



A Passionate Voice for Compassionate Care

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1785-P

Re: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Dear Ms. Brooks-LaSure:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule published in the *Federal Register* on May 1, 2023 (88 FR 26658). We appreciate the ongoing efforts of CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **Proposed Changes to Payment Rates under the Inpatient Prospective Payment System (IPPS)**

CMS is proposing to update hospital IPPS rates by 2.8 percent in fiscal year (FY) 2024. This rate update equals the hospital market basket of 3.0 percent less 0.2 percentage points for total factor productivity.

CHA believes that CMS should adjust the FY 2024 hospital update for forecast error in the FY 2022 hospital market basket just as CMS is proposing to do for the FY 2024 skilled nursing facility (SNF) update and the FY 2024 capital IPPS update. Upward pressure on hospitals costs that has been occurring throughout the pandemic has not been well represented in past year hospital market baskets, particularly FY 2022. The FY 2022 hospital update was 2.7 percent but

the hospital market basket based on later after-the-fact data was 5.7 percent—a difference of 3.0 percentage points.

The 3.0 percentage point understatement of the FY 2022 market basket results in a permanent reduction in IPPS payments below the rate of inflation. **CHA respectfully requests that CMS adjust the FY 2024 IPPS payment update with a forecast error adjustment for the understatement of the FY 2022 hospital market basket update.**

CMS has proposed to do exactly what CHA requests in two other contexts. For the FY 2024 SNF update, CMS is proposing to increase the market basket update of 2.7 percent by 3.6 percentage points for forecast error in application of the FY 2022 update (88 FR 21321). For the FY 2023 capital IPPS update, CMS is proposing a forecast error adjustment of 0.9 percentage points for an underestimate of FY 2022 capital inflation (88 FR 27229).

In both of these payment systems, CMS is applying the forecast error adjustment based on previously established policy if the difference between the update and the actual rate of inflation using after-the-fact data differs by more than a threshold amount (0.5 percentage points for the SNF update and 0.25 percentage points for the capital IPPS update). Adopting this approach at this point in the instant rulemaking would not run afoul of rulemaking procedures under section 1871 of the Act. CMS has made the inpatient update and the hospital market basket subject to public comment. CHA believes CMS could adopt a forecast error correction to the FY 2024 hospital market basket on the basis that our comment is a “logical outgrowth” of the proposed policy under consideration consistent with section 1871(a)(4) of the Act.

CHA believes the extraordinary circumstances of the pandemic and the large difference between the FY 2022 update and the market basket justify CMS making a 3.0 percentage point adjustment to the FY 2024 hospital market basket update.

- **Documentation and Coding**

Fiscal year 2024 represents the first year that CMS has not made a proposed adjustment to the hospital update for documentation and coding since FY 2008. A series of statutory requirements and regulatory provisions has resulted in CMS making temporary reductions to the IPPS update to recoup additional spending due to documentation and coding that resulted from implementation of the MS-DRGs. Once the recoupment is complete, the statute requires CMS to restore IPPS rates to what they would have otherwise been had CMS not made the recoupment adjustments from FY 2018 through FY 2023 under the provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) and the 21st Century Cures Act. Since FY 2014, CMS had made recoupment adjustments to IPPS rates totaling 3.9 percent. However, CMS only restored 2.9588 percentage points of these reductions (87 FR 48800)—a difference of 0.9412 percentage points.

CMS is required by law to restore this 0.9412 percentage point difference between the recoupment adjustments it has made and the amounts restored to the IPPS standardized amounts since FY 2018. Section 7(b)(2) and 7(b)(4) of the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (TMA)—as subsequently amended by the Taxpayer Relief Act of 2012, MACRA and the 21st Century Cures Act—are explicit that CMS may not carry forward any documentation and coding adjustments applied in fiscal years 2010 through 2017 (excepting FY 2013 where the issue is not applicable) into IPPS rates after FY 2023.

Section 7(b)(2) of the TMA states “an adjustment made under paragraph (1)(B) [documentation and coding] for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges in a subsequent year.” Section (7)(b)(4) of the TMA is explicit as to the particular years in question where documentation and coding adjustments have been applied and for which years they may not be carried forward:

Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) [documentation and coding] other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.”

CHA respectfully requests CMS to restore the full amount of the documentation and coding recoupment adjustments in the FY 2024 IPPS final rule as is required under section (7)(B)(2) and (4) of the TMA.

- **Proposed Change to the Severity Level for Homelessness**

Under the MS-DRGs, designation of a secondary diagnosis code as a complication or comorbidity (CC) or a major complication and comorbidity (MCC) signifies increased resource use for the patient. Accordingly, if a CC or MCC is coded on the inpatient claim, CMS will classify the patient into a higher paying MS-DRG.

In the FY 2023 IPPS proposed rule, CMS requested public comments on Social Determinants of Health (SDOH) diagnosis codes that are most likely to increase hospital resource utilization for inpatient care. CMS noted that homelessness is one of the more frequently reported codes that describe a SDOH and the presence of these diagnosis codes signify higher patient care costs. CMS is now proposing to update three homelessness Z codes from a non-CC to a CC.

CHA is a strong proponent of, and our members actively engage in, screening for and addressing social determinants of health. Our members track and analyze the use of Z codes and report that homelessness is one of the most commonly used. Many are actively engaged in a variety of efforts to identify and serve patients experiencing homelessness and more accurate coding, incentivized through appropriate reimbursement policy, can lead to better understanding of the needs of the patients and communities we serve.

CHA supports CMS' proposal to change the severity level of the three Z codes from non-CC to CC.

- **Changes to the Wage Index**

Beginning in FY 2020, CMS began increasing the wage index values for hospitals with a wage index in the lowest quartile by one-half the difference between a low wage index hospital's wage index and the 25th percentile. This policy was intended to allow low-wage hospitals to use the higher wage index to increase hospitals wages that will then become part of the low-wage hospital's succeeding fiscal year's wage index. As there is four years between the data year and the payment year used for the wage index, CMS was intending to keep this policy in place for four years. Fiscal year 2024 represents the first year that CMS will have data from this policy to determine whether its low-wage index policy was successful in narrowing the wage index gap between high and low wage hospitals. As CMS only has one year of data upon which to make a determination of the policy's success, CMS is proposing to extend the low-wage index policy for an additional year and make the policy budget neutral with an adjustment to the IPPS standardized amounts.

CHA believes that CMS is correct to be analyzing revisions to the wage index as concerns about its equity and accuracy have long been documented. However, we believe CMS should not reduce payments to all hospitals while it addresses issues. **We urge CMS to implement the low-wage hospital policy in a non-budget neutral manner.**

- **Disproportionate Share Hospitals (DSH)**

Determining the Aggregate Pool of Uncompensated Care Payments

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula prior to the Affordable Care Act.

The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). Hospitals receive uncompensated care payments based on their proportionate share of total uncompensated care costs using Worksheet S-10 of the Medicare cost report.

CMS estimates that the amount available to distribute as uncompensated care will decrease from \$6.87 billion in FY 2023 to \$6.71 billion in FY 2024, a decrease of 2.3 percent or \$161.4 million. The calculation of aggregate uncompensated care, once determined, is not changed to reflect subsequent updates to the data sources. For this reason, it is critical that CMS' estimates accurately reflect the latest information available.

Factor 1 is determined by taking CMS' estimate of Medicare DSH payments from FY 2020 (if Medicare were to have paid 100 percent of the formula) and applying increase factors to estimate FY 2024 DSH payments and multiplying the result by 0.75. The increase factors account for the IPPS update, changes in fee-for-service discharges, case mix and a "other" or residual of all other factors affecting Medicare DSH payments including changes in Medicaid enrollment.

Of these factors, the reduction in CMS estimates of Medicare fee-for-service discharges for FY 2022 (from -1.4 percent to -5.7 percent) and FY 2023 and FY 2023 (from a 5.0 percent increase to a 2.5 percent decrease) since last year's final rule explain in large part why Factor 1 is showing a decrease from FY 2023 to FY 2024. It is unexplained why CMS' estimates of Medicare fee-for-service discharges for FY 2022 and FY 2023 changed so dramatically between last year's final rule and this year's proposed rule. Other figures also changed significantly since last year's final rule (such as the FY 2023 other figure that changed from -2.07 percent to 4.84 percent which serves to mitigate the changed estimates for Medicare fee-for-service discharges). **CHA requests CMS provide a more detailed explanation for the change in its estimates of various factors that affect Factor 1 so public commenters can make more informed comments on these estimates.**

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2024 to the number of uninsured in calendar year 2013, before the Affordable Care Act went into effect. CMS projects the uninsured percent of the population will be unchanged between FY 2023 and FY 2024 at 9.2 percent. However, the proposed rule states "we may also consider the use of more recent data that may become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2024" (88 FR 26993).

Among the factors that CMS indicates may change its estimates of factor 2 is the impact of the expiration of the Families First Coronavirus Response Act's continuous enrollment provision for Medicaid with the end of the PHE and resulting disenrollment of beneficiaries which began on April 1, 2023.

CHA believes the proposed rule does not fully account for the effect of Medicaid disenrollment and has significantly underestimated the uninsured rate for FY 2024. CMS projects an 11% reduction in Medicaid enrollment but anticipates no change in the uninsured rate. Several studies have highlighted that the end of this policy will likely cause a spike in uninsured higher than what CMS is predicting. For example, an Urban Institute study found that more than 14 million people could lose Medicaid coverage¹ and we have already seen reports that the unwinding is going much worse than expected. While some of these individuals could be eligible for other

¹ Buettgens, Matthew and Jessica Banthin, "Estimating Health Coverage in 2023," Urban Institute, May 10, 2022, <https://www.urban.org/research/publication/estimating-health-coverage-2023>. The Kaiser Family Foundation's estimate is that between 8 and 24 million could lose Medicaid due to PHE unwinding. Burns, Alice, Elizabeth Williams, Bradley Corallo and Robin Rudowitz, "How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?" Kaiser Family Foundation, April 26, 2023, <https://www.kff.org/medicaid/issue-brief/how-many-people-might-lose-medicaid-when-states-unwind-continuous-enrollment/>

coverage, such as through the Marketplace, several factors (including state policies) could impact whether individuals receive alternative coverage. A Kaiser Family Foundation analysis found that among individuals disenrolling from Medicaid, 65 percent had a period of uninsurance in the year following disenrollment and only 26 percent enrolled in another source of coverage following the year of disenrollment.² It seems highly likely that individuals losing Medicaid coverage will not be able to obtain health insurance through the Marketplaces even with continued premium tax credits and expanded eligibility for Marketplace subsidies. For this reason, **CHA urges CMS to update Factor 2 with more timely and accurate data to reflect the likely increase in FY 2024 uninsured patients.**

Distributing Uncompensated Care Payments

For FY 2024, CMS proposes to use three years of audited Worksheet S-10 data from FY 2018, FY 2019 and FY 2020 for distributing uncompensated care payments. In the past, CHA has commented that CMS should only use audited cost report data in the distribution of uncompensated care payments and that it should ameliorate the redistributive impact of updating the data by using an average of three years of data. CHA thanks CMS for being responsive to our concerns and the concerns of other commenters regarding only using audited Worksheet S-10 data and using a three-year average. **CHA supports CMS using FY 2018, FY 2019 and FY 2020 audited Worksheet S-10 data in the uncompensated care distribution.**

Puerto Rico, Tribal and Indian Health Service Hospitals

In the past, CMS has not used Worksheet S-10 data to distribute uncompensated care payments for Puerto Rico, Tribal and Indian Health Service (IHS) hospitals. Rather, because of special reporting issues that make Worksheet S-10 inaccurate for these hospitals, CMS continued to use low-income patient days as a proxy for uncompensated care for these hospitals. **CHA supported these proposals because of the special issues faced by these hospitals and the vulnerable populations they serve.**

Beginning with FY 2023, CMS discontinued use of low-income patient days for Puerto Rico, Tribal and IHS hospitals and instead used Worksheet S-10 to determine their uncompensated care payments. CMS further made a non-budget neutral supplemental payment to these hospitals that makes their total uncompensated care payments equal to the amount received in FY 2022 adjusted by the percentage change to national uncompensated care payments since that time. CMS proposed to continue these special supplemental payments for Puerto Rico, Tribal and Indian Health Services hospitals for FY 2024. **CHA supports CMS' proposal.**

² Tolbert, Jennifer and Meghana Ammula, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," April 5, 2023, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

- **Payments for Indirect Medical Education (IME) Direct Graduate Medical Education (DGME) Costs to Rural Emergency Hospitals**

Rural Emergency Hospitals (REH) are a new Medicare provider type, effective January 1, 2023. REHs are facilities that do not provide acute care inpatient hospital services. Under current policy, hospitals may count residents training in “non-provider” sites for DGME and IME payment as long as the resident is engaged in patient care activities and the hospital incurs the costs of the resident salaries and benefits while the resident is training in the non-provider site. Non-provider sites currently include Critical Access Hospitals (CAH) but not REHs.

CMS is proposing to allow hospitals to count resident training time in REHs in their DGME and IME FTE counts as long as the residents are engaged in patient care activities and the hospital incurs the cost of the resident salaries and fringe benefits while training in the REH. As an alternative to the hospital counting the resident for DGME and IME payment purposes, CMS proposes that a REH may incur the costs of the resident training at the REH and be paid for the training at 100 percent of reasonable cost (just as CAHs do except the statute authorizes CAHs to be paid at 101 percent of reasonable cost, not 100 percent of reasonable cost). **CHA supports this proposal.**

- **Reasonable Cost Payment for Nursing and Allied Health Education Programs**

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. Under the reasonable cost payment methodology, a hospital is paid Medicare’s share of its reasonable costs. Provisions of law enacted in 1999 and 2000 require that CMS include Medicare Advantage (MA) utilization in determining the Medicare share of a hospital’s reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization are funded through a reduction to payments made to teaching hospitals for DGME and limited to \$60 million per year.

An oversight resulted in CMS not updating the factors that went into determining MA nursing and allied health reasonable cost payments for more than 17 years. As a result, schools of nursing and allied health were paid more than \$60 million annually over this time period and CMS reduced DGME payments made to teaching hospitals more than was permitted under the law. When CMS discovered this problem, it rectified the issue by repaying amounts owed to teaching hospitals for DGME and recouping hundreds of millions in reasonable cost payments from hospital-based nursing and health education schools.

Section 4143 of the Consolidated Appropriation Act (CAA), 2023 provides relief for hospitals subjected to recoupment of overpayments for 2010 through 2019. CAA, 2023 does this by not applying the \$60 million payment limit to nursing and allied health education MA payments during these years. Section 4143 also provided that CMS shall not reduce a hospital’s DGME

MA payments to offset the increase in nursing and allied health MA education payments. The proposed rule details the process CMS is instructing the MAC to use to implement section 4143.

CHA supports CMS' implementation of section 4143 of the CAA, 2023, which protects schools of nursing and allied health education from having to refund extra payments they received through no action of their own without reducing payments to hospitals that receive DGME payments.

- **Request for Information on Safety Net Hospitals**

CMS has made advancing health equity the first pillar in its Strategic Plan. CHA shares the agency's commitment to ensuring every person has the highest level of health for all people and a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes. We applaud CMS for its actions to fully integrate health equity as a goal across its programs.

The health equity pillar of CMS' strategic plan states a commitment to policies that can support safety-net providers, partner with providers in underserved communities, and ensure care is accessible to those who need it. CHA supports and appreciates these efforts.

Certain hospitals serve underserved communities, provide more care to low-income, uninsured people and Medicaid beneficiaries, and provide services essential to their communities despite inadequate reimbursement. Catholic hospitals, for example, often provide a higher percentage of public health and specialty services than other health care providers. These organizations' dedication to the common good leads them to offer these traditionally "unprofitable" services.

The term "safety net provider" is commonly used to refer to health care providers that furnish a substantial share of services to uninsured and low-income patients. [These](#) hospitals incur unusually high costs, for which they are not fully reimbursed, caring for large numbers of low-income and uninsured patients. Efforts to achieve health equity are stymied because hospitals that do more to serve patients facing challenges and inequities due to social factors that affect health do not have enough resources.

But the term "safety-net provider" is not well-defined. CMS has asked for public comment on how to clearly identify safety-net hospitals. A clear-cut definition could help ensure they get the financial resources they need. CMS has proposed two potential alternatives that it believes may better target payments to hospitals that service vulnerable communities: 1) the Medicare Payment Advisory Commission's (MedPAC's) Safety Net Index (SNI) Hospital Proposal and 2) an Area Deprivation Index (ADI).

In concept, we strongly support CMS's intent of more appropriately targeting payments intended to maintain the safety net—a recognition that these providers face unique challenges in caring for

their patient populations. However, we are concerned that the RFI does not yet offer enough insight into CMS' intended methodology for applying the safety net designation, how the designation would be used for payment, or the anticipated net impacts across all hospitals. Without additional information, we are not able to make an informed decision as to whether application of the proposed alternatives would promote sufficient ongoing support for the safety net.

The proposed alternatives do not include costs related to Medicaid patients treated by safety-net hospitals. Care for low-income Medicare beneficiaries is crucial, but some safety net hospitals care for more Medicaid enrollees than Medicare enrollees. The collective burden of both those populations could be more significant than Medicare alone.

The Area Deprivation Index (ADI) takes into consideration neighborhood or geography as impacting health outcome. While neighborhood-based measurements can help capture the social and economic environments of population, concerns have been raised that the ADI may mask disparities and may underreport underserved populations in high cost-of-living areas.³ Additional short-comings to using the ADI for this purpose include its use of proxy information (including housing) rather than identifying community residents' health status or the specific needs of patients, and its use of national rather than local or regional comparisons of equity.

MedPAC's SNI proposal would replace and redistribute Medicare DSH and uncompensated care funds. It is unclear from the proposed rule how CMS would use it or the ADI as a substitute for Medicare DSH and uncompensated care payments or other payments that CMS indicates are examples of those made to safety-net hospitals absent additional legislation. CHA strongly believes that any new safety-net designation for payment purposes should include new funding to support these hospitals, not simply redistribute funding in existing programs.

Despite our uncertainty regarding how CMS could use the SNI or ADI in determining Medicare payments, **CHA is appreciative that CMS remains concerned about safety net providers who are critical to providing needed services to the most vulnerable and underserved patients in our communities.** We urge CMS to work closely with stakeholders to consider how best to support safety-net hospitals before proceeding with any future rulemaking.

- **Hospital Inpatient Quality Reporting (HIQR) Program**

Electronic Clinical Quality Measures (eQMs)

CMS is proposing to adopt three new eQMs into the HIQR measure set (the Hospital Harm–Pressure Injury eQCM, the Hospital Harm – Acute Kidney Injury eQCM, and the Excessive

³ Azar, Kristen M.J., Maria Alexander, Kelly Smits, Audrey Tio and Lawrence deGhetaldi, "ACO Benchmarks Based On Area Deprivation Index Mask Inequities," Health Affairs Forefront, February 17, 2023, <https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities>

Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults eCQM). The measures would be added to the list of eCQMS from which hospitals can self-select beginning with the 2025 reporting period/FY 2027 payment determination.

CHA supports measures such as these, which are intended to improve patient safety, but we would prefer that CMS defer adopting any measure into the HIQR Program until review by the consensus-based entity (CBE) is completed and endorsement awarded. We encourage CMS to expeditiously seek CBE endorsement or to consider delaying measure adoption.

Potential Future Adoption of Two Geriatric Care Measures and Potential Geriatric Care Hospital Designation

CMS is considering two attestation-based structural measures, the Geriatric Hospital measure and the Geriatric Surgical measure, for the HIQR Program.

Our mission as Catholic health care providers leads us to serve a large population of vulnerable patients, including the senior population. Our members are committed to compassionately serving the elderly and chronically ill, including by providing holistic, person-centered care.

CHA commends CMS for its consideration of measures that acknowledge the importance of a more holistic approach to geriatric care needs that includes patient-centered care and that would assess geriatric care across various domains of the care continuum for aging populations with multiple chronic conditions.

CHA is a partner, along with the American Hospital Association, the Institute for Health Care Improvement and the John A Hartford Foundations, in creating Age-Friendly Health Systems. Three of the original five pioneering Age-Friendly Health Systems were from Catholic health care. The goal of the initiative has been to develop and spread a model for Age-Friendly Health Systems.

The initiative develops and spreads a model using four high-level interventions (referred to as the "4 Ms"):

- What Matters: Understanding and actively supporting what matters to older adults
- Mobility: Reviewing mobility plans for each patient
- Medications: Discussing whether medications are unnecessary or potentially harmful
- Mentation: Improve mentation by addressing problems like dementia, delirium, and depression

The two attestation-based measures being considered for future inclusion in the HIQR Program. measures for geriatric care seem to include many of these concepts. We support the potential future inclusion of measures such as the ones described.

However, we do have two concerns. The elements and domains of the two measures potentially overlap. As noted in the MAP review, reporting on two overlapping measures has the potential to create excessive and unnecessary burden. We encourage CMS to consider combining the two measures or focusing on one measure to reduce the burden of reporting. In addition, CHA continues to believe that only CBE-endorsed measures should be considered for inclusion in the HIQR measure set, and therefore we would urge that a geriatric measure or measures received CBE endorsement before being included in the HIQR.

CMS is also considering a potential geriatric care hospital designation to reflect the quality of geriatric care provided by hospitals. The designation could be based on the two geriatric care measures if such measures were proposed and finalized in the future. The designation would be publicly reported on a CMS website.

CHA agrees with CMS that more needs to be implemented to further the quality of care over the complete geriatric care spectrum. We support a potential geriatric care hospital designation as an initiative to improve the quality of geriatric care and recognize hospitals that furnish high quality care.

For the reasons we have described, however, we have concerns with basing such a designation on the two geriatric measures described by CMS. A more streamlined CBE-endorsed measure may be an alternative measure to consider as one element that could be used for purposes of such a designation. Other elements to complement such a measure may be an outcome measure or patient-reported measures, which may also have significant value in contributing to more comprehensive data for such a designation. The measures and data derived from such measures should be tested and validated for accuracy and reliability, and the meaning of such a hospital designation and the factors that contributed to such a designation should be clear and understandable for patients and their caregivers.

Proposed Updates to the HCAHPS Survey Measure

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey was adopted into the hospital IQR Program in FY 2008. In 2021, CMS conducted a large-scale experiment to test improvements to the survey, including the addition of web-based survey modes. Now, as a result of these tests, CMS proposes several changes to HCAHPS Survey administration.

CHA supports CMS's proposal to add three new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the current Mail Only, Phone Only, and Mail-Phone modes, beginning with January 2025 discharges. We agree with CMS that the addition of web-based survey modes more accurately reflects the way people communicate and will result in increased response rates

Proposed Modification to the COVID-19 Vaccination Coverage among HCP Measure

CMS proposes to modify the current Healthcare Personnel (HCP) COVID-19 vaccination measure beginning with the FY 2025 IQR program, consistent with proposals across all Medicare quality reporting programs. Specifically, CMS would replace the definition of “complete vaccination course” with a definition of “up-to-date” with Centers for Disease Control and Prevention (CDC) recommended COVID-19 vaccines. The agency proposes this modification to incorporate evolving CDC guidance related to booster doses and their associated timeframes.

CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both HCPs and the patients we serve. However, as we exit the public health emergency (PHE) and enter an endemic phase of the disease, we are concerned that the data reporting requirements associated with the measure will divert already stretched resources from patient care to administrative processes. The CDC definition of “up-to-date” can change every quarter, and it is challenging for hospitals to collect and continuously assess the vaccination status of each employee that works in the facility for a given reporting period. Further, the requirement that hospitals collect and report on this data for at least one week each month has strained the already stressed workforce.

In developing the measure, CMS relied heavily on the specifications and experience with the Influenza Vaccination Among HCP measures. The flu vaccine measure assesses vaccinations during flu season, which is defined as October through March, and is reported annually. While there are still questions about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available, an annual data collection and reporting process is significantly less burdensome than reporting data for one week out of each month of the year. As COVID-19 is now endemic, like influenza, the reporting requirements must change as well. **We urge CMS to amend the measure to require only annual reporting.**

- **Hospital Value Based Purchasing (HVBP) Program**

Proposed New Measure: Severe Sepsis and Septic Shock: Management Bundle

CMS proposes to adopt the Severe Sepsis and Septic Shock: Management Bundle measure into the HVBP program beginning with the FY 2026 program year. The measure was adopted into the Hospital IQR Program beginning with the FY 2017 payment determination and provides a standard operating procedure for the early management of patients with severe infection.

CHA supports CMS in its efforts to advance quality and safety. We have concerns, however, with a measure that requires adherence to a standardized protocol for treatment without explicit protections and authorizations for the health care provider to furnish care as medically needed and tailored to the individual patient. We bring attention to the comments raised in pre-rulemaking raising concerns over the burden associated with data abstraction, the potentially

overly prescriptive nature of the protocol required by the measure, and the potential for risks such as the overuse of antibiotics. **We urge CMS not to adopt this measure into the HVBP program** until it has ensured there is sufficient evidence from use of the measure under the Hospital IQR program of a clear linkage between adherence to the measure protocol and improved health outcomes and that there is clear and explicit flexibility for the health care provider to deviate from the protocol based on the provider's medical judgment and the individual patient's needs.

Proposed Health Equity Adjustment

CMS proposes, beginning with the FY 2026 program year, to add Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS). The HEA bonus points would be calculated using a methodology that incorporates a hospital's performance across all four domains for the program year and its proportion of patients with dual eligibility status (DES). CMS also requests information on potential additional changes to address health equity.

CHA supports establishing a health equity adjustment. We continue to support proposals that are valid, reliable, and feasible for hospitals and applaud CMS' ongoing efforts to eliminate health disparities. Our members support the advancement of strategies that will make a real difference in ending health disparities and achieving health equity. This is work that the entire health care community should be working on together. While measurement and reporting are powerful tools, we continue to urge CMS to proceed in manner that prioritizes collaboration over competition.

CHA supports and appreciates that the proposed HEA takes into consideration both performance of hospitals as well as the underserved populations served by the hospitals. CMS specifically asks about the use of DES data as an indicator for underserved populations and populations with socio-economic risk factors versus other indicators for measuring the underserved population served by a hospital. CHA supports the proposal that DES be initially used as it is a familiar indicator that is already used in the Hospital Readmissions Reduction Program. However, other indicators may also be considered in future rulemaking to provide a more complete picture of the underserved populations and communities served by hospitals. For example, CMS suggests using the Area Deprivation Index (ADI), which takes into consideration neighborhood or geography as impacting health outcome. While neighborhood-based measurements can help capture the social and economic environments of patients, as we noted above concerns have been raised that the ADI may mask disparities and may underreport underserved populations in high cost-of-living areas. We encourage CMS to also seek out alternative sources of social risk factor data in other HHS initiatives and other federal programs.

CHA supports that the HEA bonus points would be available to hospitals performing in the top two-thirds of each domain performance, rather than only those performing in the top one-third. We believe this approach is consistent with program intent to recognize and reward performance, while acknowledging the challenges faced by hospitals serving larger proportions of underserved

populations. We also support the proposal to increase the TPS maximum from 100 to 110 as this allows for already high performing hospitals to be eligible to earn the HEA bonus points.

- **Hospital-Acquired Conditions (HAC) Reduction Program**

Request for Comment: Advancing Patient Safety

CMS seeks comment on the adoption of measures, specifically on safety focused eCQMs, into the HAC Reduction Program to advance both health care safety and equity by encouraging hospitals to further focus their improvement efforts on eliminating disparities in the rate and severity of hospital acquired conditions among different patient populations. CMS specifically asks about the potential adoption of the patient safety related eCQMS that are currently used in the Hospital IQR Program as well as the three eCQMs proposed for adoption in the Hospital IQR Program.

CHA applauds the advancement of patient safety, including through quality initiatives aimed at reducing high-cost and avoidable events. We believe that, as guiding principles, any safety related eCQM adopted into the HAC Reduction Program measure set should be data-driven, actionable, have utility, give feedback, and be feasible. We also continue to believe that any such measure should be endorsed by the CBE.

CMS specifically asks about the current safety related eCQMs in the Hospital IQR Program measure set, including the Hospital Harm-Opioid-related adverse events eCQM. CHA continues to support efforts led by CMS to address our nation's opioid epidemic, but as we commented when this eCQM was proposed for the HIQR Program, we are uncertain that adoption of this measure will be useful. We do not object to the proposed measure itself, however, we note that the overall number of inpatient naloxone rescue events is small. More generally, we are concerned about the substantial cost and time burden faced by hospitals when adopting new eCQMs. The measure is currently included as an optional (not required) measure which may be self-selected to satisfy the reporting requirement under the HIQR Program beginning with the FY 2026 payment determination. While we appreciate and agree with the importance of tracking and improving monitoring and response to patients administered opioids during hospitalization, we believe time is needed to see the effectiveness, impact, and consequences of applying this measure under the HIQR Program before adopting it as a required measure with payment consequences under the HAC Reduction program. Generally, we encourage CMS to ensure such time is provided for any eCQM that is currently under the optional, self-reported category under the HIQR Program before consideration of adoption of the measure as a required measure under the HAC Reduction program.

With respect to future improvement efforts on eliminating disparities in the rate and severity of hospital acquired conditions among different patient populations, CHA continues to support many of the ongoing initiatives by CMS to advance health equity in its quality reporting and value-based programs. We believe that CMS should generally engage in extensive testing on

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specific measures and scoring methodologies before using those measures or methodologies in the programs. We further recommend strongly that all variables to be analyzed for disparities be required to have clear, standardized definitions and that practical barriers to the number of variables to be studied be taken into account, including reporting burden created for providers and optimal allocation of finite provider and CMS resources. We also believe that when considering measures for inclusion in the HAC Reduction Program that take into account social risk data to address health disparities, the statutory focus of the program to reduce payments to hospitals specifically for high-cost and avoidable events must be maintained.

Validation Reconsideration Process

CMS proposes to add a validation reconsideration process in the HAC Reduction Program, beginning with the FY 2025 program year. Under this proposed process, hospitals that fail validation would be allowed to request reconsideration of their final validation scores before use of the scores in the Program scoring calculation.

CHA acknowledges the importance of the data validation policies and supports the proposed validation reconsideration process as a valuable addition to those policies.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2024 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



Lisa A. Smith
Vice President
Public Policy and Advocacy