 2021 — would include data from the pandemic. As a result, any reported measure results likely would be unfairly biased against

hospitals highly impacted by the pandemic, and would result in misleading data for the public.

FY 2024 Suppressions. For the FY 2024 HAC Reduction Program, CMS proposes to suppress again the program's HAI measures. However, the agency would score hospitals using a modified version of the PSI 90 measure that includes technical changes intended to risk adjust for COVID-19 diagnoses.

**The AHA supports the concept of applying further measure suppressions to the FY 2024 HAC Reduction Program. However, we are concerned by the potential for the program's performance to be based solely on the PSI 90 measure.** As the AHA has repeatedly noted, the PSI 90 measure has long faced questionable levels of reliability,<sup>44</sup> and disconnects between performance captured in the claims data and clinical reality.<sup>45</sup> Furthermore, analyses have shown that the inclusion of the PSI measure in the HAC Reduction Program likely biases the program against large hospitals and teaching hospitals that care for more complex patients.<sup>46</sup> We support CMS making changes to the PSI 90 measure to better account for the impact of COVID-19 on measure performance. However, the rule did not include data demonstrating how these changes impacted measure reliability and validity, nor did it analyze how overall hospital performance may shift. We believe more data are needed to determine the appropriateness of basing HAC Reduction Program penalties on only the PSI 90 measure, and for the reasons described above, we are skeptical of that approach. CMS may find instead that it could either include some limited HAI measure data from late 2022, or choose to again suppress all of the program's measures for FY 2024.

Ultimately, none of CMS's quality measurement or value programs were designed to fully accommodate the circumstances of an unprecedented global pandemic that has so profoundly impacted hospitals and the communities they serve. CMS and hospitals alike face challenging tradeoffs and imperfect policy choices in trying to ensure a fair, equitable and transparent accounting of COVID-19's impact on hospital performance. However, CMS's measure suppression policy has provided a consistent, transparent platform for addressing these challenges. We look forward to continuing to work with the agency to mitigate COVID-19's impact on its programs while ensuring the programs help to advance hospital quality and safety.

PSI 90 Minimum Volume Threshold. In prior rulemaking, CMS adopted a sub-regulatory process to make technical measure specification updates in the HAC Reduction Program. CMS uses the proposed rule to announce an increase in the minimum volume threshold

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<sup>44</sup> See [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP\\_Measure\\_Reliability-.pdf](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf)

<sup>45</sup> Among other studies, see Ramanathan R et al. Validity of Agency for Healthcare Research and Quality Patient Safety Indicators at an academic medical center. *The American Surgeon*. 2013 Jun; 79(6):578-82.

<sup>46</sup> Koenig L et al. Complication Rates, Hospital Size and Bias in the CMS Hospital-Acquired Condition Reduction Program. *American Journal of Healthcare Quality*. Dec. 19, 2016.

for receiving a PSI 90 score. Currently, CMS requires that hospitals only have three or more eligible discharges for at least one component indicator in PSI 90 to receive a measure score. While CMS believes this lends an acceptable level of reliability, they note that “a small subset of hospitals have reliability close to zero.” To improve measure reliability, CMS will now require hospitals to meet both of the following criteria to receive a PSI 90 score:

- Have one or more component PSI measures with at least 25 eligible discharges; and
- Seven or more component PSI measures with at least three eligible discharges.

**The AHA supports CMS’s increase to the PSI 90 minimum volume thresholds. However, as noted above, we continue to have significant misgivings about the ongoing use of PSI 90 in federal programs, and are not confident these changes are sufficient to solve for the measure’s fundamental shortcomings. We again urge CMS to develop a plan to phase out the use of the PSI 90 measure from federal programs.**

PSIs use hospital claims data to identify patients that have potentially experienced a safety event. However, claims data cannot and do not fully reflect the details of a patient’s history, course of care and clinical risk factors. As a result, the rates derived from the measures are highly inexact. PSI data may assist hospitals in identifying patients whose particular cases merit deeper investigation with the benefit of the full medical record. But, the measures are poorly suited to drawing meaningful conclusions about hospital performance on safety issues. In other words, PSI 90 may help hospitals determine what “haystack” to look in for potential safety issues. But the ability of the measure to consistently and accurately identify the “needle” (i.e., the safety event) is far too limited for use in public reporting and pay-for-performance applications.

## **HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM**

The IQR program is CMS’s pay-for-reporting program in which hospitals must submit measures and meet other administrative requirements in order to avoid a payment reduction equal to one quarter of the annual market basket update. The IQR program also includes a requirement to report on selected EHR-derived eCQMs using CMS-mandated reporting standards.

CMS proposes to add 10 new measures to the IQR program, three of which are focused on health equity and two of which are focused on maternal health. CMS also proposes a new maternal health designation for hospitals, and solicits input on approaches it could take to advance maternal health in its quality programs. In addition, CMS proposes changes to the IQR’s eCQM reporting requirements that are aligned with the requirements of the Promoting Interoperability Program.

Hospital Commitment to Health Equity. CMS proposes to adopt an attestation-based structural measure beginning with the CY 2023 reporting/FY 2025 payment periods that assesses hospital leadership's commitment to health equity. Hospitals would be asked to attest to implementing a series of practices the agency believes would demonstrate an organization's commitment to advancing health equity across five domains — equity as a strategic priority, data collection, data analysis, quality improvement and leadership engagement.

**Consistent with the steadfast commitment of America's hospitals and health systems to advancing health equity within their organizations and in their communities, the AHA is pleased to support the Hospital Commitment to Health Equity structural measure. However, we urge CMS to adopt several changes that would make the measure more meaningful, actionable and transparent before requiring hospitals to report it and displaying performance publicly.**

**First, the AHA urges CMS to provide additional clarifying guidance to hospitals — including additional definitions of key terms and examples — so that hospitals can answer the attestations in as accurate, complete and consistent a manner as possible.** The proposed measure includes a total of 11 attestations reflecting specific equity-related practices in hospitals. On the whole, we believe the practices included in the attestations reflect relevant and important practices. However, some of the terms used in the attestations could be subject to a range of interpretations, and we are concerned that not all hospitals will report the measure in the same way. For this reason, we urge CMS to use guidance documents, educational resources and other mechanisms to ensure hospitals are responding in a consistent way.

Even the term "health equity" does not have a specific definition in the measure specifications. We suggest CMS provide a working definition either in the document itself or using a reference to one of its existing resources. Other areas where CMS could provide further clarification and guidance include the following:

- **Domain 1 (Equity is a Strategic Priority):** The domain asks about whether hospitals have a strategic plan to advance equity. We suggest that CMS clarify that a strategic plan related to equity could take many forms. It could be either its own document, or part of a broader prominent organizational plan that still includes the elements asked for in the measure. Furthermore, not all hospitals use the term "strategic plan" in the same way. For some hospitals, a strategic plan includes high-level objectives over a long period of time, but they may also have an "operating plan" or "annual goals" in which more specific action steps — including those like the attestations in this domain — may fit. For some hospitals, their plan for health equity may be a part of their Community Health Needs Assessment (CHNA), and that CHNA may be tied to their

strategic or operating plan. CMS should clarify that as long as the elements it is asking for in the measure are met, hospitals should be able to attest to it.

- **Domain 2 (Data Collection):** We recommend CMS provide working definitions of social determinants of health (2A-C), culturally sensitive (2B), and “structured, interoperable data elements” in 2C. The agency also could consider providing some illustrative examples or case studies on how the data collection process could work.
- **Domain 3 (Data Analysis):** We recommend CMS clarify what would count as a “key performance indicator” by including things like CMS quality measures and/or other internally tracked quality measures. We also recommend CMS provide some illustrative (though not exhaustive) examples and case studies of hospital approaches of including equity data on internal dashboards.
- **Domain 5 (Leadership Engagement):** Similar to Domain 1, we note that “strategic plans” can take different forms and have different titles depending on the hospital. We encourage CMS to clarify that as long as the elements being asked for are included, it is not essential that the plan be called a “strategic plan.”

**Second, the AHA recommends CMS revise its proposed “all or nothing” approach to scoring the measure and instead award one point for each individual attestation a hospital is able to complete. We believe this approach would make the measure more transparent and usable to both hospitals and the public.** As currently proposed, a hospital would receive a score out of five points based on how many domains are met. There is no “partial credit” — a hospital must affirmatively attest to all elements within each domain in order to earn the point.

It is not clear how CMS chose this particular weighting approach since the measure and measure score reliability/validity have not been empirically tested. However, we note that the “level of effort” for each individual attestation could look quite different. For example, the practices of articulating a strategic plan and resources outlined in Domain 1 certainly is a significant undertaking. Yet, it would effectively receive the same weight as the data collection in Domain 2, which likely entails even more significant work and resources. Furthermore, we are concerned that by rolling up practices into domain scores, CMS may inadvertently obscure hospital performance on the individual practices, making it harder to know specifically where hospitals may need improvement. It also may make it more difficult for hospitals to meaningfully benchmark themselves against others.

For these reasons, we urge CMS to simplify its approach by awarding hospitals a point for each attestation they can complete, and giving them a score out of 11 points. We also urge that on the Care Compare website CMS make it clear which practices

hospitals have attested to and which ones they have not. Once the measure has been in use, CMS could reconsider its weighting scheme, and even whether placing the practices into specific domains is still the optimal approach.

Screening for Social Drivers of Health. CMS believes that systematically screening patients for social needs that impact their short- and long-term health outcomes gives hospitals an opportunity to connect patients with supportive resources. As a result, CMS proposes a measure reflecting the extent to which hospitals conduct screenings for certain health-related social needs (HRSNs) that would be voluntary for the CY 2023 reporting/FY 2025 payment period and required starting for the CY 2024 reporting/FY 2026 payment period. The measure assesses 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. CMS also proposes a second measure that reflects the percentages of patients that screen positive for each HRSN. CMS proposes flexibilities in how hospitals would implement the measures. That is, hospitals would be allowed to choose the screening tool and mode of data collection.

**The AHA supports the inclusion of the HRSN screening measures in the IQR program. However, we recommend that CMS adopt the measures for voluntary reporting for now, and revisit a date for mandatory reporting after the first year of voluntary reporting.** This would permit CMS to review submitted data, solicit feedback from hospitals on their experience with reporting the measure, further evaluate the value of the measure in helping hospitals identify HRSNs, and enable CMS to make any needed changes before mandating it. The AHA would be pleased to work with CMS to encourage strong hospital participation in voluntary reporting so that CMS gets the data and feedback it needs to make the measure more feasible, accurate and meaningful.

The AHA agrees that screening patients for HRSNs is a foundational step to connecting them with supportive resources that could improve their health and outcomes. CMS also correctly recognizes that the measures' complexity means hospitals need time to prepare their staff and internal systems and processes to collect and report the data. **However, we are skeptical that the agency's proposed one year voluntary period is sufficient for the proposed measures for several reasons.**

**First, the level of operational complexity involved in collecting and reporting the measure data is unusually high.** The AHA greatly appreciates CMS's proposal to give hospitals flexibility in what screening tools they choose and what data collection mode they use. However, hospitals must still resolve a number of operational considerations, including, but not limited to:

- What screening tool they will use;
- How they will make that tool available to staff;
- When during the hospitalization they would perform the screening;
- Whether patients can fill out a screening tool themselves or need to be interviewed by hospital staff;
- Training staff on performing the screening in a culturally sensitive way;
- Determining what hospital IT system screening responses will be entered;
- How data will be aggregated during the reporting period;
- How numerator and denominator data will be transmitted to CMS.

These operational questions also must be resolved at a time that hospitals remain under enormous financial and operational strain from the COVID-19 PHE. With many hospitals facing staff shortages — and the potential for yet additional surges of COVID-19 patients in the coming months — we believe it is vital to provide additional time to plan and align human and technological resources to report these measures.

The operational complexity of the measures — and the wide range of choices hospitals could make about how to implement them — also raises questions about the consistency and comparability of collected measure data. For a measure to have utility in a quality reporting program like the IQR, the measure results must be reliable and accurate. **Therefore, as part of the voluntary reporting process, we encourage CMS to engage hospitals on how they are collecting and reporting the data.** For example, CMS could engage a subset of voluntary reporters in follow up qualitative and quantitative analysis that assess differences in data collection modes and whether those are linked to measure results.

**Furthermore, the AHA believes the measure as currently specified needs clarifications to make the measure more feasible and less duplicative.**

Specifically, we urge CMS to address the following:

- **Patients with multiple hospital visits in the measurement period.** We urge CMS to clarify whether it intends for hospitals to collect data on each distinct *admission* during the reporting year, or each distinct *patient*. Indeed, some patients may visit the same hospital multiple times each year for needed care, and those hospitalizations could be separated by only a short time period. We believe the most appropriate approach would be to measures whether hospitals collect data on each distinct *patient* admitted to the hospital once per year. We are concerned that asking hospitals to perform the screening on each admission could result in patients being screened multiple times within the same time period, leading to not only annoyance, but also potentially double counts in measure data.
- **Inclusion of HRSN data collected in ambulatory settings.** Many hospitals and health systems have established processes to collect HRSN data from

patients through their primary care and other ambulatory practices, and to include the results of those screenings in a patient's EHR that would be visible in both the inpatient and outpatient setting. Indeed, many hospital leaders have told us that they have had stronger response rates to HRSN screenings in the primary care setting because patients often have longer standing relationships with their practices. In addition, we are concerned that requiring a hospital to re-collect HRSN data during a hospitalization could be needlessly duplicative.

For this reason, the AHA urges CMS permit hospitals that have collected the required HRSN measure data on an admitted patient in an ambulatory setting prior to the hospitalization — but during the measure performance period — to count this screening in the measures' numerator and denominator. For example, if a patient receives an ambulatory HRSN screening in January 2024 but is admitted to the hospital in May 2024, the January 2024 screening should count. CMS could still encourage hospitals to review the results of the previously performed screening with patients, and to update the results of the screening if needed. However, we do not believe there would be value added for patients or hospitals by asking them to repeat the entire screening again during the same year.

**Lastly, the AHA believes CMS could use a lengthened voluntary reporting process to help the agency and all stakeholders examine deeper questions about the value of these proposed measures.** The AHA agrees that screening patients for HRSNs is one important part of a broader push to improve health equity. In theory, the screening can help hospitals connect patients with resources that are available to support them. Where resources do not exist, a positive screen could potentially even generate new ideas for supportive resources in the community for which hospitals could advocate.

However, there are limits of the design of the HRSN screening measures. The rate of HRSN screenings does not provide information on whether those HRSNs were actually met, nor does it provide information on whether disparities were eliminated and patients ultimately became healthier as a result of their care. The AHA believes the results should be viewed simply as a reflection of the extent to which hospitals are conducting HRSN screenings, and how many they find are screening positive for those HRSNs. **Even more critically, CMS should urge the public and users of the data to not interpret the measure results — especially the screen positive rate — as a reflection of whether hospitals are adequately “solving” the HRSNs of the patients that they serve.**

Indeed, it is clear that hospitals alone cannot solve the persistent health inequities stemming from HRSNs. Addressing these challenges takes collaboration and resources from public and private sector partners. In some communities, those



partners are willing, able and have the resources to address these challenges, but this is not the case everywhere. While hospitals are willing to accelerate their efforts to effectively screen patients for HRSNs, they have expressed concern that asking patients about their HRSNs without being able to refer them to meaningful resources could be both unfair to patients, and demoralizing for hospital teams. **Thus, throughout the voluntary reporting period, we encourage CMS to solicit information from hospitals about whether the information has added any value to their efforts to engage public and private community partners on addressing HRSNs.**

Lastly, the AHA believes the value of the HRSN screening data depends heavily on patient engagement with the screening process. CMS has proposed denominator exclusions for the measures that would remove from the measure calculation patients that opt-out of screening, or that are unable to complete the screening and have no legal guardian or caregiver that can do so on their behalf. We certainly agree that these two categories of patients should not be included in calculating measure performance. However, because the measure has not yet been tested, we also do not know how large this group of exclusions actually is. If opt outs and non-respondents are a large proportion of responses, it should prompt questions about the feasibility of the measure, whether patients view the process of being screened as valuable, and whether there are opportunities to improve screening approaches in hospitals. **Thus, as a part of the voluntary reporting period, we encourage CMS to collect data from hospitals on the rates of HRSN denominator exclusions.**

eCQM Reporting Requirements. **The AHA does not support CMS's proposal to increase the number of eQMs required for reporting from four to six measures starting with the CY 2024 reporting period. Furthermore, we do not support CMS's proposal to require the reporting of its two proposed perinatal eQMs.**

The AHA shares CMS's goal of improving maternal health. However, as described in the next two sections of this letter, we do not believe the two proposed maternal health eQMs are appropriate to mandate for reporting at this time. Furthermore, while we understand CMS's desire to incrementally ramp up eCQM reporting requirements in order to advance digital quality measurement, competing demands for limited hospital quality and health IT resources make increasing the number of eQMs required for reporting unrealistic at this time.

As we have consistently stated to CMS, many hospitals have found that their EHR vendors need considerable advance notice to complete upgrades and programming that help them meet CMS's eCQM reporting requirements. The need for advanced notice is even greater now given that the needs of the COVID-19 pandemic have drawn upon finite hospital quality and health IT resources.

Furthermore, we are concerned that expanded eCQM reporting would be added to an already lengthy list of new quality reporting requirements for hospitals that would take effect during CY 2024. Specifically, CMS will require hospitals to report data on its hybrid mortality and readmission measures, which will require both health IT and quality resources from hospitals. Furthermore, CMS has proposed HRSN screening measures that would be required for reporting during CY 2024, and we anticipate hospitals will need to draw upon significant IT resources in order to meet the measures' requirements. In the outpatient quality reporting program, CMS has proposed to require the reporting of the Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS) survey beginning Jan. 1, 2024. At a time when the hospital workforce is under tremendous strain, and quality and health IT resources are stretched thin, adding more reporting mandates to hospitals could prove unsustainable.

Compounding these challenges further, CMS has proposed significant policy changes for the Promoting Interoperability Program, all of which would draw upon the same hospital resources as eCQMs. We discuss the challenges of these new policies in the Promoting Interoperability Program section of this letter. **The AHA is very concerned that many hospitals will face an untenable situation in which they could lose their entire annual payment update — one quarter for the IQR, and three quarters for the Promoting Interoperability Program — for failing to meet an eCQM mandate that neither they nor their EHR vendors can meet because of the pandemic and other competing federal quality reporting and EHR-related mandates.**

eCQM Validation Requirements. In addition, starting with the CY 2023 reporting/FY 2025 payment years, CMS would increase eCQM validation requirements by requiring hospitals to submit 100% of requested medical records rather than just 75%. **The AHA supports this proposal.** However, some members have expressed concern about the timeliness and value of the validation results they have received back from the validation vendor, noting that the level of feedback is not as specific and usable as it could be. We encourage CMS to work with its vendor and hospitals to ensure its validation process adds value to hospital efforts to collect data reliably and accurately.

Cesarean Birth eCQM. CMS proposes to adopt this measure for voluntary reporting beginning with the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period (except for those hospitals that do not perform deliveries). The measure assesses the rate of nulliparous, term, singleton, vertex (NTSV) live-born deliveries via C-section at greater than 37 weeks gestation (i.e. low-risk deliveries).

**The AHA does not support the adoption of this measure into the IQR and does not recommend that CMS use the measure as an indicator of quality performance in other programs. Because there is no ideal rate of C-section delivery and the measure makes no distinction between medically necessary**

**and unnecessary C-section, the measure would not be an accurate predictor of clinical quality and could carry significant unintended negative consequences.**

We are troubled that CMS's justification of the measure in the rule inadvertently frames C-section births as inherently harmful. To be clear, C-sections are procedures that can save the lives of the mother and the infant. Nevertheless, CMS states that this measure addresses the Meaningful Measures quality priority of "make care safer by reducing harm caused in delivery of care" through the measure area of "preventable healthcare harm." Furthermore, CMS suggests that rising rates of C-section nationwide are an indication of poor hospital performance. Yet, CMS provides no evidence suggesting that these rates are rising solely because of hospital practice rather than changes in the underlying patient population, such as advancing maternal age. A measure that reports on the incidence of the procedure alone — even for low-risk deliveries — should not be viewed reflexively as an indicator of hospital safety. Indeed, in its review of the measure in 2018, the NQF Scientific Methods panel found that there is not a strong or convincing case that the measure addresses a real quality problem.

Consistent with other surgical procedures, C-sections are associated with higher morbidity and mortality than are vaginal deliveries; however, as noted in the rule, existing literature largely does not distinguish whether these outcomes derive from cause (higher-risk patients undergo C-section) or effect (the poorer outcomes were due to the procedure). We certainly agree that it is reasonable to avoid a C-section birth if possible. Yet, CMS believes that adoption of this measure "may ultimately reduce the occurrence of non-medically indicated C-sections," even though the measure does not differentiate between medically and non-medically indicated procedures. In addition, U.S. practice guidelines have not indicated an optimal rate of Cesarean birth or an appropriate variance rate. As a result, it is unclear how a hospital or the public would judge "good" or "poor" performance.

Further, CMS notes that it "encourage[s] hospitals whose measure rates are higher than rates at other hospitals to explore and evaluate differences in the clinical management of women in labor." Without any context, risk adjustment or benchmark rate of C-sections, this gross rate provides little useful information. If CMS is attempting to encourage hospitals to adopt clinical practices in line with evidence-based guidelines, it has already adopted a measure asking whether hospitals are participating in collaboratives that support the implementation of these practices. If CMS is attempting to improve surveillance on poor outcomes that occur in the course of delivery, the proposed severe obstetric complication eQIM CMS has proposed in this same rule would likely achieve this goal far more effectively.

In addition to the conceptual weaknesses of this measure, it carries logistical disadvantages as well. The measure only excludes patients with abnormal presentations or placenta previa; it includes no other risk adjustment. Without

accounting for patient-level factors like comorbidities (including eclampsia or pre-eclampsia, for whom Cesarean birth may be indicated but would still be included in the measure cohort) or social determinants of health, use of performance data is likely to lead to inappropriate comparisons between referral centers for more complex patients and hospitals that serve a higher proportion of patients with fewer comorbidities that increase likelihood of C-section.

We also are concerned by this measure's lack of NQF endorsement. The measure was resubmitted for consideration this spring after failing endorsement in 2017 due to low feasibility and a lack of evidence of variation in performance based on hospital rather than patient variables. CMS relies upon reliability and validity data from an analysis of hospitals that participate in The Joint Commission's ORYX initiative, which employs both the chart-abstracted and eCQM version of this measure. However, CMS would not implement this measure as has The Joint Commission; in the measure's specifications, the Improvement Notation states that "PC-06 [Unexpected Complications in Term Newborns] serves as a balancing measure for [this measure] to guard against any unanticipated or unintended consequences and to identify unforeseen complications that might arise as a result of quality improvement activities and efforts for this measure." However, the IQR does not include PC-06. The ORYX program also differentiates participation requirements for this measure based on facility volume of more than 300 live births annually, while CMS does not. Due to these discrepancies, NQF review is particularly important to understand whether the measure as proposed for adoption will have the intended outcomes.

Severe Obstetric Complications eCQM. CMS proposes to adopt this measure for voluntary reporting beginning with the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period. The measure assesses the proportion of patients with severe obstetric complications that occur during the inpatient delivery hospitalization. Severe obstetric complications are defined as certain severe maternal morbidity conditions that are not present on admission but diagnosed during the delivery hospitalization, certain procedures performed during the hospitalization, and death.

**The AHA encourages CMS to obtain NQF endorsement of this proposed measure based upon completed measure testing before finalizing it for use in the IQR. If CMS is intent on implementing the measure in the IQR before testing and endorsement are complete, we urge CMS not to require the reporting of this eCQM in the IQR.** Maternal health is a priority for the AHA and its member hospitals and health systems; a commitment to women's health, healthy pregnancy and a good start for all children is a cornerstone to improving the nation's health. We support the general concept and direction of this measure; we believe the concerns that we have regarding the complexity of the measure's specifications are likely to be addressed during testing and the NQF review process.

As the agency and its contractors acknowledge in the methodology report, there is a dearth of available outcomes-based quality measures for maternal health. The measures currently used in CMS and similar quality reporting and assessment programs evaluate perinatal processes (exclusive breast milk feeding, PC-05), attestation to involvement in perinatal quality improvement programs (maternal morbidity structural measure), or intermediate outcomes (elective delivery, PC-01). Even in Medicaid and the Children's Health Insurance Program there are only 11 voluntarily reported measures related to maternal and perinatal health, and none specifically address maternal morbidity. This measure would thus fill a critical gap. In addition, the measure's use of structured clinical data fields from certified EHR technology suggests improved accuracy over measures that are informed only by information on claims. These patient-level clinical data are vital to risk adjustment in order to identify precisely what providers can do to prevent obstetric complications. We are heartened by the progress made through the alpha and first beta phase of testing, in which the developers evaluated the data elements for feasibility and availability and removed elements that were not able to be captured accurately.

However, before implementing the measure in the IQR, we urge CMS to address several methodological considerations. First, the measure's numerator is so broad that it could put hospitals caring for more complex patients at a disadvantage. The risk adjustment methodology must be robust to account for differences in case mix. Furthermore, while instances of severe complications are a valuable outcome to track for both providers and parents, they are still very rare. In the methodology report, the measure developers note that the low rate of occurrences may necessitate a substantial sample size. This sample size may rule out many hospitals with lower volumes. According to the measure developer's testing across 60,000 delivery encounters, the severe obstetric complications rate excluding blood transfusion-only cases was 0.5% (50 per 10,000 delivery hospitalizations). We ask CMS for clarification on how the two rates would be reported if volumes were sufficient for one rate (including blood transfusion-only) but not the other.

Finally, we appreciate the thoughtful approach to addressing the interplay of patient-level characteristics with outcomes. Social determinants of health often play a major role in how patients fare, especially mothers; we want to ensure that those drivers are not ignored or explained away, but we also need to focus quality measures used in CMS programs on issues that are within the control of the provider. In this measure, the steward would account for differences in social risk by including a housing instability variable in the risk adjustment methodology. We urge CMS to wait for completed NQF review and endorsement to ensure that important information regarding social determinants of health is sufficiently captured by this code, and that the code is consistently and reliably recorded so that this eCQM is truly informed by precise clinical and patient-level data.

We recognize the difficulty of developing measures for maternal health. The patient population is not homogenous, and outcomes are influenced by a complex web of factors. We appreciate the efforts in which CMS and its contractors have engaged, and are hopeful that the agency can identify measures that accurately and meaningfully contribute to improving the quality of care for mothers and babies.

**Hospital Harm — Opioid-related Adverse Events eCQM.** **The AHA supports adding this proposed measure to the menu of available eCQMs in the IQR and Promoting Interoperability Program.** The measure assesses the proportion of inpatient hospital encounters where adult patients have been given an opioid medication and are administered naloxone within twelve hours of receiving that medication. In other words, the measure seeks to determine whether hospital staff administered the wrong medication dose, improperly monitored the patient, or failed to recognize medication interactions when providing a patient an opioid during the inpatient stay, resulting in a preventable adverse event that must be mitigated with naloxone. We appreciate the refinements made to this measure over the past few years. For example, CMS has appropriately excluded patients to whom naloxone was administered in the O.R. (these events were also found to be challenging to extract in a structured EHR field) and uses a time window of 12 hours, which would more likely exclude patients who had ingested opioids in the community and received naloxone in the hospital.

**Global Malnutrition Composite eCQM.** **The AHA does not object to the addition of this measure to the menu of available eCQMs in the IQR. However, we question its relative value in the IQR, and would urge CMS not to require its reporting in future years.** This proposed measure is intended to assess whether hospitals are screening for, documenting and developing plans to address malnutrition identified among elderly patients. Specifically, the measure assesses adults age 65 and older admitted to inpatient hospital services who received care appropriate to their level of malnutrition risk and diagnosis. In short, the measure focuses on the *documentation* of malnutrition status and plans to address it, but it does not directly assess whether patients actually receive appropriate nutrition while in the hospital, or whether their nutritional status or needs were met after they are discharged.

Furthermore, we are concerned by the potential overlap and duplication of this measure with CMS's proposed HRSN screening measure, which includes food insecurity as one of the five HRSNs for which hospitals would screen. We certainly agree that nutrition and food insecurity are important social needs. Yet, as discussed in our response to the proposed HRSN screening measures, fully addressing those needs goes well beyond what can be achieved during an inpatient hospitalization, or by a hospital alone.

**Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).** This proposed measure blends data

from multiple sources — including some data that hospitals would collect from patients and submit to CMS — to assess patient functional improvement following elective hip and knee replacement procedures. A version of this measure was implemented for voluntary reporting as part of CMS's Comprehensive Care for Total Joint Replacement (CJR) model. If finalized, it would be the first required patient-reported outcome measure (PROM) to be part of the IQR program. Initially, the reporting of the measure would be voluntary, with CMS implementing two voluntary data reporting periods, followed by mandatory reporting starting Jul. 1, 2025.

**The AHA supports the voluntary reporting of this measure, but urges CMS not to mandate its reporting at this time.** The AHA agrees with the value of PRO measures for hospital quality improvement, and potentially, for use in federal quality reporting programs. However, as noted in the eCQM reporting section of this comment letter, the AHA is very concerned that the sheer number of new quality and EHR-related reporting requirements that CMS has finalized and proposed could be unsustainable for hospitals. The proposed PRO measure would require hospitals to report 17 distinct data elements in the pre-operative period, and another 10 elements in the post-operative period. We believe that voluntary reporting would enable hospitals to gain experience with the measure, and help all stakeholders better judge whether the widespread adoption of the measure strikes the right balance of administrative burden and value.

Furthermore, elective THA/TKA procedures are increasingly migrating from the inpatient to the ambulatory setting. This could make it more challenging to have a substantial number of hospitals that can meet the minimum case threshold. This shift also makes it possible that the patients receiving THA/TKA procedures on an inpatient basis will be sicker and more complex. We would ask CMS to carefully consider how it publicly reports the measure, and would warn against direct comparisons of inpatient hospitals to either outpatient departments or ASCs.

Lastly, the proposed measure would require data collection in both the pre- and post-operative time periods. This makes it possible that patients may not respond to the post-operative survey, thereby making it impossible to calculate a score. It is not clear whether CMS has set a match rate that it expects between pre- and post-operative data. We would urge CMS to use the voluntary reporting process to set a realistic matching percentage for these assessments.

**Medicare Spending per Beneficiary (MSPB). The AHA does not support CMS's proposed update the MSPB measure.** We are especially concerned by CMS proposal to permit readmissions to trigger new episodes that could count in calculating a hospital's MSPB performance. We believe this approach could lead to the same costs being attributed to hospitals twice, thereby providing a misleading portrayal of hospital performance. Furthermore, the measure's NQF endorsement review suggested the measure's reliability and validity were quite low. Lastly, we

continue to be concerned by the lack of social risk factor adjustment in calculating MSPB measure performance.

THA/TKA Complications. CMS proposes methodology updates to its THA/TKA complications measure, and intends for the updated version of the measure to eventually replace the version used in the HVBP program. The measure would now include 26 additional mechanical complication ICD-10-CM codes. **The AHA supports this proposal.**

Refinements to Existing IQR Measures. CMS proposes updates to two of its existing IQR measures. First, CMS proposes to increase the minimum case count to calculate its excess days in acute care after hospitalization for AMI (EDAC AMI) measure beginning with the FY 2024 payment year. CMS also would update its elective THA/TKA payment measure by including the same 26 mechanical complication ICD-10-CM codes that it proposed for the THA/TKA complication measure. **The AHA supports these proposals.**

Maternal Health Designation. As part of the Administration's Maternal Health Action Plan to reduce maternal morbidity and mortality, CMS proposes to establish a publicly reported hospital quality designation specifically focused on maternal health. Hospitals would be awarded this designation based on their positive attestation to both parts of the Maternal Morbidity structural measure that was adopted in last year's rule, but the agency notes that it intends to propose a more robust set of criteria in the future. The designation would be listed on a CMS website beginning in the fall of 2023.

As stated above, the AHA and its members are committed to improving the health of mothers and babies and eliminating disparities in outcomes and quality of care. Through our [Better Health for Mothers and Babies](#) initiative, we have shared a plethora of tools, resources and educational offerings with our members to assist in their work of improving maternal health. Many hospitals already are participating in state and national collaborative efforts aimed at reducing maternal morbidity and find considerable value in leveraging such efforts to identify and implement the practices that are most beneficial to the patients and communities they serve and learning from peer institutions. We appreciate that the Administration and CMS are looking for ways to leverage policy under their jurisdiction to help achieve these goals.

**The AHA does not object to the creation of a quality designation for hospitals that provide exemplary care to mothers and babies. However, we are unsure of the usefulness of the designation as it is proposed in this rule. We also question how the designation will be informed in the future, and CMS's overarching purpose for establishing this program.**

First, receipt of the designation would at least initially be based upon a single measure, which asks whether the hospital 1) is participating in state or national quality improvement



programs related to reducing maternal morbidity and 2) has implemented certain safety practices related to reducing maternal morbidity. We did not object to the implementation of this measure when it was proposed, but we continue to question its long-term value to hospitals, the public and CMS. We believe that hospitals could make more progress — and that CMS and the public would be better informed of this progress — if CMS were to instead pursue measures that more directly assess the quality of maternal care. Because the designation is based solely upon this measure, it suffers from the same disadvantages: hospitals cannot use this measure for benchmarking purposes because all it tells them is whether their peers are participating in improvement projects. We suspect that the overwhelming majority of hospitals will attest positively, suggesting the designation will not be helpful in differentiating hospitals providing excellent care.

This raises the question of what CMS hopes to achieve with this designation. If it is to identify hospitals providing model care to help consumers make decisions about where to deliver their babies, this designation would not provide actual performance data on maternal morbidity and would likely apply to most (if not all) hospitals in an individual market. If the purpose of the designation is to encourage hospitals to improve maternal care, it would be redundant with the structural measure. If the purpose is to call attention to the importance of maternal care, this strategy is far weaker than the extensive work and advocacy occurring in the field.

We understand that CMS is limited in measures it can use to inform the designation at this time, as the IQR currently only includes three perinatal care measures — the structural measure, PC-01: Elective Delivery and PC-05: Exclusive Breast Milk Feeding (although the agency is not proposing to include the two PC measures in this designation, which we question). Developing process and outcomes measures for maternal and newborn care is a complex undertaking that will require time, stakeholder participation, measure testing and NQF endorsement to ensure that any measures are accurate, reliable and feasible to implement. Given the importance of the issue, this work is vital.

CMS notes that it intends to propose additional criteria, including additional measures that may be added to the IQR, for awarding this designation in future notice and comment rulemaking. The agency specifically references the two maternal quality eQMs proposed for adoption in this rule, Severe Obstetric Complications and Cesarean Birth. While the former measure has promise for providing relevant and actionable data on quality of care, the latter measure is not an appropriate indicator of performance and we would not support its inclusion in the criteria for this designation. We also worry that CMS could choose criteria or metrics outside of the IQR, such as invalidated patient experience information, facility characteristics like onsite NICU or specialty practitioners, or quality measures that have not gone through the NQF review and endorsement process. Such criteria would be unreliable markers of quality performance and could result in this federal designation transforming into a subjective report card.

In summation, we encourage CMS to more clearly articulate the purpose of this designation and how it aligns with the agency's goals for advancing maternal care. Without a clear path, it is difficult to select appropriate metrics in order to make progress. We encourage the agency as well as the rest of the field to engage with AHA's Better Health for Mothers and Babies initiative, which provides case studies, tools and resources, and updates on the latest research as well as specific resources on addressing maternal mental health and health equity in maternal and child care. Together we can save lives of mothers and babies with evidence-based clinical innovations and community partnerships.

## **REQUEST FOR INFORMATION: OVERARCHING PRINCIPLES FOR MEASURING HEALTH CARE QUALITY DISPARITIES ACROSS CMS QUALITY PROGRAMS**

Hospitals and health systems share CMS's deep commitment to advancing health equity within their organizations and in the communities they serve. Our members are eager to engage with CMS as it considers health equity policy approaches across its programs. Given that one of the primary aims of health equity efforts is to eliminate disparities in quality performance and outcomes, the AHA believes that there is a role for health equity-related measures in CMS's quality measurement programs. However, as discussed above, there are both practical and conceptual challenges to developing meaningful and actionable health equity measures, limits to what quality measures alone can achieve, and potential unintended consequences that could stem from inappropriate use of quality measure data.

We appreciate CMS using the proposed rule to solicit feedback on overarching guiding principles to measuring health disparities. We agree with CMS that its efforts should prioritize using existing clinical quality measures that have evidence of disparities in treatment and outcomes. We also appreciate CMS's attentiveness to methodological issues such as ensuring adequate sample sizes for reliable comparisons.

CMS's RFI also discusses what data elements the agency could consider using in stratifying hospital performance, including both patient-level data from administrative sources, and "imputed" indices that use available sources to estimate the social risk and demographic composition of communities. The AHA believes that patient level data remain the "gold standard." However, depending on the proposed application, both sources of data could have some potential utility. We suspect that for measures that are focused on hospital practice and outcomes, patient-level data likely will be of greater utility. However, for measures that encompass outcomes that depend on community factors — such as readmissions, mortality, cost — the use of imputed indices could provide insights on the differences in the types of communities that hospitals serve, and may help with comparison among different providers. That said, we would be reluctant to support imputed indices in things like risk adjustment, peer grouping and other comparative performance applications unless CMS tests their use on specific measures and scoring methodologies.

Lastly, as CMS continues to develop health equity policy related to quality measurement and the use of data, the AHA offers the following additional recommendations to guide the agency's work:

- **Focus hospital health equity measures on hospital-level practices and data.** Hospitals believe the foundation of their work to advance health equity should be to eliminate any disparities in their care stemming from race, ethnicity, gender, sexual orientation or other demographic characteristics. The measures CMS selects for implementation should focus on the structures, processes and outcomes that hospitals are most able to influence and that are shown to have a meaningful impact on improving health equity.
- **Employ approaches to accountability that promote collaboration, not competition.** The AHA believes that advancing health equity is of such universal importance that it is vital for all public and private stakeholders to collaborate and learn from one another to address it. That is why we believe CMS should not use health equity measures in its value programs such as VBP, HAC Reduction program and the HRRP. In addition, as noted in our response to the HRSN screening measures, hospitals alone cannot solve the persistent health inequities stemming from HRSNs. Addressing these challenges takes collaboration and resources from public and private sector partners. We would urge CMS not to use policy approaches that inappropriately hold hospitals accountable for community-level outcomes that they may not be able to control.
- **Ensure any health equity-related measures are appropriately specified and tested before implementation.** Given the urgency of addressing health equity, we understand CMS's desire to get health equity measures into its programs expeditiously. However, we are concerned that none of the three proposed health-equity related measures has been fully tested in hospitals or endorsed by NQF. These steps are critically important for ensuring measures are accurate, reliable, feasible to collect and actionable. In earlier sections of the letter we offered recommendations for how to make CMS's three proposed measures more workable for hospitals in the short-term. However, for future equity measures, we urge CMS to adhere to its typical practice of measure testing and endorsement prior to adoption in hospitals.
- **Establish feedback loops to ensure health equity quality measures keep up with evolving practices in the field and measurement science.** As hospitals accelerate their commitment and resources to address health equity, we expect "best practices" will evolve and emerge. CMS develop mechanisms to track these changes in practices, assess how well its existing health equity measure align with those approaches, and be prepared to develop new measures or retire existing

ones where necessary. CMS could consider using a Technical Expert Panel or other mechanism to advise it on this process.

- **Work to foster alignment and standardization of approaches to collecting, analyzing and exchanging demographic and social risk data.** This includes a consistent approach across CMS itself, and across other federal agencies and programs. Given the breadth of health equity issues, and the wide range of stakeholders affected by it, CMS can help ensure that all stakeholders use consistent definitions and standards. Furthermore, such standards should be thoroughly field tested before broader implementation.
- **Prioritize the use of extant data to which CMS itself may already have access before considering new data reporting requirements.** For example, to the extent CMS is collecting demographic and social risk data during the time of enrollment in Medicare, the agency should explore ways of improving its accuracy, and determine whether the data could be linked to quality measure data for hospitals and other health care providers. These steps could help provide additional data for CMS's efforts to identify disparities in performance and outcomes, while reducing the need for additional data collection by hospitals and other providers.

## **HOSPITAL INFECTIOUS DISEASE DATA REPORTING CONDITION OF PARTICIPATION FOR COVID-19 AND FUTURE PUBLIC HEALTH EMERGENCIES**

In 2020, CMS adopted a condition of participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 and other acute respiratory illnesses (i.e., influenza) to HHS. While the CoP was written to expire at the conclusion of the COVID-19 PHE, CMS suggests its need to monitor the impact of the pandemic could extend beyond the current PHE. As a result, CMS proposes to revise the COVID-19 hospital data reporting CoP it adopted in 2020 so that hospital COVID-19-related reporting would continue after the conclusion of the current PHE through April 30, 2024, unless the Secretary establishes an earlier end date. The broad data reporting categories proposed in the rule align with current reporting requirements.

In addition, CMS proposes to establish a new CoP for future public health emergencies that would require hospitals and CAHs to report certain data to the CDC in the event of a PHE declaration for an infectious disease. CMS proposes several broad categories of data that it could ask hospitals to report. CMS also proposes that it would generally require hospitals to report person-level information on each applicable infection (confirmed and suspected) and if applicable, vaccination data at the person-level. This person-level data would need to include a medical record identifier, race, ethnicity, age, sex, residential county, zip code and relevant co-

morbidities for affected patients. Finally, CMS would generally require hospitals to report request data to the CDC on a daily basis.

**As the AHA [noted](#) in our November 2020 letter, we object to the needlessly heavy-handed approach CMS and HHS have used to compel hospitals to report COVID-19 data to the federal government. We urge CMS to let its current COVID-19 data reporting CoP expire at the end of the COVID-19 PHE, and work in a collaborative fashion with hospitals to obtain a streamlined set of COVID-19 related data.**

**Furthermore, we are deeply troubled by the unrealistic scale and scope of the data collection CMS seeks to require in future infectious disease-related PHEs.** Just as with COVID-19, we expect that another infectious disease pandemic would require hospitals to be fully and rapidly engaged in saving the lives of those suffering from the infectious disease as well as those who need other types of emergent and urgent care. In addition, they will likely be standing up additional treatment spaces, supporting staff dealing with tremendously stressful situations, and seeking needed supplies. To assume that hospitals will be able to engage staff in taking on a new and burdensome data collection in the middle of all of these other activities is misguided. **Rather than jeopardizing hospitals' Medicare participation status through the establishment of unrealistic reporting requirements, CMS, HHS and other relevant federal agencies should take thoughtful, long-term steps to invest in the infrastructure needed to make the sharing of important data on infectious diseases less burdensome and more meaningful.**

COVID-19 Data Reporting CoP. The AHA's opposition to the use of CoPs to compel reporting should not be construed as an unwillingness to share important data on the COVID-19 pandemic with the federal government. In fact, the evidence is clear that hospitals were more than willing to voluntarily report important COVID-19 data to the government. Prior to the issuance of the 2020 interim final rule, the federal government itself repeatedly noted that 94% of hospitals were reporting requested data. That is because hospitals and health systems have understood the critical value of providing COVID-19 related data — such as the number of COVID-19 positive patients, number of intensive care unit (ICU) beds available — and take seriously our role in the data collection and submission process. Hospitals have dedicated substantial staffing and technical resources to meet the numerous, frequently shifting and sometimes inconsistent requests for data at the local, state and national level. That is why it was so disappointing to hospitals and health systems to see their good faith collaboration with the government to provide data to inform the federal response to COVID-19 pandemic set aside in favor of a regulatory approach that threatens not only their financial viability, but ultimately, access to the care their communities depend upon.

**Furthermore, the AHA continues to believe that CMS's COVID-19 data reporting CoP is inconsistent with the core intent of Medicare's CoPs, which is to set health and safety standards for the delivery of health care. The same would be true of a data**

**reporting CoP tied to a future PHE.** As CMS has stated, CoPs are “health and safety standards [that] are the foundation for improving quality and protecting the health and safety of beneficiaries.” CMS has asserted that these data reporting CoPs fit within its Infection Control standards. Yet, as important as the data hospitals are sharing with the federal government are, none of the COVID-19 data are direct or even indirect reflections of hospital infection control policies or practices. Rather, they are important but largely descriptive public health information about numbers of infections, bed capacity, supplies of equipment and therapeutics and so forth. Again, we are not suggesting that reporting COVID-19 data is unimportant. However, it is a stretch of logic to suggest that reporting data that are not directly about the health and safety of care delivery can be the basis for developing and implementing a CoP. Furthermore, we believe CMS’s interpretation of CoPs here sets a troubling precedent of relying on CoP-level enforcement to meet any demand the agency seeks to impose upon hospitals and health systems. Rather than continuing to improperly employ such a heavy-handed approach, the agency should consider a more collaborative approach with hospitals and health systems while bolstering nationwide public health capabilities.

Notwithstanding their objections to the use of CoPs for COVID-19 data reporting, hospitals have continued to make every effort to comply with what CMS has asked of them, and compliance with the CoP is nearly universal. We also appreciate that HHS and CMS have reached a modicum of stability in both the data elements they have asked hospitals to report, and in the data submission mechanisms used. CMS and HHS have also established more reliable mechanisms for communicating changes to reporting and giving hospitals time to comply with these changes.

**The AHA understands the potential need for the federal government to continue to have some key data elements on the status of COVID-19 even after the PHE ends.**

We believe the optimal approach to obtaining these data would be to:

- Let the COVID-19 data reporting CoP expire at the end of the PHE, and re-establish HHS’s voluntary mechanism to collect COVID-19-related data;
- Retain the reporting guidance, portals and process that HHS has already established so that hospitals still have a usable mechanism to share data with the government; and
- Streamline the number of requested data elements and reduce the frequency of reporting.

If CMS is intent on retaining its COVID-19 data reporting CoP, our recommendations around reporting process and streamlining data elements would still apply. We encourage CMS and HHS to engage hospitals and health systems in a dialog about how frequently data would be needed to monitor COVID-19 status, and what data elements would be necessary. At a minimum, we believe reporting frequency could be reduced to weekly, and perhaps even to every other week or monthly. Furthermore, we believe that most of the data fields around supplies could be sunset. We also note that the worker COVID-19

vaccination fields are redundant with CMS's mandatory IQR measure on health care personnel vaccination rates, and recommend it be removed from reporting.

**With respect to CMS's proposed data reporting CoP for future PHEs, the AHA is very concerned by CMS's proposal to request patient-level data on each applicable infection (confirmed and suspected) and if applicable, vaccination data at the person-level.** Hospitals and health systems already have struggled to marshal the resources necessary to provide HHS with aggregate-level data during the COVID-19 PHE. The collection of patient-level data would entail significantly more effort, and would require not only internal system changes, but also changes at the bedside in order to collect new information from patients in an accurate way. The unprecedented stress and strain placed on our health care workforce during the COVID-19 pandemic should make us all question the viability and sustainability of asking them to effectively serve as data entry personnel. For smaller hospitals with fewer resources, it also raises the very real potential that data collection could come at the expense of delivering patient care and maintaining access to care.

In addition, the transmission of patient-level data to the federal government raises numerous concerns about how to ensure sensitive health information is de-identified and protected. It is also unclear what data infrastructure the CDC and CMS have to accept the volume and detail of data that would stem from a requirement to report patient-level data. A lack of appropriate infrastructure could lead to confusion. It also could lead to hospitals Medicare participation status being threatened by an inability to submit data due to either unavailable or poorly functioning systems.

For these reasons, we urge CMS not to finalize its proposed data reporting CoP for future PHEs. Instead, we urge CMS and other federal agencies to focus its efforts on building out the infrastructure our nation desperately needs for sharing important public health information between health care providers and federal and state agencies. For example, we were heartened by the U.S. Digital Service's efforts during the COVID-19 pandemic to explore automated approaches to reporting COVID-19-related data, and relieve the data entry and collection burdens of hospitals. We believe HHS, CMS and CDC should pursue further efforts to lower the data collection and reporting burden posed by PHEs so that hospitals can focus on delivering care, and hospitals and the federal government alike can focus on *using* the data to more effectively respond to pandemics.

## **REQUEST FOR INFORMATION: CLIMATE CHANGE AND HEALTH EQUITY**

We appreciate CMS' focus on the important issue of climate change and its intersection with the U.S. health care sector. The AHA, in collaboration with the American Society for Health Care Engineering (ASHE), a professional membership group of the AHA, has developed and made available several tools and resources aimed at improving sustainability. These tools provide immediate, achievable steps that can be taken, as well as longer-term organizational restructuring to de-silo environmental sustainability issues and capital investment considerations. While many of the AHA's hospitals and health

systems take advantage of these programs, significant challenges and barriers exist that prevent other hospitals from being as actively engaged in these efforts to reduce their carbon footprint.

As an organization that represents nearly 5,000 hospitals and health systems, our members include a broad and diverse group of providers. While several of our members are far along in their sustainability efforts, some are in the infancy of their work in this space, while still others have yet to begin and are only starting to determine how to approach this issue. Recognizing these differences from hospital to hospital, the AHA and its professional membership groups do not believe a “one-size-fits-all” approach is in the best interest of achieving this goal. Rather, we urge CMS to take into consideration the circumstances of each hospital and health system and how these circumstances govern their path forward. As we continue to take steps to provide hospitals and health systems with tools and resources aimed at increasing environmental sustainability, we discover how each hospital’s needs and circumstances may dictate a different approach to this work. For example, older physical structures may not be able to undergo the same type of retrofitting of heating or cooling systems compared to a newer facility, and the heating and cooling needs will vary based on the climate found in that location. Certain geographic locations require different approaches to remain resilient and sustainable.

As the importance of this work continues to grow as a focus of our membership, several factors play into the varied sustainability progress across America’s hospitals and health systems, including resource allocation, workforce expertise, organization-wide engagement and other competing challenges. The top priority for our members is to provide high quality effective and efficient care to patients, which requires a thoughtful balancing of priorities, ensuring regulatory compliance and taking steps to ensure continuity of health services to their respective communities. In addition, the COVID-19 pandemic has created increased strain on our members through ramping up operations to meet capacity needs, managing financial shortfalls and navigating significant workforce challenges.

**As our members engage more in sustainability efforts, the AHA urges the agency to take into consideration the multitude of financial, professional and regulatory challenges that our members face so that we can determine the most meaningful and beneficial approach to supporting the field.**

Finally, we must be clear that, while the AHA is deeply involved in work to prepare our members with efforts to reduce their carbon emissions, **we have serious concerns whether HHS has the legal authority to impose requirements on hospitals to address threats created by climate change.** See, e.g., *City of Providence v. Barr*, 954 F.3d 23, 45 (1st Cir. 2020) (“Here, the DOJ took an impermissible shortcut when it attempted to impose the challenged conditions on the Cities’ FY2017 Byrne JAG grants—conditions that Congress had not vested the DOJ with authority to impose.”); *City of Chicago v. Barr*, 916 F.3d 276, 820 (7th Cir. 2020) (“The imposition of the challenged



conditions in this manner is an abrogation of the legislative process.... Accordingly, we affirm the grants of declaratory relief as to the declarations that the Attorney General exceeded the authority delegated by Congress in the Byrne JAG statute, 34 U.S.C. § 10151 et seq., and in 34 U.S.C. § 10102(a), in attaching the challenged conditions to the FY 2017 and FY 2018 grants, and that the Attorney General's decision to attach the conditions to the FY 2017 and FY 2018 Byrne JAG grants violated the constitutional principle of separation of powers.”); see also *South Dakota v. Dole*, 483 U.S. 203, 207-08 (1987) (“[C]onditions on federal grants might be illegitimate if they are unrelated “to the federal interest in particular national projects or programs.” (quoting *Massachusetts v. United States*, 435 U.S. 444, 461, 98 S.Ct. 1153, 1164, 55 L.Ed.2d 403 1978) (plurality opinion)). If the agency attempted to impose any such requirements, it must thoroughly explain its statutory and constitutional authority to do so.

Moving forward, we stand ready to partner and work with other stakeholders in the field — specifically the U.S. medical device and pharmaceutical supply chains, which are the sector’s largest contributors to carbon emissions — to significantly improve the health care sector’s environmental sustainability and hope CMS will offer support and tools to hospitals and health systems as they continue to take steps to reduce their carbon footprint.

#### **REQUEST FOR PUBLIC COMMENTS: IPPS PAYMENT ADJUSTMENT FOR N95 RESPIRATORS THAT ARE WHOLLY DOMESTICALLY MADE**

We appreciate CMS’ recognition of the significant and costly supply challenges America’s hospitals and health systems have been forced to navigate throughout the course of the pandemic. Specifically, the agency’s focus on the difficulties of acquiring an adequate supply of N95 respirator masks demonstrates a keen awareness of the hurdles our members have faced, especially during the height of COVID-19 surges across the country. To be clear, N95s were, and remain, critical in keeping not only health care workers safe, but also their patients. However, the supply acquisition difficulties experienced by our members were not and are not limited to N95s, and many of these difficulties, while exacerbated by the pandemic, existed prior to the onset of COVID-19. For example, in the months prior to COVID-19’s emergence, surgical kits, gowns and gloves were in dire short supply due to the temporary shutdown of a manufacturing facility in China as a result of quality control concerns. The onset of COVID-19 made those types of shortages more acute and as America’s hospitals and health systems continue to weather the COVID-19 storm, they have been met with shortages of additional critical supplies, like ventilators, tubing components for medical devices, testing supplies and contrast media, to name a few. **There is no doubt that the scale and severity of supply shortages and the impact those shortage have on providers and patients require a rethinking of how the supply chain should function for not just N95s, but many medical supplies. To achieve this goal, actions that go well beyond the introduction of Medicare reimbursement mechanisms is necessary.**

Moving forward, restructuring the national medical supply chain will require significant private and public sector coordination and investment. Part of the solution must include

efforts to “fatten” the otherwise fragile and easily disrupted supply chain that currently exists. Transitioning from a lean, “just-in-time” method, to a more stable, reserve on-hand approach can help alleviate the immediate impact of future disruptions. Another piece of the solution, as CMS rightfully suggests, is to incentivize increased domestic manufacturing in an effort to not only expand capacity, but mitigate potential disruptions. However, it is worth noting that, while increases in domestic production capacity play an important role in mitigating disruptions, efforts to incentivize manufacturing near-shore also are vital. Moving forward, establishing more redundancy and taking steps to diversify the medical supply chain will be imperative in ensuring adequate availability of medical supplies even during unprecedented demand like we witnessed during the peak of COVID-19.

**The AHA wants to be clear that we agree with the agency that increased domestic manufacturing of medical supplies is vital to reforming the medical supply chain, but much more beyond CMS’s control must be done.** While we appreciate the agency’s novel approach to incentivizing domestic manufacturing of N95 respirator masks, we have identified several potential unintended consequences of the agency’s proposal and also express some concern with the long-term viability of such an approach. Given those limitations, **we appreciate CMS recognition of a need to assist our members in supply acquisition, but believe large-scale supply chain reform is necessary and are concerned the proposed reimbursement proposals by the agency are unlikely to achieve broad change.**

**That said, we support CMS’s proposal to increase Medicare reimbursement for those hospitals that purchase domestically manufactured N95 respirators. We also urge CMS to make any additional payment in a non-budget neutral way.** We offer a series of questions that raise pertinent issues and set forth several potential unintended consequences. Specifically, we offer the following:

- Has CMS considered the disadvantages this may pose for hospitals and health systems that serve a significant number of Medicaid patients as this proposal only would apply to Medicare fee-for-service patients?
- Medicare fee-for-service utilization varies state-by-state across the country. In those situations, has the agency considered the potential lack of a level playing field that may exist for providers depending on the state(s) in which they operate?
- In its proposal, the agency suggests that hospitals, either on a claims basis or on a bulk basis, would be required to report how many domestically N95 masks were purchased. This poses a series of potential challenges. First and foremost, has the agency considered the increased reporting burden this will have on hospital staff and frontline workers? Rather than require providers to track this

level of information, requiring manufacturers to meet new labeling and reporting requirements that would be more efficient and less burdensome.

- As with many products, it can be difficult to ascertain whether a product was manufactured domestically or abroad. Has the agency considered the challenges associated with confirming whether a product was manufactured domestically and has it determined how it intends to define “manufacturing origin”?
- While CMS’ proposal to increase reimbursement in an attempt to offset increased costs associated with purchasing domestically manufacturer N95s is an innovative approach, the offset in and of itself may not result in a significant decrease in cost for providers given the increased price associated with the purchase of domestically produced N95 respirator masks.
- N95 respirator masks remain critical in combatting COVID-19; however, demand for specific supplies changes based on need and market availability. Our current supply chain requires reform that expands far beyond N95 production diversification in an effort to bolster overall medical device availability moving forward. In addition, it is unclear which products will be most critical in responding to the next pandemic. Given that uncertainty and the broad reforms necessary to mitigate future challenges, we are concerned that the agency’s focus solely on the domestic manufacturing of N95 respirator masks may fail to recognize the need for other products to care for patients.
- While this lays outside of CMS’s exclusive authority, has the agency considered coordinating with broader efforts to incentivize manufacturers to establish efficient, sustainable, and long-term domestic and near-shore production capabilities? Many of these conversations currently are ongoing and those efforts present an opportunity for substantial positive changes to our medical supply chain that stretch well-beyond provider reimbursement.



REPORT

# Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System

## Overview

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule for the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS), projecting a market basket update of 3.1 percent, to be reduced by a 0.4 percent productivity adjustment.<sup>1</sup> This year marks the third consecutive rate setting period mired in pandemic-related uncertainty. While federal relief funding sustained hospitals and health systems through the initial waves of COVID-19, providers continue to grapple with myriad financial pressures, from supply chain disruptions to labor shortages to rising inflation. FTI Consulting's analysis finds that reliance on lagging indicators of hospital costs to determine prospective market basket and productivity adjustments in this highly dynamic and uncertain health care environment would likely result in significant underpayments to acute care hospitals in FY 2023.

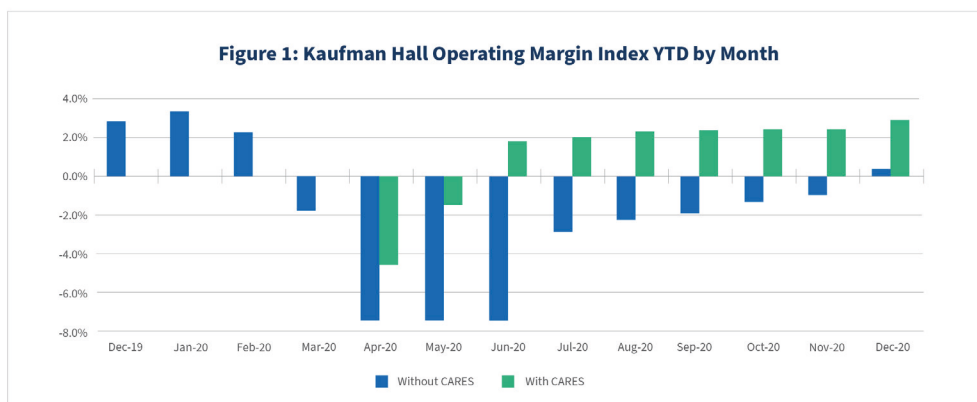
<sup>1</sup> FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. <https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps>.

## Background: Financial Condition of U.S. Hospitals *Impacts of COVID-19 Continue to Reverberate*

The U.S. health care system has undergone a period of severe disruption in recent years driven by the COVID-19 pandemic and record-high inflation. In the early stages of the pandemic, hospitals curtailed elective procedures to free up capacity to care for COVID-19 patients while demand for emergency services dropped as a result of lockdowns.<sup>2,3</sup> Coupled with a rise in the number of uninsured patients, this dramatic decline in patient volume cut off many hospitals' most essential revenue streams,<sup>4</sup> just as the cost of providing care began to rise. Although Congress and the Biden Administration implemented numerous policies to lessen the adverse impact of the pandemic, including the creation of the Provider Relief Fund (PRF), which allocated over \$170 billion to health care providers,<sup>5</sup> financial challenges persist for many hospitals.

Though many hospitals have long struggled to stay afloat on narrow margins, the COVID-19 pandemic put additional,

unforeseen strains on hospitals and health systems, particularly in rural and underserved areas. Skyrocketing expenses – driven by the rising cost of supplies, supply chain issues, and labor shortages – led to a 14.4 percent increase in labor expenses per adjusted discharge in 2020 compared to pre-pandemic levels.<sup>6</sup> As a result of this and other pandemic-related challenges, hospitals' median operating margins fell 55.6 percent in 2020 and have yet to fully recover (Figure 1).<sup>7</sup> More recently, during the peak of the Omicron surge in early 2022, government assistance to hospitals was insufficient to fully offset inflationary pressures, alongside continuing supply chain challenges, and widespread labor shortages that caused wage escalation, leaving many hospitals in the red.<sup>8</sup> In April 2022, total expenses and total labor expenses were 25.2 and 26.2 percent higher than 2020 levels, respectively.<sup>9</sup> As federal COVID-19 funds are depleted and inflationary pressures continue to escalate, hospitals are likely to remain embroiled in a precarious financial position throughout the remainder of 2022 and into FY 2023.



Source: "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021.

<sup>2</sup> Mattingly, Aviva S., Liam Rose, Hyrum S. Eddington, Amber W. Trickey, Mark R. Cullen, Arden M. Morris, and Shery M. Wren. "Trends in US Surgical Procedures and Health Care System Response to Policies Curtailing Elective Surgical Operations During the COVID-19 Pandemic." JAMA Network Open. JAMA Network, December 8, 2021. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786935>.

<sup>3</sup> Hartnett, Kathleen P., Aaron Kite-Powell, Jourdan DeVies, Michael A. Coletta, Tegan K. Boehmer, Jennifer Adjemian, and Adi V. Gundlapalli. "Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019–May 30, 2020." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, June 11, 2020. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm>.

<sup>4</sup> Boserup, Brad, Mark McKenney, and Adel Elkbuli. "The Financial Strain Placed on America's Hospitals in the Wake of the COVID-19 Pandemic." The American Journal of Emergency Medicine. Elsevier Inc., July 2021. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7347328/#:~:text=The%20financial%20strain%20created%20by,the%20current%20surge%20in%20unemployment>.

<sup>5</sup> Biniek, Jeannie Fuglesten, Nancy Ochieng, MaryBeth Musumeci, and Tricia Neuman. "Funding for Health Care Providers during the Pandemic: An Update." KFF, January 27, 2022. <https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/>.

<sup>6</sup> "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021. <https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2021>.

<sup>7</sup> "High Hospitalization Rates, Consumer Fears Hit Hospitals, Physician Groups Hard." Kaufman Hall, January 25, 2021. <https://www.kaufmanhall.com/news/high-hospitalization-rates-consumer-fears-hit-hospitals-physician-groups-hard>.

<sup>8</sup> Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. <https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022>.

<sup>9</sup> Ibid.

Even setting aside pandemic-related pressures, Medicare has historically under-reimbursed hospitals for their services, putting them in a deficit position. Hospitals' aggregate Medicare margins have ranged from -5.4 percent to as low as -9.9 percent over the last decade according to the Medicare Payment Advisory Commission (MedPAC).<sup>10,11</sup> In its most recent report to Congress, MedPAC predicted that IPPS hospitals' Medicare margins will be around -9 percent in 2022 even after COVID-19 relief funds are factored in, and nearly -10 percent without COVID-19 relief.<sup>12</sup> These persistent negative margins in uncertain economic times demonstrate the importance of ensuring that adjustments to IPPS payment rates reflect the current financial reality faced by hospitals and health systems.

### Macroeconomic-Level Factors

IPPS, which determines payments for acute care hospital inpatient stays under Medicare Part A, relies on lagging indicators of hospital costs to set reimbursements prospectively.<sup>13</sup> For example, the FY 2023 proposed payment adjustments incorporate FY 2021 Medicare Provider Analysis and Review (MedPAR) data, as well as FY 2020 Medicare Cost Reports, while relying upon a 2018-based market basket to determine cost and expenditure weights and the third quarter 2021 Employment Cost Index (ECI) to predict changes in the price proxies.<sup>14</sup> This results in a projected market basket update of 3.1 percent, which is then reduced by 0.4 percentage points to account for a productivity adjustment.<sup>15</sup> To the extent that historical data are good

**“To the extent that historical data are good predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment.”**

predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment. To that end, these lagging indicators and outdated data do not adequately capture and thereby cannot predict the significant disruptions created by the COVID-19 pandemic for hospitals, health systems, and other providers.

The demand and supply shocks experienced during the early years of the pandemic and continuing well into this year strongly indicate that great caution and consideration must be factored into calculating the market basket and productivity adjustments in setting prospective payment rates. In the FY 2023 IPPS proposed rule, price proxies in the market basket reflect IHS Global Inc.'s (IGI's) fourth quarter 2021 forecast, which is based on a four-quarter percentage change in the moving average. Although these adjustments are based on forecasts using the most recent data available at the time of the proposed rate setting, the results are released on a lagged basis, usually three to four months after preparation of the forecast. As such, they do not adequately account for recent economic trends that have significantly increased costs to hospitals, including labor and inflation.

### Hospital Labor Costs and Workforce Shortages

Hospitals and health systems have been especially hard hit by the workforce shortages associated with the pandemic. The pandemic exacerbated existing shortages of physicians, nurses, and other hospital personnel by increasing competition for workers, as well as driving up the burnout rate among clinicians.<sup>16</sup> With hospital workers stretched to the limit due to the demand for hospital services and the burden of caring for severely ill patients in record numbers, widespread burnout placed enormous pressure on health

<sup>10</sup> “March 2021 Report to the Congress: Medicare Payment Policy.” MedPAC, March 15, 2021. <https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/>.

<sup>11</sup> “March 2022 Report to the Congress: Medicare Payment Policy.” MedPAC, March 15, 2022. <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>.

<sup>12</sup> Ibid.

<sup>13</sup> “FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P.” CMS, April 18, 2022. <https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipp-and-long-term-care-hospitals-ltch-pps>.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> “Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce.” The Office of the Assistant Secretary for Planning and Evaluation (ASPE). Department of Health and Human Services, May 3, 2022. <https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf>.

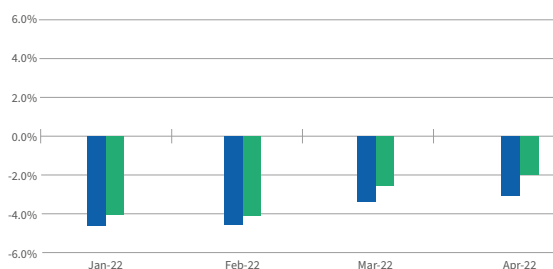
systems to pay more to attract and retain workers. That trend has yet to abate: a March 2022 report from Elsevier Health found that 47 percent of U.S. clinicians plan to leave their jobs in the next two to three years.<sup>17</sup>

Moreover, hospitals face more competition than ever from travel and temporary nurse staffing firms that are attracting a greater share of the workforce with higher pay and more generous benefits, a trend driving up hospital labor costs.<sup>18</sup> The cost of contract labor relative to total labor expenses increased five-fold in 2022 compared to 2019, primarily due to the need to replace departing staff nurses with travel or agency nurses.<sup>19</sup> Median wages for contract nurses reached triple the median wages of employed nurses in March 2022.<sup>20</sup> Due to rising labor expenses coupled with only small increases in volume and revenue, hospitals saw large declines in operating margins in January through March 2022.<sup>21</sup>

Although the inflated wages and benefits offered by traveling and temporary staffing nursing agencies have somewhat moderated in recent months,<sup>22</sup> it is unlikely that the upward pressures on labor costs for hospitals will be mitigated anytime soon. An October 2021 survey by Kaufman Hall indicated that 92 percent of hospitals have experienced challenges in attracting and retaining support staff.<sup>23</sup>

Significant increases in hospitals' labor costs, coupled with workforce shortages, continue to place immense strain on the health care system. All told, as of March 2022, hospital labor expenses had increased by more than one-third relative to pre-pandemic levels.<sup>24</sup> Hospital financials for the first quarter of 2022 returned to worrisome levels due to the Omicron surge in early 2022 (Figure 2).<sup>25</sup> Inflationary pressures within the economy and fierce competition for health care workers will continue to put upward pressure on wages and benefits through 2022 and likely into 2023. Using data that typically lags two to four years to project labor costs in this uncertain economic environment will fail to account for the ongoing staffing challenges faced by acute care hospitals. CMS should recognize in its market basket adjustments how the understated market basket forecasts for 2021 and 2022 due to COVID-19 and inflation are embedded in payments, as well as how upward pressure on wages and benefits, and costs of supplies and pharmaceuticals, will likely be a mid- to long-term factor adversely affecting hospital operating costs and margins.

**Figure 2: Kaufman Hall Operating Margin Index YTD by Month**



Source: Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022.

<sup>17</sup> "Clinician of the Future Report 2022." Elsevier, March 15, 2022. [https://www.elsevier.com/\\_data/assets/pdf\\_file/0004/1242490/Clinician-of-the-future-report-online.pdf](https://www.elsevier.com/_data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf).

<sup>18</sup> Yang, Y. Tony, and Diana J. Mason. "Covid-19's Impact on Nursing Shortages, The Rise of Travel Nurses, And Price Gouging." Health Affairs, January 28, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220125.695159/>.

<sup>19</sup> "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. <https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report>.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Norman, Hannah. "Travel Nurses Raced to Help during Covid. Now They're Facing Abrupt Cuts." NBCNews.com. NBCUniversal News Group, May 8, 2022. <https://www.nbcnews.com/health/health-news/travel-nurses-raced-help-covid-now-facing-abrupt-cuts-rcna27716>.

<sup>23</sup> "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. <https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates-a-challenging-environment>.

<sup>24</sup> "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. <https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report>.

<sup>25</sup> Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. <https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022>.



## Current and Projected Inflation

In an era of historic inflation across the broader economy, the Altarum Institute notes that health care inflation hovers close to its historic average of two percent as a result of prospective rate-setting.<sup>26</sup> This contrasts sharply with the Consumer Price Index (CPI), a measure of general inflation, which hit 8.6 percent over the 12-month period ending in May 2022.<sup>27</sup> The differential exists because health care costs paid by consumers typically reflect rates negotiated in the year prior, rather than the actual cost of inputs borne by hospitals and health systems at the time of care delivery.<sup>28</sup>

In a steady state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. That is the rationale for using historical data and adjusting IPPS

price proxies using the ECI, a measure of compensation costs, despite its reliance on lagging indicators. However, significant changes in the CPI, which measures changes in prices paid by consumers, and the Producer Price Index (PPI), which tracks changes in price experienced by producers, can have a major impact on wage and salary expectations that can feed into future changes to the ECI. Higher inflation can create upward pressure on wage expectations as workers seek an increase in wages to better meet the increasing cost of living. This can be exacerbated when labor is in short supply, as is currently the case in the hospital sector. Figure 3, below shows the major price indices relevant to understanding these inflationary pressures for hospital workers. These data reveal that – despite shocks in price indices over time – the market basket captures these in a muted way that is in stark contrast to what hospitals and health systems actually experience.

**Figure 3: Price Index, Cost Index, and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)**



Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

<sup>26</sup> "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. <https://www.advisory.com/daily-briefing/2022/04/15/inflation-us>.

<sup>27</sup> "Consumer Price Index Summary - 2022 M05 Results." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, June 10, 2022. <https://www.bls.gov/news.release/cpi.nr0.htm>.

<sup>28</sup> "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. <https://www.advisory.com/daily-briefing/2022/04/15/inflation-us>.



Figure 3: Price Index, Cost Index and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2015-2022)

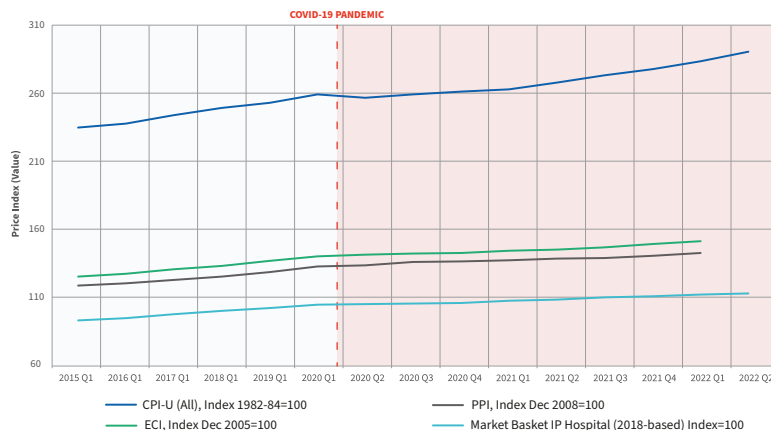


Figure 3: Price Index, Cost Index, and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)



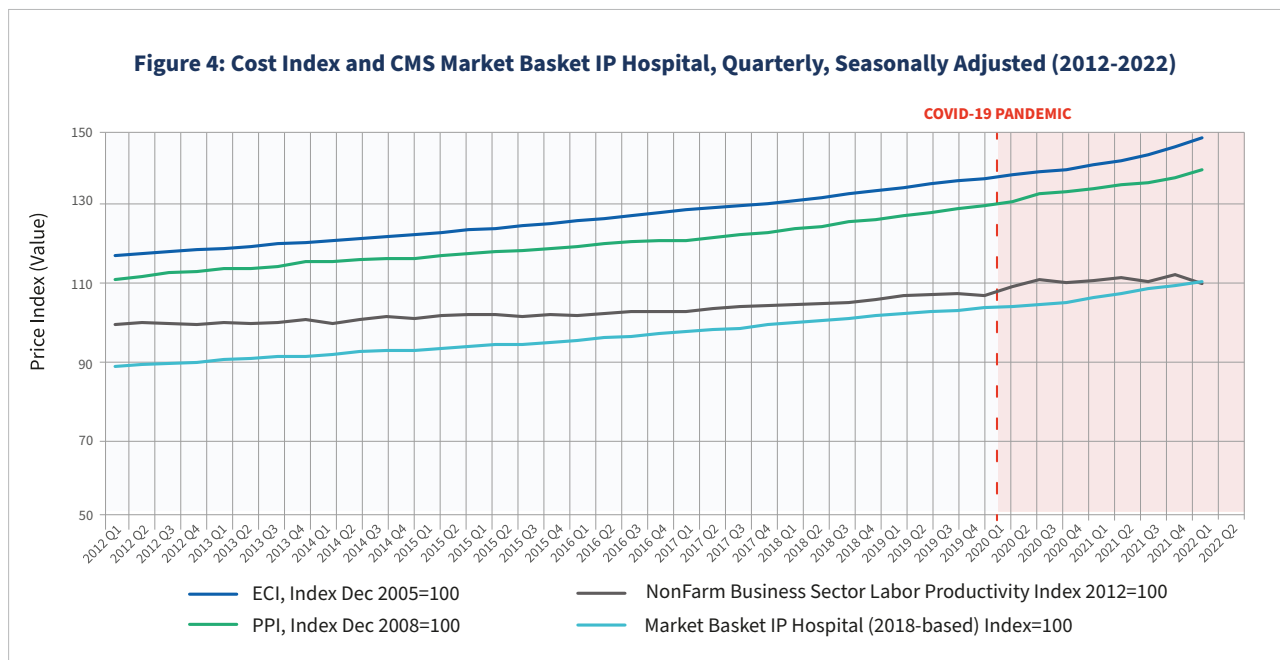
Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

The CPI for All Urban Consumers (CPI-U) for all services shows a significantly steeper upward trend than is reflected in the market basket for inpatient hospital services. Since the start of the pandemic, this growth has exceeded growth in the Market Basket for Inpatient Hospital Services (Figure 3).<sup>29</sup> These more recent inflationary pressures are likely to work their way into wage expectations, particularly in industry sectors where labor is in short supply, thus driving up labor costs even further.

Using the third quarter 2021 data for market basket forecasting, as the FY 2023 IPPS Proposed Rule would do, risks capturing only the very beginning of this upward pressure on prices and wages in the economy (Figure 4).<sup>30</sup> Although the ECI has historically been fairly stable with annual growth rates ranging from a low of about 1.6 percent to a high of 2.8 percent just prior to the beginning of the pandemic, compensation costs have increased rapidly over the past year. From 2.6 percent in April 2021 to the most current estimate of 5.0 percent in January 2022, workers are commanding significantly higher wages. Historical data from the fourth quarter of 2021 misses this continuing upward trend in early 2022.

<sup>29</sup> Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

<sup>30</sup> Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group



Source: Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

Although it may reach its peak in 2022, the high rate of inflation the U.S. economy is experiencing is not projected to abate in the near term, furthering the critical need to consider the likelihood that these inflationary pressures will factor into costs and wage expectations. Fannie Mae projects that inflation, as measured by the CPI, peaked in March 2022 at an annual rate of 8.5 percent, although month-to-month changes may continue.<sup>31</sup> Nonetheless, Fannie Mae forecasts inflation to remain elevated, averaging 5.5 percent in the fourth quarter of 2022.<sup>32</sup> With respect to ECI, the Congressional Budget Office (CBO) projects a 5.4 percent

increase for 2022 and a 4.1 percent increase for 2023.<sup>33</sup> The CBO estimates the ECI increased 5.0 percent in 2021. The CBO's projections typically fall in the middle range of the likely outcomes under current law, suggesting the possibility that the actual increase in compensation costs could be even higher.<sup>34</sup>

Accounting for recent and future trends in inflationary pressures and cost increases in the Hospital Market Basket will be essential to ensuring that Medicare payments for acute care services in FY 2023 more accurately reflect the cost of providing hospital care.

<sup>31</sup> "Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing,'" Fannie Mae, April 19, 2022. <https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing#:~:text=Inflation%2C%20as%20measured%20by%20the,and%20declines%20in%20auto%20and.>

<sup>32</sup> Ibid.

<sup>33</sup> "The Budget and Economic Outlook: 2022 to 2032." Congressional Budget Office, May 25, 2022. <https://www.cbo.gov/publication/58147>.

<sup>34</sup> Ibid.

## Productivity

Under the Affordable Care Act (ACA), CMS is required to annually adjust hospital payments under the IPPS to reflect anticipated gains in productivity over time.<sup>35</sup> The productivity adjustment is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).<sup>36</sup> The measure is intended to contain health care spending by ensuring payments more accurately reflect the true cost of providing hospital care. In the FY 2023 IPPS Proposed Rule, CMS proposes using IHS Global, Inc.'s (IGI's) fourth-quarter 2021 forecast of the IPPS market basket rate of increase, which uses data through third-quarter 2021.<sup>37</sup> This produces a projected productivity adjustment of 0.4 percentage points to the proposed FY 2023 market basket adjustment of 3.1 percent, reducing the update to 2.7 percent.<sup>38,39</sup>

The use of nonfarm business TFP by CMS in its productivity adjustment formula is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills, and changes in production.<sup>40</sup> Using private nonfarm business TFP effectively assumes the hospital sector should be able to mirror productivity gains across the broad private nonfarm business sector. However, in an economy marked by great uncertainty in performance due to the demand and supply shocks of dealing with a public health crisis such as COVID-19, this assumption may generate significant departures from economic reality.

Basing the adjustment on a 10-year moving average of the change in TFP also mitigates large year-to-year fluctuations that might occur. Over the last decade, there have been only four periods of productivity decreases. Notably, two of the periods of decreased productivity occurred during the COVID-19 pandemic – a 0.4 percent decline in July 2021 and a 0.6 percent decline in January 2022.<sup>41</sup> Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. Although the productivity adjustment uses a 10-year moving average for private nonfarm business productivity gains, two declines in this productivity metric should be noteworthy when considering the appropriate payment updates in the FY 2023 IPPS.

CMS has acknowledged the disconnect between Medicare productivity and the 10-year moving average private nonfarm business TFP. A 2016 analysis by the CMS Office of the Actuary (OACT) found that the average growth rate of hospital multi-factor productivity (now referred to as TFP) ranged from 0.1 percent to 0.6 percent compared with the average growth of private nonfarm business multifactor productivity (MFP) of 1.0 percent.<sup>42</sup> More recent research cited in the CMS OACT analysis indicates that hospitals could achieve productivity gains of 0.4 percent per year over the long run compared with an assumed growth in private nonfarm business MFP of 1.1 percent, representing just over one-third (36.3 percent) of the gains in the private nonfarm business sector.<sup>43</sup> Particularly in a period of record inflation and unprecedented public health challenges, using the 10-year moving average nonfarm business sector TFP to adjust the market basket percentage increase could exacerbate Medicare underpayments to hospitals.

<sup>35</sup> "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP\\_Methodology.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf).

<sup>36</sup> "Compilation Of The Social Security Laws." Social Security Administration. Accessed June 1, 2022. [https://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm).

<sup>37</sup> "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP\\_Methodology.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf).

<sup>38</sup> Total factor productivity is calculated as follows:  $TFP\ growth = Output\ growth - [(labor\ input\ growth * labor\ share) + (capital\ input\ growth * capital\ share)]$ . This is a measure of changes in efficiency that cannot be accounted for by the change in total combined inputs (i.e., hours worked, capital and intermediate purchases).

<sup>39</sup> "FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. <https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps>.

<sup>40</sup> Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP\\_Methodology.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf).

<sup>41</sup> "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP\\_Methodology.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf).

<sup>42</sup> Spitalnic, Paul, Stephen Heffler, Bridget Dickensheets, and Mollie Knight. "Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies." CMS, February 22, 2016. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf>.

<sup>43</sup> Ibid.

The COVID-19 pandemic continues to negatively affect hospital services, unlike other areas of private nonfarm business economy. Whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services.<sup>44</sup> Generally, hospital services have been slower to return to pre-pandemic levels,<sup>45</sup> and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the FY 2023 IPPS prospective rate adjustments. An October 2021 survey conducted by Kaufman Hall found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.<sup>46</sup>

CMS currently relies on the most recent TFP forecast available even when economic trends, such as employment and labor productivity, are uncertain or highly variable. Recently, the COVID-19 pandemic, along with the trillions of dollars in relief funds appropriated in response, injected significant volatility into the U.S. economy. This in turn exacerbated the disconnect between projections used in the proposed rules and the most recent data available prior to finalizing the IPPS productivity adjustment. For example, in FY 2021, CMS initially proposed a negative productivity adjustment of .4 percent to the IPPS market basket,<sup>47</sup> which was ultimately set to zero in the final rule.<sup>48</sup>

According to the Bureau of Labor and Statics' (BLS) most recent release on TFP, nonfarm business sector labor productivity decreased 7.3 percent in the first quarter of 2022 as output decreased 2.3 percent and hours worked increased 5.4 percent.<sup>49</sup> This represents the largest decline in quarterly productivity since the third quarter of 1947.<sup>50</sup> This decrease in TFP is more akin to FY 2021 productivity adjustments where a decrease in productivity of 0.1 percent points resulted in a zero productivity adjustment.<sup>51</sup> Here, if the decrease in productivity continues into the second quarter, we should expect to see a significant reduction in the productivity adjustment, possibly even a zero productivity adjustment. It is important to note that the FY 2021 zero adjustment is based on a forecast of a 0.1 percentage point decline in TFP that pales in comparison to the most recent productivity declines.

Significant uncertainty will persist into the first half of 2023, and likely beyond, regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions, and the war in Ukraine) have affected productivity. This uncertainty, as well as the likely greater divergence of hospital services productivity from overall private nonfarm business sector productivity, should be considered in settling on a productivity adjustment for FY 2023.

<sup>44</sup> "Employment Recovery Continues In 2021, With Some Industries Reaching or Exceeding Their Prepandemic Employment Levels." U.S. Bureau of Labor Statistics, May 2022. <https://www.bls.gov/opub/mlr/2022/article/employment-recovery-continues-in-2021.htm>.

<sup>45</sup> Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. <https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022>.

<sup>46</sup> "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. <https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates-a-challenging-environment>.  
text=2021%20State%20of%20Healthcare%20Performance%20Improvement%20Report%3A%20COVID%20Creates%20a%20Challenging%20Environment,-October%2018%2C%202021&text=The%20COVID%2019%20pandemic%20continues,health%20systems%20across%20the%20country.

<sup>47</sup> "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P), CMS, May 11, 2020. <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute>.

<sup>48</sup> "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule (CMS-1735-F)." CMS, September 2, 2020. <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0>.

<sup>49</sup> "Productivity and Costs, First Quarter 2022, Revised." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, May 5, 2022. <https://www.bls.gov/news.release/pdf/prod2.pdf>.

<sup>50</sup> Ibid.

<sup>51</sup> FY 2022 IPPS productivity adjustment was proposed at 0.2 percentage points based on IGI's fourth quarter 2021 forecast of TFP but IGI's second quarter 2021 forecast reflected a significant change in the estimate to 0.4 percentage points for FY 2022. The FY 2021 productivity adjustment proposed was 0.4 percentage points using IGI's fourth quarter 2019 forecast. More recent data based on IGI's June 2020 forecast indicated a -0.1 percentage point growth for FY 2021. As section 1886(b)(3)(B)(xi)(I) of the Act requires a reduction not an increase for the productivity adjustment, the adjustment was set to zero.

## Conclusion: Current Economic Realities Are Not Reflected in Proposed IPPS Update, Put Hospitals' Financial Viability at Risk

As CMS prepares to finalize the FY 2023 IPPS and LTCH PPS Rule – as well as Fiscal Year 2023 Inpatient Rehabilitation Facility (IRF), Inpatient Psychiatric Facility (IPF), and Medicare Hospital Outpatient Prospective Payment System (PPS) Final Rules – considering the ongoing impacts of COVID-19 and recent inflationary pressures will be essential to ensuring the stability and resiliency of the health care system as it emerges from a global pandemic. Hospital operating margins in 2022 reveal the adverse impact of higher costs and a change in the mix of resources needed to respond to new surges and new COVID-19 variants. The proposed FY 2023 IPPS rate adjustment effectively attempts to return to the steady-state lagged adjustment methodology used prior to the pandemic without fully accounting for dynamics like the continuing effects of wage and inflationary pressures. Given the long history of Medicare underpayments, the failure to account for these pressures in the latest IPPS rule will likely exacerbate the deficit in Medicare funding that hospitals already experience and create further challenges for our hospitals and health system, at a time when they remain vulnerable to financial distress.

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