July 10, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-1735-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Administrator Verma:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America’s Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services’ (CMS) work to improve the delivery of high-quality health care across the care continuum while reducing provider burden associated with reporting programs. We recommend the agency’s regulatory flexibility to date as hospitals respond to the unprecedented COVID-19. As the agency finalizes Medicare inpatient payment policies, we ask that it consider the following comments on reducing burden and providing flexibility to hospitals that will be critical in light of COVID-19.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.5 percent on average compared with 7.6 percent for all hospitals nationwide.1 These narrow operating margins result in minimal reserves and low cash

on hand, circumstances which have been exacerbated by the financial pressures of COVID-19.

Essential hospitals are on the front lines of responding to the COVID-19 pandemic—they are screening, testing, and treating COVID-19 patients in their communities. Whether in hotspots, such as New York, Michigan, and Arizona, or in states seeing lower numbers of COVID-19 infections, our members have invested substantial resources toward preparing for and responding to the public health emergency. They continue to respond to the COVID-19 pandemic—including by increasing capacity through alternative care sites, maintaining sufficient quantities of personal protective equipment and other critical supplies, and ensuring staff capacity. Hospitals have made these investments while facing double-digit drops in revenue due in part to decreasing the number of planned and elective procedures and other ancillary services to stand ready for COVID-19 patients. As a result, essential hospitals face an uncertain financial future and many other challenges as they continue to respond to and recover from this public health emergency.²

Compounding these challenges are essential hospitals’ complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospitals’ patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. Approximately 10 million people in essential hospital communities have limited access to healthy food, and nearly 24 million live below the poverty line.³ To address the needs of these populations, members of America’s Essential Hospitals constantly engage in robust quality improvement initiatives, and have created programs to break down language barriers, address social determinants, and engage patients and families to improve quality of care and equity.

As the nation continues to confront the unprecedented COVID-19 pandemic, we urge the agency to prioritize finalizing only statutorily required policies, while avoiding new policies that will strain hospitals’ limited resources. The flexibility that CMS has offered through its Section 1135 waiver authority to date has allowed providers to increase access to care for their patients and reduce administrative burden. CMS’ flexibility on Medicare inpatient payment policies through this rulemaking will be imperative not only for the duration of the public health emergency but also as hospitals and their communities recover and prepare for future outbreaks. As proposed, additional reporting requirements for hospitals’ negotiated charges with insurers, as well as steep reimbursement cuts in the form of Medicare disproportionate share hospital (DSH) payment reductions, will devastate hospitals facing an uncertain financial future. To

ensure our members have sufficient resources to continue responding to COVID-19 and are not unfairly disadvantaged for providing comprehensive care to complex patients, CMS should consider the following recommendations when finalizing the above-mentioned proposed rule.

1. **CMS should ensure data used to implement the Affordable Care Act’s (ACA’s) Medicare DSH payment methodology accurately capture the full range of uncompensated care (UC) costs hospitals sustain when caring for disadvantaged patients.**

The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC. In 2018, our members provided $6.6 billion in UC, representing 16 percent of all UC nationwide.⁴

As mandated by Section 3133 of the ACA, the majority of Medicare DSH payments is distributed based on a hospital’s UC level relative to all other Medicare DSH hospitals (factor 3). While DSH hospitals continue to receive 25 percent of their otherwise payable Medicare DSH payments, the remaining 75 percent is decreased to reflect the change in the national uninsured rate and distributed based on UC burden (referred to as UC-based Medicare DSH payments). This change incorporates UC costs into the Medicare DSH formula to better target dollars to hospitals with the greatest need.

While we welcome the targeting of DSH funds to hospitals serving the greatest numbers of uninsured and low-income patients, we are concerned about the reductions to DSH payments that occurred because of the new DSH methodology. From fiscal years (FYs) 2014 to 2017, aggregate UC-based payments decreased rapidly, from $9 billion in FY 2014 to less than $6 billion in FY 2017—constituting a 33 percent cut in payments. Partly due to a change in the data source used to calculate the national uninsured rate, aggregate UC-based DSH payments in FYs 2018 through 2020 increased for the first time since the Medicare DSH cuts went into effect. In FY 2021, however, this upward trend is expected to reverse, with a decrease in projected DSH payments. CMS estimates total UC-based DSH payments will be $7.8 billion, a $500 million reduction compared with FY 2020. Total DSH payments are estimated to be $11.66 billion, which is nearly $1 billion lower than total DSH payments in FY 2020 and 25 percent lower than the $15.5 billion that CMS would have paid hospitals under the pre-ACA methodology. For essential hospitals, which bear the burden of treating disproportionate numbers of uninsured and underinsured patients, these cuts are unsustainable. Essential hospitals will feel the impact even more profoundly in FY 2020, as they experience declines in admissions and revenues due to COVID-19 that likely will continue into FY 2021.

Although the ACA has increased access to coverage nationally, essential hospitals still provide high levels of UC as part of their mission. Hospitals in states that have not expanded Medicaid are not experiencing the drop in UC that hospitals in expansion

---

⁴ Ibid.
states have seen. Even in expansion states, essential hospitals continue to provide large amounts of UC in different forms, such as treating underinsured patients and increased Medicaid shortfalls. Targeting DSH payments based on a hospital’s UC levels might mitigate the effect of the lack of Medicaid expansion, but the overall magnitude of cuts to the UC pool often outweighs any redistributive benefit. As a result, steep cuts to Medicare DSH payments are detrimental and unjustifiable for essential hospitals.

We urge the agency to consider how changes in Medicare DSH policy will affect essential hospitals and the communities they serve. In particular, the agency should consider how to accurately capture changes in the uninsured rate, which in turn plays a role in determining aggregate DSH payments. CMS also should consider how to define UC for allocating UC-based Medicare DSH payments among eligible hospitals, and continue efforts to accurately capture all UC costs as data sources evolve and coverage patterns change. In addition, clarifying the Medicare cost report and other guidance would ensure Medicare DSH payments are targeted toward hospitals that need them most. In accounting for these considerations, CMS can ensure essential hospitals receive adequate Medicare DSH payments to provide vital care to vulnerable populations.

a. Calculation of estimated pre-ACA DSH payment amounts should be transparent and include detailed data on each of the assumptions leading to the estimate.

CMS should publish a detailed methodology explaining how it estimated total UC-based DSH payments, specifically its factor 1. To calculate the overall pool of UC-based DSH payments in a year, CMS first estimates what hospitals would have been paid in the aggregate using the pre-ACA methodology and reduces that amount by 25 percent to yield factor 1. CMS then reduces factor 1 by the change in the uninsured rate (factor 2), to produce the aggregate UC-based amount to distribute across all Inpatient Prospective Payment System (IPPS) hospitals receiving DSH payments. Because factor 1 determines the size of the UC pool before the adjustment for the change in uninsured rate is applied, CMS’ estimates must be accurate and its methodology transparent; stakeholders must be able to replicate the data to verify the accuracy of the figures CMS uses to derive its factor 1.

Since the implementation of the ACA’s Medicare DSH methodology in FY 2014, CMS’ estimate of factor 1 has increased annually, which is expected given the factors the agency uses to trend forward previous years’ pre-ACA DSH estimates. For the first time since the implementation of the ACA methodology, the factor 1 in the proposed rule is inexplicably lower than the previous year’s factor 1. In FY 2021, CMS estimates pre-ACA DSH payments at $15.36 billion—$1.2 billion lower than the amount used in FY 2020.
### Yearly Factor 1 Amounts from IPPS Final Rules (in billions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalized Factor 1</td>
<td>$9.58</td>
<td>$10.04</td>
<td>$10.06</td>
<td>$10.80</td>
<td>$11.65</td>
<td>$12.25</td>
<td>$12.44</td>
<td>$11.52</td>
</tr>
</tbody>
</table>

To estimate how much Medicare DSH the agency would have distributed in the absence of the ACA’s DSH methodology, CMS uses the latest available year of complete Medicare DSH payment data and trends it forward using four factors: the annual payment update, estimated changes in discharges, estimated changes in case-mix, and an “other” category. The “other” category includes the effect of Medicaid expansion on Medicare DSH payments and other payment updates not captured in the annual update category. While the payment update factor is determined in each year’s rulemaking, CMS has to estimate the three other factors using incomplete data (due to a data lag in the availability of full discharge information, for example) and various assumptions. In the proposed rule, CMS revises downward the discharges, case-mix, and other factors for FYs 2018 through 2021. CMS should clarify what additional data and assumptions led the agency to adjust these factors downward. In particular, the “other” category for FY 2020 decreased in this year’s proposed rule compared with last year’s final rule. Because the “other” category is driven by many assumptions, CMS should describe the reasons for the drop in the “other” factor, as well as the case-mix and discharge factors. **CMS should be transparent and detailed in explaining its methodology so stakeholders can replicate this information, which directly relates to the aggregate amount of DSH payments paid in a given year.**

b. **CMS should ensure its estimates of the uninsured rate are current and account for regulatory and legislative changes, as well as other timely external factors.**

CMS should ensure its estimates of the uninsured rate are up to date and incorporate the effects of regulatory or legislative changes that could drive up uninsured rates. CMS also should account for other external factors, such as **changes in the economy, that result in changes in the uninsured rate.** The ACA directs CMS to reduce the total funds available for the UC-based Medicare DSH payment by a factor based on the estimated decline in the national uninsured rate (factor 2). Until FY 2017, CMS used estimates from the Congressional Budget Office (CBO), as required by statute. Since FY 2018, CMS has used estimates of the uninsured rate from the National Health Expenditure Accounts (NHEA), produced by CMS’ Office of the Actuary. **We urge CMS to be transparent in providing the assumptions behind its calculations of the uninsured rate, and to ensure its data source for factor 2 is the most accurate source publicly available.**

The NHEA figures used to calculate the uninsured rate for FY 2021 are projections using historical data from 2018 that do not consider late-breaking developments, such
as the effect of COVID-19. The COVID-19 pandemic has caused a rapid and unprecedented deterioration in economic conditions, including a surge in unemployment claims and the unemployment rate. From March to April, the unemployment rate increased by more than 10 percentage points, to 15 percent, constituting the largest one-month increase and the highest unemployment rate since the Bureau of Labor Statistics began tracking the data in 1948.\(^5\) Many of those who became unemployed likely will lose their employer-sponsored health insurance. One study estimates up to 25 million Americans could lose their employer-sponsored insurance, with some of these workers shifting to Medicaid and others becoming uninsured.\(^6\) This will have a pronounced impact on the uninsured rate in FY 2021, which the Office of the Actuary acknowledges is not accounted for in its projection.\(^7\) CMS must ensure significant external factors, such as the COVID-19 pandemic and the resulting recession, are included in its factor 2 estimates. Failing to do so will produce an artificially low uninsured rate, which will result in a low aggregate UC-amount. The Office of the Actuary can update its NHEA projections for 2020 and 2021 to account for the economic downturn and the resulting increase in uninsured rates that were not included in projections used to calculate the proposed rule factor 2. We urge CMS to revise its methodology to incorporate the effects of COVID-19 on the uninsured rate in FY 2021 and similar occurrences in future years.

c. CMS should continue its work to accurately capture hospital UC costs in its calculation of Medicare DSH allocations.

Given the importance of UC to the Medicare DSH program, we urge CMS to continue to refine its methodology to accurately capture these costs. This should include providing clear and consistent guidance to auditors and contractors tasked with reviewing hospital-reported UC costs. Under the ACA’s Medicare DSH methodology, CMS determines a hospital’s qualifying UC burden by estimating its percentage of the total UC costs incurred by all DSH hospitals. Hospitals report their UC costs and other indigent patient care costs on worksheet S-10 of the Medicare hospital cost report form. For FY 2021, CMS proposes to continue the FY 2020 policy of using one year of data—in this case, from the audited FY 2017 S-10. As CMS relies solely on the S-10 for calculating UC costs, the accuracy and equity of S-10 data will be increasingly important to ensure consistency across the field. We urge the agency to incorporate the below recommendations to ensure a more accurate representation of each hospital’s total UC costs.


i. CMS should mitigate the effect of anomalies in FY 2020 cost report data that will have an adverse impact on UC-based DSH payments in future years.

During the COVID-19 public health emergency, hospitals—at the prompt of federal guidance and state orders—suspended their regular operations, including postponing non-emergent and elective procedures. In addition to these actions by hospitals, patients were reluctant to seek care, whether in the emergency department or in outpatient clinics, even for severe conditions such as heart attack or stroke. One survey showed that nearly half of Americans put off seeking care because of COVID-19. This has disrupted hospitals’ day-to-day operations and changed the types of patients and cases they normally see. For some, this means a focus primarily on COVID-19 patients, with other cases being delayed and many shifted to telehealth. Other hospitals in cities with fewer COVID-19 cases might not have seen the same surge in COVID-19 patients but nonetheless were required to postpone their non-emergent cases in preparation for a possible surge. Therefore, hospitals are likely to have seen substantial changes in their usual payer mix during the pandemic. Hospitals with predominantly uninsured and public-payer patients likely experienced a drop in the number of these patients seeking care, as well. It is probable that the drop in volume will have reduced the amount of UC many hospitals provided this year, compared with what they typically provide. These changes in UC will vary by geographic region and differences in the severity of COVID-19 in various locations.

While it is too early to know the exact variation in UC provided by each hospital, CMS should begin to consider policies that will mitigate any atypical drops in UC that some hospitals likely will experience. The cost report data from FY 2020 that coincides with COVID-19 likely will be used for FY 2024 rulemaking, and CMS should begin considering steps to dampen the effect of large downward swings in UC attributable to COVID-19 that will have large redistributitional effects on UC-based payments.

ii. CMS should provide clear guidelines on its audit protocols and ensure S-10 reviews are done equitably and uniformly across all hospitals.

CMS so far has conducted partial audits of FYs 2015 and 2017 data and is in the process of conducting FY 2018 audits. CMS has yet to make public its audit protocols; it is imperative that the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. Hospitals and other stakeholders audited or involved in audits of FY 2015 data underscored the need for this transparency. We urge the agency to disclose the criteria it uses to identify hospitals for audits. Given the relative and redistributive nature of Medicare DSH payments, it is important to ensure audits are conducted consistently and equitably. Under the

---

methodology of CMS’ Medicare DSH calculation, a change in even one hospital’s reported UC costs will alter its factor 3 and, in turn, affect all other hospitals’ factor 3 values. As a hospital’s factor 3 changes, so does the amount of UC-based DSH payments it receives (as this is the product of factor 3 and total UC-based payments). Thus, any inaccurate audits or audits conducted selectively for some hospitals but not others will skew Medicare DSH payments across the board. Further, CMS must minimize burden associated with audit documentation requests and conduct the audits well in advance of the use of the data for payment purposes so hospitals have the opportunity to address adverse findings.

For its audits thus far, CMS and Medicare Administrative Contractors (MACs) worked with external auditing firms to review data for a subset of all hospitals receiving Medicare DSH nationwide. These audits include extremely burdensome documentation requests by MACs, requiring hospitals to compile and turn over large amounts of information not already available in their financial recordkeeping systems. The audits, particularly in FY 2015, were conducted in a haphazard manner, with hospitals informed of last-minute unjustified reductions in their UC costs due to arbitrary decisions made by MACs or subcontractors. Numerous concerning auditing practices have been uncovered so far, including:

- arbitrary selection of hospitals to be audited, resulting in the inclusion of some hospitals in audits but the exclusion of the majority of hospitals eligible to receive DSH;
- voluminous data requests of hospital financial records, including detailed charity care listings with revenue and transaction codes for each claim;
- large reductions in hospitals’ claimed charity care costs based on CMS’ incorrect direction to MACs to offset such costs with related artificial “expected and actual payments” stemming from flawed cost report instructions for FY 2015. This resulted in substantial downward adjustments, leaving negative or no charity care costs for hospitals that actually provided large amounts of charity care;
- other retroactive adjustments to hospitals’ UC amounts based on flawed interpretations of S-10 instructions, such as deeming that insured patients’ copayments could not be claimed as charity care, based on a distinction made by MACs between copays and coinsurance; and
- inconsistent audit findings by MACs, such that certain hospitals received negative adjustments for a given issue while others did not.

CMS can avoid these issues in the future by providing more transparency on its audit protocols. Publishing the audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address any findings. Because of the relative nature of UC-based payments, CMS also must select hospitals for audits in an equitable and systematic way. CMS should review audit findings to ensure MACs and subcontractors consistently apply audit protocols across hospitals nationwide. Finally, CMS should complete audits well in advance of its rulemaking for a given year to ensure the cost report data used is accurate and final. The accuracy and uniformity of audits across DSH hospitals is critical to ensure that the data CMS uses to calculate
UC-based payments are accurate and do not unfairly disadvantage audited hospitals at the expense of hospitals that were not audited.

**iii. CMS should not adjust hospital UC costs or cost-to-charge ratios (CCRs) of hospitals reporting accurate values.**

Because some hospitals report what CMS refers to as anomalous UC costs, the agency proposes to continue its policy of adjusting UC values of hospitals with “extremely high” ratios of UC costs to total operating costs on the cost report year used for calculating Medicare DSH payments. If a hospital cannot justify high UC costs to its MAC, CMS would scale those costs. The agency would base this scaling factor on the ratio of UC costs to total costs from the next year’s cost report—for FY 2021 DSH payments, that would mean the FY 2018 cost report if CMS finalizes its proposal to use FY 2017 UC costs. We agree with the need for data integrity and accurate reporting of UC costs. However, CMS should quickly discern erroneous data from legitimate instances in which a hospital might incur very high UC costs. Essential hospitals serve as the primary health care safety net in their communities, especially in heavily populated metropolitan areas, and have very high volumes of uninsured and low-income patients that drive up their UC costs. **We are encouraged that CMS has revised its policy this year to clarify the UC cost adjustment will not apply to hospitals for which UC values have been audited and found in compliance. We call on CMS to finalize this policy and continue to work with its MACs to distinguish inaccurate UC values from legitimately high values.**

**CMS also should finalize its policy to exclude all-inclusive rate providers (AIRPs) from its CCR trim methodology.** CMS proposes to continue its policy of identifying hospitals with abnormally high CCRs and applying a trim methodology to assign an alternate ratio. The proposed methodology would assign the respective urban or rural statewide average to hospitals with CCRs greater than three standard deviations above the national geometric mean CCR. CMS then would use this alternate ratio, instead of the CCR reported on the S-10, to convert the hospital’s UC charges to costs. For FY 2021, however, CMS says it will not trim the CCRs of AIRPs. We commend CMS for this step.

Due to their differing charge structures, AIRPs have used alternative, CMS-approved methodologies to apportion costs on their cost reports. These hospitals’ charge structures are not the same as other hospitals, because they do not charge on a service-specific basis. Accordingly, the CCRs calculated on their cost reports might end up higher than other hospitals. These hospitals are not falsely reporting information or inflating their costs. In fact, as essential hospitals treating many patients eligible for no-cost or discounted care, they often have charges lower than other hospitals in their community. Applying a trimmed CCR to lower charges will underrepresent the true UC costs for these hospitals. **Therefore, we support CMS’ proposal to exclude these hospitals from the CCR trim.**
iv. **CMS should include all patient care costs when using the S-10 to determine UC costs.**

The S-10 does not account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues using the S-10 as the data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs—including those for teaching—into the CCR. In particular, CMS should:

- use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component; and
- use worksheet C, column 8, line 200, as the charge component.

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently in the S-10.

CMS should include GME costs when calculating a hospital’s CCR. Excluding these costs will disproportionately affect teaching hospitals by reducing their share of the UC pool in relation to other hospitals. Essential hospitals are committed to training the next generation of health professionals. In 2018, the average member hospital trained 244 physicians, more than three times as many as other U.S. teaching hospitals.\(^9\) Further, our members trained an average of 49 physicians above their GME funding cap, versus 11 at other teaching hospitals.\(^10\) So, the costs associated with direct GME constitute a significant portion of overall costs at essential hospitals. Leaving out these costs in the CCR understates teaching hospitals’ UC costs when it converts those hospitals’ UC costs to charges. Incorporating GME costs into the CCR would reflect the full range of costs incurred by teaching hospitals. By excluding these costs, CMS’ proposed CCR for determining UC costs will penalize hospitals, such as academic medical centers, which tend to provide high levels of UC. **We strongly urge CMS to include teaching costs when converting charges to ensure accurate distribution of UC pool funds to hospitals with the highest levels of UC.**

CMS also should include the cost of providing physician and other professional services when calculating UC. In addition to employing physicians and paying community specialists directly for patient care, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other UC, CMS

---


\(^10\) Ibid.
should recognize them when determining UC. By refining the S-10 to reflect these issues, CMS will accurately measure the UC costs hospitals incur to serve low-income and uninsured patients.

v. CMS should issue clarifying guidance as soon as possible to improve the consistency and accuracy of S-10 data and, in particular, the accuracy of UC amounts on the S-10.

A review of S-10 data indicates an inconsistency in how hospitals categorize and report charity care versus bad debt. While CMS can overcome this data limitation using the sum of charity care and bad debt, the agency still should issue clarifying guidance so there is consistency across the field in how hospitals report these costs.

CMS should treat the unreimbursed portion of state or local indigent care programs as charity care. Many state or local indigent care programs are not formal insurance products, but rather local coverage programs that help reduce hospitals' overall UC costs through de minimis reimbursement for services. These programs typically support the same populations that qualify for hospital charity care policies. Just as the unreimbursed costs for charity care patients are recognized in the S-10, so should the unreimbursed portion (i.e., the shortfall) of state or local indigent care programs.

Moreover, the agency must revise the S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. CMS to date has not used Medicaid shortfalls from the S-10 in the calculation of UC costs. We agree that Medicaid shortfalls, as currently reported on the S-10, should not be included in the calculation of UC. All information produced on the S-10, including data not used in CMS' Medicare DSH calculations, should be an accurate representation of a hospital’s uncompensated care and other costs. Data on Medicaid shortfalls increasingly will be useful for informational purposes as previously uninsured low-income individuals gain access to health coverage through Medicaid. And, data on the unreimbursed costs of providing care to Medicaid patients (many of whom formerly were uninsured) will provide information on Medicaid underpayment and, thus, should be accurate. Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs is an inaccurate way to measure shortfall. Second, the S-10 should consistently allow hospitals to reduce their Medicaid revenues by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are used to finance the nonfederal share of Medicaid and are critical to a state’s ability to fund the program at adequate levels.

Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. Because of this discrepancy in the instructions and the different
types of permissible financing arrangements used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients. The agency should allow hospitals to include coinsurance and deductibles on the S-10 without multiplying these amounts by the CCR. CMS’ revised cost report instructions and guidance dictate hospitals do not have to multiply nonreimbursed Medicare bad debt by the CCR, because coinsurance and deductibles are actual amounts expected from the patient (as opposed to charges, which are not the actual amounts a patient is expected to pay). However, CMS’ September 2017 transmittal states that hospitals still should multiply their non-Medicare bad debt by the CCR.

The different treatment of nonreimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients other than Medicare fee-for-service (FFS) patients, such as those with Medicare Advantage, are actual amounts the hospital expects the patients to pay. Therefore, hospitals should list unpaid coinsurance and deductible amounts as bad debt in their entirety and CMS should not reduce those amounts by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts that patients do not have the ability to pay—do not have to be reduced by the CCR. CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR.

vi. CMS should clearly communicate S-10 changes to stakeholders.

CMS should provide ample opportunities for stakeholder feedback and education before issuing substantive revisions to the S-10. We urge the agency to clearly communicate to stakeholders any revisions, as well as information about extended submission deadlines.

CMS should conduct additional educational outreach to hospitals as the agency transitions to using S-10 data. The S-10 has assumed increased importance as it becomes the sole basis for UC-based Medicare DSH payments; as such, it is critical that CMS provide necessary guidance to hospital staff tasked with completing Medicare cost reports. Hospitals report that the S-10 and its corresponding instructions are ambiguous in certain respects, including directions on how hospitals should report non-Medicare bad debt. CMS should provide educational resources to hospitals in the form of agency conference calls, webinars, frequently asked questions documents, and examples illustrating how to report values on the S-10. Because the data entered on the S-10 will significantly affect hospital reimbursement, CMS should work with hospitals
to ensure they have appropriate and thorough direction when completing the worksheet.

2. **CMS should not finalize data collection proposals that require hospitals to report payer-specific negotiated charge information on their cost report. The agency also should not move forward with a potential relative weight methodology based on this information.**

In an effort to develop a market-based approach to payment under Medicare FFS, CMS proposes that hospitals be required to report certain market-based payment rate information on their Medicare cost report for periods ending on or after January 1, 2021. Specifically, hospitals would report median payer-specific negotiated inpatient services charges for Medicare Advantage (MA) organizations and for all third-party payers (including MA) by Medicare severity diagnosis related group (MS-DRG). For third-party payers that do not use the MS-DRG classification system, the hospitals would have to crosswalk the negotiated charges for services, whether paid on per diem rates or all patient refined (APR)–DRGs, to MS-DRGs. Additionally, the agency seeks comments on incorporating this market-based rate information into a potential IPPS MS–DRG relative weight methodology, beginning in FY 2024.

CMS reasons that because hospitals already are required to publicly report payer-specific negotiated charges that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome. America’s Essential Hospitals supports efforts to improve transparency and ensure patients have access to vital information to make informed decisions about their care. However, we have previously expressed strong opposition to and concern about the public disclosure of payer-specific negotiated rates, required by last year’s hospital price transparency final rule.\(^\text{11}\) For the reasons below, we caution against requiring reporting of third-party rate information, as well as any potential use in the development of future Medicare payment methodologies.

a. **CMS does not have the authority to compel hospitals to report third-party negotiated charge data.**

To date, CMS’ approach to price transparency and its related policies only serve to confuse—not help—patients in understanding their potential out-of-pocket cost obligations; severely disrupt contract negotiations between providers and health plans; and exceed the administration’s legal authority. We continue to believe that CMS does not have the authority to establish requirements for disclosure of payer-specific negotiated charges. CMS’ authority to mandate the disclosure of negotiated charges is the subject of ongoing litigation challenging CMS’ hospital price transparency final

---

rule. This litigation challenges the price transparency rule’s required disclosure of negotiated rate information on statutory, procedural, and constitutional grounds. Although the federal district court ruled in favor of the agency, the plaintiffs in the case have filed an appeal with the United States Court of Appeals for the District of Columbia Circuit. Therefore, the courts have yet to have their final say on the lawfulness of the price transparency final rule.

The new policies CMS proposes in the FY 2021 IPPS rule raise similar legal questions because they build on the requirements of the hospital price transparency final rule. In the IPPS rule, CMS is proposing that the same negotiated rate information be reported but by MS-DRG. Because we believe CMS acted unlawfully in mandating the disclosure of negotiated rate information in the price transparency rule, CMS’ proposed data collection in the IPPS rule is unlawful for the same reasons.

b. **Requiring public posting of third-party negotiated charges will stifle competition and the move toward value-based care.**

The data proposed for collection will be public by virtue of being on a hospital’s cost report. Every data point from hospital cost reports is reflected on the Hospital Cost Report Information System dataset and available for public access and use. The public posting of fees—including discounts and other pricing terms typically negotiated between health care providers and plans, in confidence—could undermine the effectiveness of selective contracting. This mechanism is used by health plans to lower costs and improve overall value in health care delivery. At least one commercial health insurer warned that disclosure of payer-specific negotiated charges would “impair the movement to value-based care” and allow “[d]ominant health plans to seek and use that information to deter and punish hospitals that lower rates or enter into value-based arrangements with the dominant plan’s competitors.”

c. **CMS’ proposed data collection will be administratively burdensome for hospitals.**

CMS proposes required reporting of median negotiated charge data across all third-party payers by MS-DRG. While CMS implies this will be a relatively easy undertaking because the charge data must be reported under the hospital price transparency final rule, presenting the data by MS-DRG is a difficult process that involves subjective decisions on the part of hospital staff responsible for extracting this information.

As CMS acknowledges in the rule, not all payers use the MS-DRG classification system to set inpatient payment rates. Third-party payers, including MA plans, often use variants of CMS’ MS-DRG system, distinct DRG systems such as APR-DRGs, or per

---

13 Ibid.
diem payment arrangements. This is problematic in the context of CMS’ proposal for several reasons. First, these classification systems might have more or fewer MS-DRG codes than CMS’ classification system and might not have direct equivalent codes. For example, the APR-DRG system assigns knee and hip replacement surgery to separate APR-DRGs, while CMS combines hip and knee replacements into the same MS-DRG (with distinct MS-DRGs depending on the existence of other comorbidities during the inpatient stay).

Second, APR-DRGs and MS-DRGs adjust for severity of an inpatient admission, based on the presence of comorbidities or complications. The method of adjusting payment for patient comorbidities and complications differs based on classification system. While there are different MS-DRGs for a given diagnosis depending on the presence of comorbidities or complications, APR-DRGs use different severity levels within the same APR-DRG. It is unclear from the rule how hospitals are to account for these differences because there is not a one-to-one relationship between classifications made based on a per diem system or APR-DRG system and Medicare MS-DRGs. There will be subjectivity involved in determining how to crosswalk these systems to MS-DRGs, which will result in non-uniform and unreliable data for public use.

Third, there is not a standard “negotiated charge” that the provider receives from the payer that is consistent across all patients with the same diagnosis. Certain high-cost cases, for example, receive outlier payment amounts that differ on the costs of a given case and are not equivalent to a flat negotiated rate. In the case of per diem payment arrangements, the actual amount paid will vary based on the number of days associated with the inpatient admission. The payment amounts in per diem arrangements can also vary as many contracts carve out high-cost items and services, such as surgical implants and costly drugs, from the per diem amount. Other payment arrangements, whether in per diem or APR-DRG systems, can include percentage of charges or stop-loss arrangements. Due to the variance in payments that can be made for a given diagnosis, it would be impractical and extremely cumbersome to produce a median negotiated charge across all payers for publication on hospital cost reports. These are just some examples of the difficulty associated with CMS’ negotiated charge proposal.

d. CMS should not use third-party payer data to recalculate MS-DRG weights.

CMS seeks comment on implementing a policy in FY 2024 to use median MA charge data or median third-party payer charge data to set MS-DRG payment weights. Instead of using hospital cost and charge data as reported on the cost report, CMS would use median rate information to set weights for each MS-DRG, which then would determine the payment amount for each MS-DRG.

America’s Essential Hospitals opposes the use of market-based data to determine payment rates for Medicare beneficiaries. As outlined above, there are significant questions about CMS’ authority to collect proprietary charge data, so CMS should not use this information to set MS-DRG weights. Even if CMS were to proceed with its data collection proposal, there are reasons to believe the data proposed would be unreliable.
and inconsistently reported across hospitals, due to the difficulty associated with crosswalking third-party payment rates to MS-DRGs. As outlined above, hospitals will have to make subjective decisions on how to report their charges at the MS-DRG level, which will result in data potentially reported differently by hospital and unfit for use in setting Medicare payment rates. There is too much variability in the data that will be produced for CMS to consider using it for payment purposes.

CMS’ proposal to recalibrate MS-DRG weights using third-payer data is arbitrary and capricious. Under the current MS-DRG weighting methodology, CMS uses hospital costs to calculate the relative resource intensity associated with each MS-DRG, as required in Medicare statute. Specifically, the Social Security Act, in describing the methodology for calculating MS-DRG weights, says CMS is to “assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.”

The use of third-party payer data does not capture the relative resources used by hospitals to treat Medicare beneficiaries. There are significant differences between commercially insured patients, for example, and Medicare FFS beneficiaries. Paying hospitals for the treatment of Medicare FFS beneficiaries based on what an MA plan might pay for the same condition risks underpaying, or even overpaying, relative to the hospital’s actual resource cost for patients with that condition. In the proposed rule, CMS does not describe how calculating MS-DRG weights using third-party payer data will be reflective of the hospital resource use, as required by the MS-DRG weighting methodology prescribed by the Social Security Act. Therefore, CMS’ proposal to set MS-DRG payment weights based on third-party payer data is arbitrary and capricious.

For these reasons, we urge CMS to strongly consider the consequences that could come from disclosure of negotiated rates and the use of rate information for payment purposes. CMS should abandon this proposal and limit its policies in the IPPS final rule to those that are statutorily required.

3. CMS should finalize the new MS-DRG for chimeric antigen receptor (CAR) T-cell therapies and set an appropriate payment weight that accounts for resource use.

CMS should finalize its proposed new MS-DRG for CAR T-cell therapies and ensure it is accurately capturing costs associated with these therapies in calculating the MS-DRG weight. CMS proposes to create a new MS-DRG code (MS-DRG 018) for CAR T-cell therapies due to the availability of data on the cost of procedures involving the use of such therapies and the expiration in FY 2021 of new technology add-on payments for these therapies. CAR T-cell therapies are a cutting-edge form of immunotherapy to combat some forms of cancer. These therapies are costly for hospitals due to their relatively new nature and the specialized way in which they are administered. Many CAR T-cell therapies still are done in a clinical trial setting. To

---

15 Social Security Act §1886(d)(4)(B).
ensure hospitals’ costs of providing CAR T-cell therapies are adequately covered, in calculating the weight for MS-DRG 018, CMS should ensure it is appropriately separating out the costs of clinical trial cases in which CAR T-cell therapy is used, since these cases will cost less. In doing this, CMS will avoid artificially deflating the reimbursement amount for CAR T-cell therapies.

4. CMS should implement policies that reduce administrative burden on hospitals in the Medicare and Medicaid Promoting Interoperability Programs (PIPs) and allow hospitals to dedicate their resources to providing patient-centered care.

CMS proposes changes to the Medicare and Medicaid PIPs in calendar year (CY) 2021 and beyond, including a 90-day reporting period for objectives in the PIPs and progressively longer reporting periods for electronic clinical quality measures (eCQMs). Eligible hospitals still face obstacles to the meaningful use of health information technology (HIT). In looking to develop future policies, CMS should take additional steps to reduce provider burden and enable hospitals to deliver high-quality, patient-centered care. The recommendations below will ensure providers have sufficient time and flexibility to attain true interoperability and extend the benefits of electronic health records (EHRs) to their patients.

a. CMS should finalize a 90-day reporting period for CY 2022.

CMS should finalize its proposal to shorten the CY 2022 PIP reporting period to 90 days, which will offer much-needed relief as providers continue to work toward interoperability. CMS previously reduced the CYs 2019 through 2021 reporting periods to 90 days, and in this year’s rule, again proposes a 90-day reporting period for CY 2022. America’s Essential Hospitals strongly supports a 90-day reporting period, which allows providers the flexibility to develop their reporting infrastructure and make necessary updates to their EHRs to comply with evolving PIP requirements. As CMS makes changes to the measures and scoring methodology of the PIPs, hospitals will benefit from additional preparation time resulting from a shorter reporting period. The shorter reporting period will give hospitals time to adjust to these changes and make system changes necessitated by revised measures. Accordingly, CMS should finalize the 90-day reporting period for CY 2022.

b. CMS should keep the prescription drug monitoring program (PDMP) measure voluntary until the agency has adequate standards and specifications.

CMS should keep the PDMP measure voluntary until there is uniformity across states in the adoption of these practices, as well as adequate standards and certification criteria. Essential hospitals are on the front lines of treating patients most affected by the opioid crisis and have implemented innovative strategies to reduce opioid dependence. As leaders in population health, essential hospitals continue to develop programs that prevent opioid misuse among vulnerable populations. They partner with pharmacies, public health departments, law enforcement, emergency medical services, and other community providers to combat the crisis. As key
stakeholders in combating the opioid epidemic, essential hospitals stand ready to implement practices that have proved effective in reducing opioid dependence. While the intent of using EHRs to fight the opioid crisis is commendable, there are significant barriers to the use of IT to report the PDMP measure CMS includes in the PIPs.

The PDMP measure requires eligible hospitals and critical access hospitals to use data from certified EHR technology to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. After initially proposing to require this measure in 2019, CMS reversed course and kept it voluntary. CMS again proposes to keep the measure voluntary in 2021, and we applaud the agency for this decision. While the measure is voluntary, we urge CMS to work with stakeholders toward PDMP integration.

The PDMP measure is not ready for inclusion in the PIPs because it lacks uniformity of adoption across states and providers. PDMPs are state-level databases that can increase provider awareness of at-risk patients and thus reduce prescription drug misuse, but they are unevenly used across the country due to varying state requirements governing PDMPs. Not all states require the use of PDMPs and one—Missouri—does not even have a PDMP. Additionally, platforms differ by state, creating a lack of uniformity in accessing PDMP data and difficulty in establishing standards for the use of EHRs to access such data. There are no standards or certification criteria for the use of PDMPs or their integration into EHRs. **CMS should work with other agencies to rectify this lack of uniform governance before requiring the use of these databases as part of the PIPs.**

In addition to the lack of standards and certification criteria, the use of PDMPs can cause workflow disruptions when practitioners check a patient’s opioid medication history. Our members have indicated to us that accessing PDMPs can be an arduous process that requires the provider to close the EHR and provide credentials to log on to a state PDMP website. In other words, a provider cannot always seamlessly access PDMP information from within the EHR when electronically prescribing a medication. **Until CMS can confirm PDMP integration and workflow issues are resolved, it should keep the PDMP measure voluntary.**

c. **CMS should delay longer eCQM reporting periods and public reporting of eCQMs until these measures are reliable and valid.**

CMS proposes to require hospitals report on eCQMs for progressively longer periods, beginning with CY 2021, and publicly display these measures. In CY 2020, CMS requires hospitals to report on four measures for one self-selected quarter. CMS proposes to require reporting of two quarters of data in CY 2021, while increasing the reporting period each year by one quarter until requiring four quarters of data in CY 2023. **CMS should keep the eCQM reporting period at one quarter until at least CY 2023 and not require public reporting until the agency has fully resolved questions about the reliability, validity, and accuracy of eCQM specifications.**
A shorter eCQM reporting period and fewer required measures will help hospitals undergoing EHR upgrades. The additional flexibility CMS provides also will give the agency more time to verify these measures are reliable and valid and have accurate specifications. CMS should work with EHR vendors to make electronic reporting of measures a viable option for all hospitals. The extracted EHR data differ from data obtained from chart-abstracted measures and, thus, are not reliable for display in a publicly reported program. For example, chart-abstracted measures allow trained staff to mediate inconsistent provider documentation, whereas only structured, encoded documentation is acceptable for EHR data. Because of the differences between data extracted from eCQMs and chart-abstracted quality measures, CMS should adopt a validation process and conduct robust testing to ensure data from eCQMs are accurate and comparable to chart-abstracted information.

Further, it would be premature for CMS to require electronic reporting before all measures are fully electronically specified and field tested. In general, there are specific requirements for types of information to document for electronic measures; they require more standardization than non-electronic measures. Without detailed electronic specifications available far in advance, many providers will not have enough time to bring their reporting systems up to date. Providers are adapting their workflows to ensure meticulous entry of standardized data into their EHRs. However, it is a process that requires extensive training and resources. Often, the data produced by chart-abstracted measures and eCQMs vary significantly. Therefore, it is unwise to finalize any electronic measure until there is enough evidence of its validity in the field to justify its inclusion as a truly meaningful measure.

**Due to the unresolved issues with electronic reporting for providers, vendors, and the agency, we urge CMS to keep a one-calendar-quarter reporting period for eCQMs and delay the public reporting of eCQM data until at least CY 2023.**

5. **CMS should ensure its bad debt collection policies account for the realities of hospital accounting practices and the patients essential hospitals serve.**

CMS proposes changes to the regulations governing Medicare payment for uncollectible bad debt. Medicare pays hospitals for allowable bad debt—beneficiary coinsurance and deductibles for which the hospital is unable to collect payment. CMS proposes to codify various changes to bad debt collection requirements. Specifically, CMS proposes to allow hospitals to write off bad debt as uncollectible 120 days after issuing a bill to the patient. However, CMS notes that if a patient makes a partial payment toward the amount owed, the hospital must restart the collection effort for another 120 days. This is impractical, burdensome, and contrary to the spirit of the provider reimbursement manual (PRM) instructions on bad debt collection. The provider reimbursement manual states that if bad debt “remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary,” it is presumed to be uncollectible.\(^{16}\) Even if a

---

\(^{16}\text{CMS Provider Reimbursement Manual §310.2.}\)
partial payment is made, the total amount owed would still be considered unpaid under the instructions in the PRM. Further, if a hospital were required to constantly restart the collection process due to a de minimis payment made, this would add burden to the hospital and delay its ability to write off and claim the bad debt. To this end, CMS should not restart the 120-day collection period after a partial payment unless it is part of an installment collection plan determined between the hospital and patient.

CMS also should allow hospitals to use presumptive eligibility tools to determine indigence for bad debt purposes. CMS proposes a list of factors that a provider must review to determine if a non–dual eligible beneficiary is indigent, including assets, liabilities, income, and expenses. When a beneficiary is determined to be indigent, the provider can write off any owed amounts without first having to go through the collection process. Many hospitals already use these processes, which are efficient and reliable, for determining if patients qualify for financial assistance. CMS should consider allowing presumptive eligibility determinations to help determine indigence for bad debt purposes, as well.

6. CMS should continue to refine the hospital Inpatient Quality Reporting (IQR) Program measure set so it contains only reliable, valid measures that provide an accurate representation of care quality.

CMS should continue to tailor the IQR Program measure set so it helps hospitals improve care quality and benefits the public by accurately reflecting hospital care. America’s Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. However, CMS must verify the measures are properly constructed and do not lead to unintended consequences. Further, when a conceptual and empirical basis exists, quality measures should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure the measures reflect quality of care, rather than factors outside of hospitals’ control.

Outcomes measures, especially those for readmissions, do not accurately reflect hospitals’ performance if they do not account for sociodemographic factors that can complicate care. Patients who do not have a reliable support structure at discharge are more likely to be readmitted to a hospital or other institutional setting. CMS should not include in the IQR Program outcome measures sensitive to sociodemographic factors—e.g., readmissions, mortality, episode payments—until the measures have been risk adjusted.

Additionally, quality measurement and reporting should have a clear tie to improving patient safety and advancing CMS’ existing quality priorities. Through focus, consistency, and organization, measures can help drive overall effectiveness in improving health system performance. However, the number of measures and measure reporting requirements must not jeopardize the effectiveness of efforts to make meaningful quality improvements. We applaud CMS’ efforts to increase measure alignment across programs and reduce provider reporting burden through its Meaningful Measures initiative. Through this initiative, the agency has taken significant
steps to identify high-priority areas for quality measurement and improvement and remove duplicative measures. Future proposals to enhance the effectiveness and efficiency of the health care quality system, including the National Health Quality Roadmap, should align with the Meaningful Measures framework, as well as examine potential gaps in quality measurement, such as behavioral health and equity of care.

7. CMS should promote culturally appropriate collection of patient race, ethnicity, and language (REL) data in a standardized and useful way to help identify disparities and target improvement activities to achieve equity.

Essential hospitals’ commitment to caring for all people, including the vulnerable, has made them providers of choice for patients of virtually every ethnicity and language. In 2018, racial and ethnic minorities accounted for more than half of discharges at essential hospitals.17 America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. By involving the patient as an active participant in their care, hospitals can better assist patients in identifying care choices, as well as clinical and social needs that might improve health outcomes.

America’s Essential Hospitals supports gathering accurate, standardized information on patient demographic data. In 2011, the association partnered with other industry leaders in the National Call to Action to Eliminate Health Care Disparities, which promotes the culturally appropriate collection of patient REL information. We believe the collection of REL data supports hospitals’ efforts to identify preferences and needs and to tailor a care plan to specific patient characteristics. For example, collecting preferred language helps identify appropriate interpreter services, as necessary. The ability to monitor and stratify data also helps front-line staff identify problems and standardize efforts across hospitals. As noted by CMS, “Comprehensive patient data on race, ethnicity, language, and disability status are key to identifying disparities in quality of care and targeting quality improvement interventions to achieve equity.”18 CMS should encourage efforts to collect REL data in a culturally appropriate and standardized way.

The unconscionable rates of COVID-19 infections and deaths among Blacks, Latinos, and other minorities have emphasized the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language of patients. Further, the COVID-19 pandemic has shown that pervasive disparities only deepen during times of crisis. Our members face a reality every day that the communities they serve are plagued by social and economic disparities rooted in a history of systemic racism. These

inequities manifest as chronic stress and chronic medical conditions, traumatic injuries, substance use disorders, and other profound challenges for marginalized people.

A recent Centers for Disease Control and Prevention study of characteristics associated with hospitalization among patients with COVID-19 found a higher rate of COVID-19 hospitalizations among Black people. The agency noted that these higher rates “might indicate that Black persons are less likely to be identified in the outpatient setting, potentially reflecting differences in health care access or utilization or other factors not identified through medical record review.” Data are critical to understanding the unique challenges and disparities patients face. While some of the data collection efforts included in recent COVID-19 legislative packages seek to deepen our understanding of these disparities and their root causes, it is clear that more can and should be done to ensure all Americans have equitable access to high quality care.

8. CMS should consider applying the extraordinary circumstances exception (ECE) policy for additional quarters, and conduct measure reliability analyses to ensure sufficient data to calculate performance in quality reporting and value-based programs.

America’s Essential Hospitals appreciates CMS providing some administrative burden relief, though the use of the ECE policy during the COVID-19 public health emergency. This policy also ensures data from the time of the COVID-19 public health emergency, which are not representative of true performance, are not used in public reporting. Specifically, CMS is excluding Q1 and Q2 2020 qualifying claims from the claims-based measures in its hospital quality reporting and value-based purchasing programs. CMS recently announced that it will be discontinuing the ECE policy for COVID-19 on July 1. We support the continued application of the ECE policy, given the adverse impact COVID-19 could have on quality performance, leading to a decrease in reimbursement. As recent developments demonstrate, COVID-19 continues to spread at record-breaking rates, with more than 50,000 new cases reported on July 1. The increase in cases is leading to more hospitalizations, decreasing hospital bed availability, and threatens to tax hospital resources in states like Arizona, Florida, and Texas that are seeing surges in cases. Continued flexibility will be critical while hospitals direct their resources to treating COVID-19 patients. In light of CMS’ announcement discontinuing the ECE

---


policy, we encourage the agency to consider whether applying the ECE policy for additional quarters might be warranted, given the evolving nature of the pandemic.

We also understand **there are potential implications of exempting quarters of data from reporting, such as measure reliability and accuracy in future public reporting.** It is important to closely examine performance measures or policies in Medicare that are tied to payment. **CMS must ensure accuracy and completeness of data submitted. We urge CMS to conduct measure reliability analyses using shortened performance periods to ensure it has sufficient data to calculate performance accurately, and to make public the results of any such analysis.**

9. **CMS should refrain from publicly posting overall hospital quality star ratings until methodology updates are proposed and implemented that account for differences among hospitals.**

We expected to see proposed changes to the overall hospital quality star ratings methodology in rulemaking, based on feedback received through various workgroups and a technical expert panel convened last fall. We understand the circumstances providers, health care systems, and the administration face during this public health emergency; however, we call on CMS to make necessary changes to the star ratings through rulemaking as soon as possible.

America’s Essential Hospitals supports sharing meaningful hospital quality information with patients. However, we believe there is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most vulnerable patients. Health care consumers need accurate, relevant information to make the best care decisions; the current star ratings do not meet this need. The ratings rely on a methodology that fails to account for differences among hospitals and, therefore, could mislead rather than inform consumers.

We previously commented on specific changes to the program, including the use of peer grouping as an interim step on the way to true risk adjustment. Directionally, this is where the star ratings program should be headed—acknowledging and accounting for the differences in hospitals, unrelated to the quality of care they provide, that impact measure performance and ratings.

Additionally, we believe the methodology—with its use of latent variable modeling—remains overly sensitive to subtle changes in the underlying data. This is problematic because it means a hospital’s rating could hinge on measures that reflect only a narrow aspect of hospital care (e.g., hip and knee replacements) and that critical, universal quality measures, such as infection measures, might have almost no importance in determining the star rating. **The program would benefit from a simplified methodology (e.g., explicit approach) for better hospital and patient understanding.**
Overall, the methodology used for the star ratings should reflect true differences in quality and must ensure accuracy, reliability, and fairness. Further, patients should feel confident that the rating they use to make care choices is a true reflection of quality. We are committed to working with CMS to fix the flaws that exist within the program. We strongly urge the agency to cease publication of the ratings until CMS proposes changes through rulemaking; all interested stakeholders review such proposals; and necessary changes are implemented.

******

America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO