



AMERICA'S ESSENTIAL HOSPITALS

June 9, 2023

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

Ref: CMS-1785-P: 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 Administrator Brooks-LaSure:

Thank you for the opportunity to comment 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 and to close the existing health equity gap. As the agency finalizes Medicare inpatient payment policies, we ask that it consider the following comments on supporting the unique role essential hospitals play in promoting health equity by crafting policies that define these hospitals, protect them from payment cuts, and ensure their continued stability.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care (UC), 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 less than half that of other hospitals—3.2 percent on average compared with 7.7 percent for all hospitals nationwide.¹ These narrow operating margins result in minimal reserves and low cash on hand—circumstances exacerbated by financial pressures related to COVID-19. As essential hospitals rebound from the pandemic, they face new challenges, such as rising workforce costs and shortages, rising supply costs, and supply shortages.

¹ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 12, 2023.

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. To meet 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 the quality and equity of care.

As the nation emerges from the COVID-19 pandemic, the importance of a robust, resilient health care safety net to respond to public health crises and provide high-quality care to all people has become even more apparent. Essential hospitals have yet to return to their pre-pandemic outlook—they still face unprecedented financial and operational challenges. We applaud CMS for recognizing the need to define these safety net hospitals and to tailor policies to ensure they receive stable, consistent support. **We urge the agency to implement policies that will ensure sustained support for essential hospitals serving marginalized patients and promoting health equity.**

CMS' flexibility on Medicare inpatient payment policies through this rulemaking will be imperative as hospitals continue to grapple with these challenges. Hospitals will rely on this flexibility as they help their communities recover; provide care to the large number of patients who avoided seeking care during the pandemic and, therefore, will be sicker and costlier to treat; and prepare for future outbreaks. As proposed, continued reimbursement cuts in the form of Medicare disproportionate share hospital (DSH) payment reductions will hurt hospitals facing an uncertain financial future. To ensure our members have sufficient resources to continue responding to future public health emergencies 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.

Safety Net Hospital Request for Information

- 1. CMS should define a category of hospitals that disproportionately serve marginalized patients and implement policies to protect and support these essential hospitals' critical work.**

Essential hospitals form the fiber of the nation's health care safety net. **CMS should adopt payment policies that recognize the unique role of essential hospitals in promoting health equity and should protect essential hospitals from the adverse effects of payment cuts and other policies that affect patient access.** The administration has emphasized as a top priority the importance of tackling structural racism and promoting equity throughout the federal government.² From low payment rates in Medicare and Medicaid—insurance on which low-income people rely—to worse health outcomes for people of color, the lingering effects of structural racism drive health disparities and represent a continued public health threat.

We are encouraged that in the rule's request for information (RFI), CMS has heeded our calls to define and support safety net hospitals through Medicare payment policies. As CMS notes,

² Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, E.O. 13985 (2021).

these hospitals “play a crucial role in the advancement of health equity by making essential services available to the uninsured, underinsured, and other populations that face barriers to accessing healthcare, including people from racial and ethnic minority groups, the LGBTQ+ community, rural communities, and members of other historically disadvantaged groups.”³

The need to define this core group of hospitals and ensure they have stable, sustainable support to continue fulfilling their missions is long overdue. The Institute of Medicine’s clarion call in 2000 to ensure safety net providers, which rely on tenuous funding sources, are “sustained and protected” is as relevant today as it was when it was made more than two decades ago.⁴ The same issues the safety net faced in 2000—chronic underfunding, reliance on an unstable patchwork of funding sources, a higher uninsured and public payer mix, and treating complex patients—continue to undermine the viability of safety net hospitals and pose an equally, if not more dire, threat in 2023. **To further the administration’s and essential hospitals’ shared goals of tackling health disparities and promoting health equity, it is imperative CMS recognize these hospitals when crafting Medicare payment and other policies.**

a. Essential hospitals are distinguished by the vital role they serve in their communities and the unique challenges they face.

In the RFI, CMS solicits comments on the main challenges safety net hospitals face. Essential hospitals are defined by their indispensable role in their communities, the diversity of the patients they serve, and the unique challenges they face that threaten their viability. Essential hospitals, by virtue of their very mission and diverse communities, are experts in addressing social determinants of health (SDOH) and advancing health equity. This expertise stems from essential hospitals’ firsthand experience witnessing and tackling the effects of structural racism and how it routinely disadvantages and produces cumulative and chronic adverse outcomes for people of color. Racial and ethnic minorities made up more than half of member discharges in 2020.⁵ Patients of essential hospitals are negatively impacted by SDOH that affect their health, well-being, and quality of life. Essential hospitals reached nearly 16 million people who live below the federal poverty line, 370,000 individuals experiencing homelessness, and nearly 8 million people experiencing food insecurity.⁶

As essential hospitals, our members are committed to ending health disparities and providing high-quality care to all, including underrepresented and marginalized populations. But the ability to sustain this critical work is hampered by challenges essential hospitals face, including financial instability driven by insufficient payments and skyrocketing costs. Essential hospitals are chronically underfunded, due to their lower share of commercially insured patients relative to other hospitals and their high level of uninsured patients and patients insured by public payers. The disproportionately high amount of UC they provide, and the chronic underfunding of the disparate payment sources on which they rely make it challenging for these hospitals to fulfill their mission. Federal policy changes, such as Medicare payment cuts, disproportionately

³ 88 Fed. Reg. 27187.

⁴ Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *America’s Health Care Safety Net, Intact but Endangered*. 2000. <https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered>. Accessed May 23, 2023.

⁵ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America’s Essential Hospitals 2020 Annual Member Characteristics Survey*. America’s Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 12, 2023.

⁶ Ibid.

impact these hospitals, which already operate on financial margins narrower than the average hospital. Such policy changes also undermine Medicare beneficiaries' access to the linguistically and culturally competent care essential hospitals provide.

Essential hospitals are distinguished by the diverse patients they treat, serving high proportions of Medicaid, Medicare, and uninsured patients, in addition to racial and ethnic minorities. Due to their payer mix, they also provide a much higher share of UC than the average hospital. In addition to this vital safety net role, essential hospitals serve other key roles in their communities. They:

- Provide specialized, lifesaving services, such as level I trauma and neonatal intensive care, emergency psychiatric services, and burn treatment.
- Train the next generation of health care professionals to ensure the community's supply of doctors, nurses, and other caregivers meets demand.
- Deliver comprehensive, coordinated care across large ambulatory networks to bring services to where patients live and work.
- Meet public health needs by improving population health and preparing for and responding to natural disasters, public health emergencies, and other crises.
- Advance health equity to meet the needs and challenges of patient populations that face the greatest disparities and barriers to receiving quality care.

By providing this array of services, essential hospitals serve as anchor institutions and providers of choice for their communities. In the RFI, CMS cites many of these characteristics as defining qualities of safety net hospitals, including playing a crucial role in advancing health equity by treating the uninsured, underinsured, and other populations facing barriers to health care; providing burn and trauma care; partnering with local health departments to address SDOH; and serving as providers of culturally and linguistically competent care in their underserved communities.⁷

b. CMS must define the select group of hospitals with a safety net mission that provide a substantial share of UC and serve a high number of low-income patients.

CMS requests feedback on how safety net hospitals should be identified or defined. We welcome the agency's interest in defining and supporting these hospitals. To further the administration's and essential hospitals' shared goals of tackling health disparities and promoting health equity, it is imperative CMS recognize these hospitals when crafting Medicare payment and other policies. It will be critical that the agency develop a reliable, cross-cutting definition of a safety net hospital that ensures these hospitals are defined and supported, not just for Medicare payment but for other payments under CMS' purview. CMS has expressed interest in supporting safety net hospitals in contexts outside of the Inpatient Prospective Payment System (IPPS):

- CMS has incorporated health equity adjustments into quality programs related to accountable care organizations (ACOs), as well as in determining advance investment payment amounts for ACOs.
- The CMS Innovation Center, as part of its initiative to advance health equity, seeks to increase participation of safety net providers in payment and service delivery models.

⁷ 88 Fed. Reg. 27187.

- In the Medicaid managed care context, CMS acknowledges the financing challenges safety net hospitals face and proposes changes that would allow states to design directed payments that increase reimbursement for these hospitals.

Other payers, too, will look to CMS' work to define safety net hospitals, elevating the importance of holistically defining this group of hospitals. Instead of adopting a piecemeal approach with disparate definitions of safety net hospital both within and outside CMS, it is imperative that any adopted definition be comprehensive and broadly applicable to all public policy and public health purposes. Once CMS has defined safety net hospitals, it can tailor policies to support these hospitals that are specific to each payer and payment system. That is, the underlying definition should be consistent across payers, with the policies meant to support these providers differing by payer and context. Appropriately defining the full scope of the nation's safety net hospitals is the first step in developing policies that target these hospitals for sustained support.

With a clear definition, CMS can identify providers that fill these specific roles in the health care system and assess how current and future policies impact them. This identification will ensure CMS can target support to this specific group of hospitals and protect them from harmful policies. **In crafting a definition of safety net hospital, we urge CMS to look beyond the limited context of Medicare policy and create a definition that will be applicable across all payers, agencies, and policymakers so that CMS and other stakeholders can consistently identify this singular group of hospitals for targeted support.**

There is precedent for uniformly designating a group of safety net providers, such as with federally qualified health centers (FQHCs). FQHCs are defined in both the Medicare and Medicaid statutes and receive dedicated payment rates specific to their provider class. Beyond Medicare and Medicaid, policymakers have used the FQHC definition to provide targeted support, such as Provider Relief Fund assistance during the COVID-19 public health emergency (PHE) and recognition as the only provider type eligible to distribute free vaccines to underinsured children through the Vaccines for Children program. FQHCs also are automatically designated by the Health Resources and Services Administration as health professional shortage areas (HPSAs), which provides special treatment for payment purposes, such as special consideration for certain grant programs.

Similar to FQHCs, essential hospitals serve a safety net role by caring for marginalized patients. Codifying a definition of safety net hospital will be critical to ensuring support for all safety net provider types. Similar to the aligned definition of FQHCs across payers and policies, ensuring safety net hospitals receive reliable, consistent support will be predicated on having an aligned definition of "safety net hospital" across payment systems.

In addition to the vital roles cited above, safety net hospitals are defined by their commitment to fulfilling their mission of serving all patients, regardless of economic circumstance, while operating on narrow margins. Their fulfillment of this mission is reflected in their payer mix—they treat a disproportionately high share of uninsured and publicly insured patients, and as a result, provide substantially high levels of UC relative to the average hospital. For essential hospitals, three-quarters of their patients are publicly insured or uninsured, and they provide eight times as much UC, on average, compared with other hospitals. Thus, unlike other hospitals, their share of commercially insured patients is small, resulting in an average margin 40 percent that of other hospitals. **To capture the safety net mission of, and types of**

low-income patients served by, safety net hospitals, we urge CMS to incorporate these metrics into the definition:

- The Medicare disproportionate patient percentage (DPP). The DPP captures a hospital's proportion of Medicaid inpatient days and low-income Medicare inpatient days.
- A measure of a hospital's share of UC costs relative to all hospitals' UC costs, such as the Medicare uncompensated care payment factor (UCPF). CMS currently measures each hospital's share of UC costs using the Medicare UCPF.
- Being designated as a deemed DSH hospital. Defined in the Medicaid statute, the deemed DSH designation is used to identify hospitals that have high Medicaid and low-income utilization rates.

These three metrics are currently used in different contexts to identify hospitals with a high level of need and that qualify for additional financial support. The DPP is an established metric CMS has used in the Medicare DSH context to define which hospitals qualify for traditional Medicare DSH payments. The relative share of UC costs is currently used for Medicare DSH UC-based payments to target DSH payments to hospitals with high levels of UC. It is derived from Medicare cost report data and is annually audited. Finally, defined by statute, the deemed DSH designation is used to identify hospitals that have high Medicaid and low-income utilization rates.⁸ Together, these metrics are a suitable proxy for hospitals serving vulnerable patients, and by association, treating very few commercial patients relative to other hospitals. By using these metrics, CMS will ensure it is capturing the full breadth of the safety net—that is, by incorporating these different metrics, CMS is not focusing on one segment of low-income patients but is capturing the full scope of low-income patients safety net hospitals treat. Further, all our proposed metrics are vetted, reliable data sources that have been in use for decades (in the case of DPP and deemed DSH) and nearly 10 years, in the case of the UCPF.

CMS will be able to use these data sources without requiring additional revisions to methodology to ensure their reliability, unlike many of the new, less-tested metrics CMS seeks comment on in the RFI, which we discuss further below.

c. The Medicare safety net index is an untested definition with significant flaws and is not suitable to be tied to the identification of the full scope of safety net hospitals.

CMS seeks comments on two potential approaches to defining safety net hospitals, the first of which is the Medicare safety net index (MSNI), an approach the Medicare Payment Advisory Commission (MedPAC) proposed in its March report to Congress. **We urge CMS not to adopt the MSNI as a basis for defining safety net hospitals, as it is a narrow definition that has significant methodological flaws.**

The MSNI metric is the sum of three components:

- Medicare share—a hospital's Medicare inpatient days over all patient days (weighted at 0.5).

⁸ 42 U.S.C. § 1396r-4(b).

- Low-income subsidy (LIS) share—the percentage of the hospital’s Medicare patients (inpatient and outpatient) dually eligible for Medicaid or the Part D low-income subsidy.
- Uncompensated care share—the hospital’s UC costs as a percentage of the hospital’s total patient revenue.

In addition to proposing the MSNI as a definition of safety net hospitals, MedPAC recommended Congress retarget Medicare DSH payments based on this new metric and phase out the use of the DSH adjustment percentage and UCPF to calculate hospitals’ DSH payments. **America’s Essential Hospitals strongly opposes using the MSNI to retarget Medicare DSH payments.** Retargeting Medicare DSH payments as MedPAC recommends would undermine the very hospitals a safety net definition seeks to help and contravene congressional intent. **As we further outline below, separate from our opposition to redistributing DSH payments, the MSNI falls short of accurately defining the full cohort of the country’s safety net hospitals and should not be used to identify this group of hospitals for any purpose.**

- i. *The MSNI omits key characteristics defining safety net hospitals, such as the amount of UC they provide and their non-Medicare low-income patients.*

Due to the three inputs in the MSNI, the metric heavily favors hospitals with higher Medicare volume while omitting non-Medicare low-income patients. Even though the MSNI weighs the Medicare volume at one-half the hospital’s Medicare share, Medicare volume is still a substantial contributor to a hospital’s overall MSNI. The MSNI also accounts for Medicare patients in the LIS component of the metric, which measures low-income Medicare patients. Therefore, the MSNI incorporates Medicare patient load in at least two components while omitting Medicaid patients, which are included in the DPP, the current metric used to determine Medicare DSH eligibility. By omitting Medicaid patients from the formula, the MSNI overlooks a significant part of the safety net patient population that disproportionately comprises people of color and for whom hospitals receive significantly less reimbursement—Medicaid payment rates are well below commercial rates and 22 percent below Medicare rates.⁹

While overemphasizing the role of Medicare volume, the MSNI significantly underemphasizes another key segment of underrepresented patients—the uninsured. The MSNI methodology does include UC over patient revenue as one of three components, but it is weighted equally to the other two components of the MSNI, even though the values for UC as a share of revenue tend to be much lower. For example, in our analysis of Medicare cost report data, the average hospital UC percentage was slightly greater than 2 percent, compared with an average LIS share of 32 percent and an average Medicare share of 36 percent (which would receive a one-half weighting in the MSNI, equaling 18 percent). In the illustrative case of a hospital with average performance on the three components of the MSNI, the UC over patient revenue component would make up only 4 percent of the total MSNI—that is, 96 percent of the hospital’s MSNI value would be driven by the LIS and Medicare share components.¹⁰

⁹ Mann C, Striar A. How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost. The Commonwealth Fund. August 17, 2022. <https://www.commonwealthfund.org/blog/2022/how-differences-medicare-medicare-and-commercial-health-insurance-payment-rates-impact>. Accessed May 15, 2022.

¹⁰ The MSNI of the average hospital was calculated as the sum of the three percentages (expressed as decimals). The UC over revenue for the average hospital, at 0.02, represents just less than 4 percent of the MSNI for this hypothetical hospital.

Further, the spread across low-performing and higher-performing hospitals is much greater for the LIS share and Medicare share components than for the UC over revenue component, meaning a hospital with a relatively high UC over revenue percentage would see a much smaller increase in its MSNI than a hospital with relatively high LIS share and Medicare share values. A hospital with a UC percentage of 2.7 percent would be at the 75th percentile relative to other hospitals. By comparison, a hospital with a 1 percent UC over revenue share would be at the 25th percentile. Yet, the hospital at the 75th percentile would see a mere increase of 0.017 in its MSNI compared with the hospital at the 25th percentile because the MSNI is derived as the sum of the three components. Conversely, the variance across hospitals in Medicare share and LIS percentage values is much higher, so that a hospital treating a higher share of LIS patients relative to other hospitals realizes a much larger increase to its MSNI than a hospital providing high levels of UC.¹¹ **Therefore, by undervaluing the UC component, the MSNI inherently suppresses the importance of providing high levels of UC. In doing so, the MSNI does not appropriately account for safety net hospitals treating large numbers of uninsured patients and providing large amounts of charity care.**

- ii. *The MSNI fails to accurately capture the full cohort of the nation's safety net hospitals.*

Due to the omission of these key elements that define safety net hospitals, the MSNI fails to accurately identify the nation's safety net hospitals and should not be adopted as a safety net hospital definition. The MSNI methodology heavily favors hospitals with high Medicare volume while disadvantaging a substantial number of hospitals that are unquestionably considered the safety net institutions in their communities, as evidenced by the disproportionate amount of UC they provide and the specialized services only they can provide. MedPAC acknowledged this fact, noting that the MSNI is "Medicare-centric by design" and that "the MSNI tends to benefit hospitals with high Medicare shares and reduce payments to hospitals with low Medicare shares and high uncompensated care costs."¹²

Our analysis shows that the use of the MSNI as a measure of hospitals' safety net role disfavors many large safety net hospitals while favoring smaller community hospitals. Many of the hospitals that are on the lower end of the MSNI distribution are those considered to be the safety net institution in their city or state or, even, a multistate region. These hospitals distributed in the bottom half of SNI percentiles are governmental hospitals with insignificant percentages of commercially insured patients and high proportions of publicly insured patients and that provide large amounts of UC. These institutions tend to be level I trauma centers (often the only one in the region), major teaching hospitals, major research sites conducting cutting-edge research and clinical trials, and transplant centers. This point also was raised by multiple commissioners in the November 2022 MedPAC public meeting, where they expressed concern that the MSNI would disadvantage large, governmental hospitals and jeopardize critical services, such as burn and trauma care.¹³ Surely, a policy intended to be a safety net

¹¹ Compared with the UC percentage, which has an interquartile range (which represents the spread between the 25th and 75th percentiles) of 0.017, the interquartile range is 0.081 and 0.208 for the Medicare share and LIS share components, respectively. Similarly, the standard deviation, representing the spread of the values from the mean, are 0.0674 for the Medicare share, 0.0422 for the UC percentage, and 0.1861 for the LIS share.

¹² MedPAC March 2023 Report to Congress. 83, 86.

¹³ Transcript of MedPAC November 2022 meeting. <https://www.medpac.gov/wp-content/uploads/2021/10/November-2022-MedPAC-meeting-transcripts-SEC.pdf>. Accessed May 17, 2023. See comments of commissioners Lynn Barr, Jonathan Jaffery, and Wayne Riley. E.g., "...the sort of

policy cannot leave these crucial institutions in a more financially precarious predicament than their current state.

Within the context of Medicare, if CMS were to adopt this definition or a version of it, it could further direct already limited resources away from these financially fragile providers. Perhaps more concerning, outside of the Medicare context, CMS and other policymakers will undoubtedly look to CMS' definition to define safety net hospitals for non-Medicare policies, which would be a narrow and misleading definition of safety net hospitals, given even MedPAC's recognition that the MSNI policy is meant to tie provider need to their dependence on Medicare.

d. CMS should not use area-level indices, due to shortcomings of these approaches and their lack of previous use in payment programs.

In addition to the MSNI, CMS seeks comment on whether it could use area-level indices, in particular the area deprivation index (ADI), to identify safety net hospitals. **We caution CMS against adopting the ADI or other area-level indices as a basis for defining safety net hospitals, due to the recent and untested nature of these measures, their lack of adoption in federal programs, and methodological issues with area-level measures.**

Area-level indices measure the prevalence of social risk factors within a geographic area. The ADI was developed by the Health Resources and Services Administration and has since been maintained and updated by researchers at the University of Wisconsin-Madison. It incorporates 17 measures that capture social risk factors related to income, education, employment, and housing quality. Notably, until last year, it never had been used in federal programs for purposes of identifying safety net providers or the social risk factors of their patients. CMS finalized calendar year 2023 policies in the Medicare Shared Savings Program to provide upfront payments to ACOs based on the ADI of the beneficiaries assigned to the ACO and to make a health equity adjustment to ACOs' quality performance scores. CMS has also used the ADI in the ACO REACH model as part of the health equity benchmark adjustment.

The ADI and other area-level indices of social risk factors have been used for research purposes but, to date, have not been used in any federal payment programs, except for the limited uses for ACOs. It is still too early to determine whether the ADI can be used as a reliable measure of patients' social risk factors. In a report surveying the use of approaches to account for social risk and SDOH in health care payment programs, the Department of Health and Human Services (HHS) noted that area-level indices have not been used in any payment programs other than the MSSP.¹⁴ Even among state-level programs targeting patients with social risk factors, the metrics used were patient-level metrics, such as the use of ICD-10 Z codes, instead of area-level indices. As the HHS report stresses, significant modifications might be necessary to ensure area-level indices appropriately capture the social risk factors a given policy intends to address

erosion that some public general hospitals will have with the new methodology, again, we need to be mindful of that because it does have the effect of eroding critical services that other hospitals do not want to do, such as Level 1 trauma, burns, perinatal center, the really critical things that we look to from our public general hospitals.”

¹⁴ Breslau J, et al. *Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments*. RAND Health Care. Prepared for the Office of the Assistant Secretary of Planning and Evaluation. September 2022.

<https://aspe.hhs.gov/sites/default/files/documents/8dc674c904723bf8a5ce4cfc8d3dcdad/area-level-sdoh-indices-report.pdf>. Accessed May 31, 2023.

and to ensure they account for variations at the community level. Given the lack of use in the federal policymaking space, it would be premature to adopt area-level indices to define safety net hospitals.

In addition to the untested nature of area-level indices, these indices are problematic because they do not appropriately capture patient-level social risk factors. Instead, they measure aggregate social risk factor data across a geographic area—for the ADI, the data is aggregated at the census block group level. Therefore, the fact that a patient lives in an area classified as disadvantaged might suggest the patient is more likely to have social risk factors, but that is not always the case. For transient patients, such as those experiencing homelessness and housing instability or seasonal workers, their presence in an area at the time of admission to a hospital does not necessarily mean it is where they permanently live or is reflective of their individual social risk factors. Similarly, the presence of a hospital in a disadvantaged area or an area not considered disadvantaged lacks a direct correlation to the social risk factors of its patients.

The poor association between the ADI and patient-level characteristics was explored in a recent peer-reviewed study, which found that “the ADI explained little variation in health care spending, was negatively correlated with spending conditional on demographic and clinical characteristics, and was poorly correlated with self-reported social risk factors.¹⁵ The use of ADI without further adjustment or refinements was found to run “counter to the aims of health equity” and, when used in risk adjustment models, ended up reducing spending for Black, low-income, and rural beneficiaries, as well as those with self-reported social needs.¹⁶ A different study that looked at another area-level index, the social deprivation index, confirmed the weak association between community-level indices and patient-level risk factors.¹⁷

The tenuous link between area-level indices and patient-level characteristics is underscored by numerous examples of hospitals near one another and with comparable service areas but with significant variations in their patient population. For example, consider two large academic medical centers in a large metropolitan area in the southern United States that are in adjacent city blocks. One of these hospitals, a public hospital considered the safety net institution in its metropolitan area, has a DPP (capturing its Medicaid and low-income Medicare patients) of nearly 90 percent, while the other has a DPP of 15 percent (half the national mean DPP of 30 percent). More than 60 percent of the safety net hospital’s Medicare beneficiaries are dually eligible or eligible for the LIS, compared with 20 percent for the other hospital.¹⁸ The substantially higher DPP and low-income Medicare payer mix exemplify the higher complexity of the patients of the one hospital, but using an area-level index could mask the true differences in the characteristics of these two hospitals’ patients. By using area-level indices, such as the ADI, CMS would not capture patient-level characteristics and could hinder its health equity advancement efforts.

Even as a measure of area-level social need meant to be a proxy for individual-level social need, the ADI has significant shortcomings. The ADI for each census block group is determined by ranking all census block groups nationally and assigning each a percentile, with higher numbers indicating greater disadvantage in a census block group. An ADI of 85 or greater is associated

¹⁵ Powers B, et al. Association Between Community-Level Social Risk and Spending Among Medicare Beneficiaries: Implications for Social Risk Adjustment and Health Equity. *JAMA Health Forum*. 2023;4(3):e230266.

¹⁶ *Ibid*.

¹⁷ Cottrell EK, et al. Comparison of Community-Level and Patient-Level Social Risk Data in a Network of Community Health Centers. *JAMA Netw Open*. 2020;3(10):e2016852.

¹⁸ Data from FY 2024 IPPS proposed rule impact file and beneficiary characteristics file.

with areas of significant disadvantage. Because of the metrics used in the ADI, as well as the fact that it is a national ranking, it fails to account for state and local variations in income and other measures of social need. For example, because the ADI uses metrics such as median family income and median home value, areas within states with higher average incomes, including some of the poorest neighborhoods in New York, California, and Washington, D.C., are not considered disadvantaged under ADI because of the relatively high property values and average income compared with other parts of the country.¹⁹ For example, multiple hospitals in New York with DPPs greater than 70 percent and LIS and dually eligible percentages greater than 50 percent fare very poorly on the ADI metric due to these methodological flaws. These hospitals, which serve a safety net role in their communities, would be disadvantaged by the use of the ADI. The ADI also has a weak correlation to other indicators of health outcomes, such as life expectancy. **While the goal of incorporating metrics of social risk is commendable, there are glaring flaws of the ADI and other social-level indices that must be addressed before they can be used in policies that identify and support safety net hospitals.**

- e. Once CMS has defined this group of hospitals, the agency should implement policies throughout the Medicare program that can support these hospitals and change policies that disproportionately harm them.**

With a safety net hospital definition in hand, CMS could turn to certain areas in the proposed rule that offer policymaking opportunities to target support for essential hospitals, such as ensuring stable Medicare DSH funding and implementing the Value-Based Purchasing (VBP) Program health equity adjustment. We discuss these policies in the respective sections of our comment letter below.

In addition to implementing our specific recommendations throughout this letter, CMS should continue this work in future rulemaking to evaluate policies to support and protect hospitals serving a safety net role. Within CMS' jurisdiction, this group of safety net hospitals should be defined so that CMS can target policies to support these providers across Medicare's distinct payment systems (including fee-for-service and Medicare Advantage), in the Medicaid program, and through demonstration projects under the purview of the Innovation Center. For example, CMS should consider the following policy approaches to supporting safety net hospitals:

- Incorporating an essential hospital definition in peer grouping methodology for the Hospital Readmissions Reduction Program (HRRP).
- Adding hospital characteristics, including classification as an essential hospital, to the confidential reporting of across-hospital disparity method results.
- Ensuring essential hospitals are supported in efforts to address disparities and promote equity measurement.
- Exempting provider-based departments of essential hospitals, which bring access into underserved communities, from site-neutral payment cuts.
- Ensuring adequate networks and rate sufficiency for essential hospitals in Medicare Advantage.
- Prioritizing the availability of new graduate medical education slots to essential hospitals.

¹⁹ Azar K, et al. ACO Benchmarks Based On Area Deprivation Index Mask Inequities. Health Affairs Forefront. February 17, 2023. [10.1377/forefront.20230215.8850](https://doi.org/10.1377/forefront.20230215.8850). Accessed May 31, 2023.

- Targeting Medicaid DSH funds to hospitals serving a safety net role to better align the program with statutory intent.
- Identifying Innovation Center models to support safety net hospital participation.

f. CMS can use its existing statutory authority to implement these changes.

The Medicare statute gives CMS wide latitude to implement many of these changes. In addition, in instances where additional funding for essential hospitals is warranted or protection from proposed and existing payment cuts are necessary, CMS might be able to rely on its statutory exceptions and adjustment authority under Section 1886(d)(5)(I) of the Social Security Act. There is precedent both in this rule, as well as in previous rulemaking, for CMS to protect certain hospitals from financial losses or to increase payments to all hospitals or groups of hospitals. Most recently, CMS has used this authority to:

- Provide a supplemental payment to Puerto Rico (PR) and Indian Health Service (IHS) hospitals to make them whole for reductions in DSH payments.
- Create a new COVID-19 treatments add-on payment.
- Hold teaching hospitals harmless from the impact of increased beds on indirect medical education payments during the COVID-19 PHE.

In working to identify and support essential hospitals, CMS would advance its commitment to health equity, protect the interests of the Medicare program, and preserve access to care for the most disadvantaged Medicare beneficiaries. We urge CMS to follow these recommendations, and we look forward to working with the agency to advance our shared goals.

Provisions of Proposed Rule

2. CMS should increase its proposed annual hospital payment update to account for rapidly rising costs of hospital goods and services.

CMS proposes a net annual payment update of 2.8 percent, resulting from a 3 percent market basket update minus a 0.2 percentage point productivity adjustment. **We urge CMS to adjust its methodology for calculating the annual payment update for fiscal year (FY) 2024 to ensure it provides a robust payment update that adequately incorporates the effects of inflation and rising workforce costs on hospitals.**

Hospitals continue to incur soaring costs as they recover from the COVID-19 pandemic, feel the effects of inflation, experience unprecedented increases in labor costs, and encounter supply chain issues and shortages. One analysis found hospitals' per discharge labor costs increased 37 percent from 2019 to 2022.²⁰ The pressure on hospital input costs has continued into 2023, with one analysis of hospital finances citing increased material costs and increased labor costs attributable to persistent workforce shortages. This analysis shows a 4 percent increase in hospital expenses in March 2023 compared with March 2022 and an 18 percent increase in

²⁰ Kaufman Hall. *The Financial Effects of Hospital Workforce Dislocation. A Special Workforce Edition of the National Hospital Flash Report*. May 2022. <https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf>. Accessed May 26, 2023.

expenses so far in 2023 compared with 2020.²¹ These trends are not expected to abate anytime soon, with clinical labor costs expected to outpace inflation and increase by 6 to 10 percent over the next two years.²² Essential hospitals, in particular, have incurred considerable costs associated with hiring bonuses, retention bonuses, and increased salaries to recruit and retain nurses and other staff in short supply. These challenges have persisted even as COVID-19–related hospitalizations decrease and stabilize. Ongoing challenges from the protracted battle against COVID-19 and the consequential emotional toll on staff remain evident. The pandemic has led to burnout on an unprecedented scale, and essential hospitals have expended significant resources to recruit and retain clinical and nonclinical staff—a costly undertaking in the already competitive marketplace for health care workers.

In the context of historical inflation and workforce challenges, a net 2.8 percent payment update is insufficient to truly capture year-over-year changes in hospital costs. **To that end, we encourage CMS to update the market basket by at least 5 percent, to use its statutory authority to waive the productivity adjustment in FY 2024, and to make a one-time retrospective adjustment to account for the insufficiency of the market basket update in FY 2022.** In determining the annual payment update for hospitals, the CMS Office of the Actuary (OACT) first estimates the market basket percentage increase, which reflects the annual change in the mix of goods and services used for providing inpatient hospital services. OACT’s use of the IHS Global Inc. forecast of the market basket rate of increase clearly does not account for the true cost increases hospitals face, particularly when there are sudden increases in prices attributable to unprecedented circumstances, such as the COVID-19 pandemic, as well as historic level of inflation. CMS is not bound to use this data source, because the statutory provision at section 1886(b)(3)(B)(iii) of the Social Security Act provides CMS with discretion to “estimate” the market basket percentage increase. Instead, CMS could look to alternative sources of cost data, such as data from Medicare cost reports, as a truer representation of hospital-reported cost increases to support providing a market basket update of at least 5 percent.

CMS also should waive the negative 0.2 percent productivity adjustment. While this adjustment is required by statute, CMS can waive it using its Section 1886(d)(5)(I) exceptions and adjustment authority. **Furthermore, CMS can use this authority to implement a one-time retrospective adjustment to account for the underestimate of the FY 2022 market basket update, which was finalized at 2.7 percent.** CMS should implement an adjustment equal to the difference between the most up-to-date market basket data for FY 2022 and the finalized market basket update of 2.7 percent. **We emphasize that this should be a one-time adjustment to account for the rapid increase in costs in FY 2022 attributable to the COVID-19 pandemic and inflation.** By adjusting the annual payment update to account for increasing hospital input costs, CMS can ensure hospitals can continue to provide high-quality care and meet the needs of their patients.

3. CMS should use its authority to maintain stability in total DSH payments, accurately capture the full range of UC costs hospitals sustain when caring for

²¹ Kaufman Hall. *National Hospital Flash Report*. April 2023. https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf. Accessed May 15, 2023.

²² McKinsey & Company. *The gathering storm: The transformative impact of inflation on the healthcare sector*. September 19, 2022. <https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector>. Accessed May 15, 2023.

disadvantaged patients, and ensure the transparency of its Medicare DSH methodology.

The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC. Our members represent about 5 percent of all U.S. hospitals yet provided 27 percent of all charity care (the primary component of uncompensated care) nationwide, or about \$7.4 billion.²³

As mandated by Section 3133 of the Affordable Care Act (ACA), the majority of DSH payments are 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 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 DSH payments). This change incorporates UC costs into the DSH formula to better target dollars to hospitals with the greatest need.

We are concerned about the continued DSH payment reductions due to the ACA DSH methodology. After multiple years of substantial decreases, beginning in FY 2014, and two years of slight increases, aggregate UC-based DSH payments have been decreasing since FY 2020. Based on CMS' estimates, hospitals will see a cut to UC-based DSH payments for a fourth year in a row in FY 2024—a nearly \$200 million reduction from last year, to \$6.71 billion. Since 2020, UC-based DSH payments will have decreased about \$1.64 billion—by 20 percent. Total DSH payments, including the estimated empirically justified amount, are estimated to be \$10.12 billion, or \$240 million lower than total DSH payments in FY 2023. For essential hospitals, which treat disproportionate numbers of uninsured and underinsured patients, these cuts are unsustainable. Essential hospitals will feel the impact profoundly in FY 2024, as they continue to recover from substantial financial losses related to COVID-19 and incur higher costs related to inflation and workforce challenges.

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 states have seen. Even in expansion states, essential hospitals continue to sustain significant UC costs in various forms, such as from 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. Further, recent Medicaid coverage gains are beginning to evaporate as the COVID-19 PHE ends and states process Medicaid redeterminations. This will result in an increase in hospital UC and the uninsured rate. As a result, steep cuts to DSH payments are detrimental and unjustifiable for essential hospitals.

We urge CMS to consider how changes in Medicare DSH policy will affect essential hospitals and the communities they serve. In particular, the agency should mitigate losses to essential hospitals related to decreases in the Medicare DSH UC-based pool by capping year-to-year losses. CMS also should consider how to accurately estimate traditional DSH payments and capture changes in the uninsured rate, which, in turn, plays a role in determining aggregate DSH payments. In addition, as data sources evolve and coverage patterns change, CMS should

²³ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 12, 2023.

continue efforts to accurately capture all UC costs for allocating UC-based DSH payments among eligible hospitals. Finally, clarifying the Medicare cost report and other guidance would ensure DSH payments are targeted toward hospitals that need them most. In accounting for these considerations, CMS can ensure essential hospitals receive adequate DSH payments to provide vital care to underrepresented populations.

a. CMS should exclude FYs 2021 and 2022 discharges from the calculation of factor 1 for FY 2024 and be transparent about the other assumptions it uses in estimating factor 1.

As noted previously, CMS’ estimate of total UC-based payments in FY 2024 is about \$200 million lower than the aggregate UC-based payments it finalized for FY 2023. This reduction is driven largely by methodological choices and assumptions CMS makes in estimating the total amount of DSH payments it would have paid hospitals using the pre-ACA methodology. **CMS can address this issue by omitting FYs 2021 and 2022 data in calculating factor 1 and publishing a detailed methodology explaining how it estimated 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 one minus the change in the uninsured rate (factor 2) to produce the aggregate, UC-based amount to distribute across all 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.

From the implementation of the ACA’s DSH methodology in FY 2014 until FY 2020, CMS’ estimate of factor 1 increased annually, which is expected, given the elements the agency uses to trend forward previous years’ pre-ACA DSH estimates. In FY 2024, for the fourth year in a row, factor 1 in the proposed rule is inexplicably lower than the previous year’s factor 1. In FY 2024, CMS estimates pre-ACA DSH payments at \$13.621 billion—\$0.33 billion lower than the amount used in FY 2023 and \$0.36 billion lower than the amount used in FY 2022.

YEARLY FACTOR 1 AMOUNTS FROM IPPS RULES (IN BILLIONS)

| RULE* | ESTIMATED PRE-ACA DSH AMOUNT | FINALIZED FACTOR 1 |
|--------------|-------------------------------------|---------------------------|
| FY 2014 FR | \$12.77 | \$9.58 |
| FY 2015 FR | \$13.38 | \$10.04 |
| FY 2016 FR | \$13.41 | \$10.06 |
| FY 2017 FR | \$14.40 | \$10.80 |
| FY 2018 FR | \$15.53 | \$11.65 |
| FY 2019 FR | \$16.34 | \$12.25 |
| FY 2020 FR | \$16.58 | \$12.44 |
| FY 2021 FR | \$15.17 | \$11.38 |
| FY 2022 FR | \$13.98 | \$10.49 |
| FY 2023 FR | \$13.95 | \$10.46 |
| FY 2024 NPRM | \$13.62 | \$10.22 |

**FR = final rule; NPRM = notice of proposed rulemaking*

To estimate how much DSH funding the agency would have distributed in the absence of the ACA's DSH methodology, CMS uses the latest available year of complete DSH payment data (FY 2020) 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 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 estimates 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 rule, CMS revises downward the discharges factor for 2021 and 2022 because of the effect of COVID-19 on Medicare discharges. As expected, during the peak of the COVID-19 pandemic, Medicare discharges dropped significantly—a trend in line with the general drop in utilization during the pandemic, caused in large part by postponed or canceled procedures. The decline in discharges in FYs 2021 and 2022 was significant, causing a large decrease in CMS' estimate of pre-ACA DSH payments. **CMS should exclude discharge data from these two years because they represented an anomaly and a stark departure from usual trends in Medicare discharges, sharply skewing the estimate of pre-ACA DSH payments.** Including data from these two years results in a substantial reduction in DSH payments at a particularly inopportune time, as hospitals emerge from the pandemic and face new challenges.

Omitting data from these years would be consistent with CMS' authority in the Medicare statute and with other policies it has implemented to control for the effects of the pandemic. The paragraph of the Medicare statute that dictates how CMS is to calculate factor 1 notes that the estimate of DSH payments that would have been made in the absence of the ACA is to be "estimated by the Secretary," thus affording CMS significant discretion over how to calculate factor 1.²⁴ In the FY 2022 IPPS final rule, CMS alluded to the detrimental effect using 2020 data could have on setting prospective payment rates. For example, CMS used FY 2019 claims data instead of FY 2020 data in setting FY 2022 payment rates, noting that in 2020, the "utilization of inpatient services was generally markedly different for certain types of services in FY 2020 than would have been expected in the absence of the [PHE]." Further, in calculating each hospital's per-discharge, UC-based payment amount in FY 2024, CMS proposes to use three years of hospital discharge data but exclude FY 2020 discharges, due to the decrease during the pandemic. CMS should apply this logic consistently by excluding the affected years of data from the estimate of pre-ACA DSH payments, as well.

In addition to omitting 2021 and 2022 data, CMS should be transparent about the other assumptions it uses in its factor 1 estimate. In the rule, CMS also revises downward the "other" factor for FY 2021. CMS should clarify what additional data and assumptions led the agency to adjust these factors downward. Because the "other" category is driven by many assumptions, CMS should describe the reasons for the drop in the "other" factor. **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.**

²⁴ Social Security Act §1886(r)(2)(A).

- 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 economic shifts, that could change the uninsured rate. The ACA directs CMS to reduce the total funds available for the UC-based 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, as required by statute. Since FY 2018, CMS has used estimates of the uninsured rate from the National Health Expenditure Accounts (NHEA), produced by OACT. There is a direct relationship between the uninsured rate and total UC-based DSH payments, such that aggregate UC-based DSH payments decrease as the uninsured rate decreases. Therefore, it is critical CMS accurately project uninsured rate changes. **Going forward, 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 2024 are projections using historical data from 2020. OACT's projections, last updated in March 2022, are outdated and do not incorporate the latest estimates of expected coverage losses that will occur as a result of the expiration of flexibilities tied to the COVID-19 PHE. In 2021 through early 2023, the uninsured rate decreased, due to increases in Medicaid enrollment associated with a continuous enrollment requirement and enhanced federal matching funds, as well as increased health insurance marketplace subsidies enacted by the American Rescue Plan Act. States were allowed to begin disenrolling individuals from Medicaid in April, as the Medicaid continuous enrollment requirement expired on March 31. This change is expected to lead to substantial coverage losses in 2023 and 2024. Based on reputable analyses by the Kaiser Family Foundation and the Urban Institute, an estimated 17 million to 18 million people could lose Medicaid enrollment.²⁵ While many of the disenrolled Medicaid beneficiaries could seek coverage through other programs, this process will take time and will be complex to navigate. Many individuals might find themselves in a coverage gap, even if they are ultimately able to gain new coverage. Additionally, states will have to redetermine the eligibility of their Medicaid enrollees—a process that is expected to be time consuming and could lead to states mistakenly disenrolling Medicaid beneficiaries as they rapidly process these redeterminations.²⁶

These policy changes will have a pronounced impact on the uninsured rate in FY 2024, which, in turn, would increase the UC-based pool. CMS projects only a minimal increase in the uninsurance rate from 2022 to 2023, from 8.9 percent to 9.3 percent. From 2023 to 2024, CMS

²⁵ Buettgens M, Green A. The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage. Urban Institute. December 2022. <https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage>. Accessed May 15, 2023; Burns A, et al. 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-medicare-when-states-unwind-continuous-enrollment/>. Accessed May 15, 2023.

²⁶ Ollove M. Many Medicaid Recipients Could Lose Coverage as Pandemic Ends. The Pew Charitable Trusts. March 11, 2022. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/11/many-medicare-recipients-could-lose-coverage-as-pandemic-ends>. Accessed May 15, 2023.

projects the uninsurance rate will rise by only 0.1 percentage point, to 9.4 percent. OACT's estimates of Medicaid disenrollment during this period pale in comparison to the estimates published by reputable third-party sources. For example, OACT projects 2.6 million Medicaid enrollees would lose coverage from 2022 to 2023, compared with the nearly 18 million predicted by others cited above. **CMS must include significant external factors, such as expected Medicaid coverage losses, 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. OACT should update its NHEA projections to account for these projected coverage losses and the resulting increase in uninsured rates used to calculate the proposed rule factor 2.**

- c. **CMS should prevent year-over-year decreases in essential hospitals' Medicare DSH payments attributable to decreases in the overall UC-based pool.**

CMS should use its statutory authority to protect essential hospitals, as defined above in section 1 of our letter (response to the safety net RFI), from fluctuations in DSH payments. As described above, CMS' proposed UC-based pool is projected to decrease for a fourth consecutive year, by 20 percent compared with FY 2020. These cuts to the UC-based pool trickle down to all hospitals but disproportionately affect essential hospitals, which, on average, provide more than seven times as much UC compared with other hospitals.²⁷ The impact of these cuts will be especially pronounced, given the tenuous circumstances in which hospitals find themselves as they emerge from the pandemic and face rising labor and other costs. As individuals become uninsured or underinsured due to policy changes, such as Medicaid redeterminations, hospitals are likely to incur higher levels of UC to care for these patients. It is counterproductive for CMS to reduce overall DSH payments when hospitals continue to incur high levels of UC. **Given the purpose of the Medicare DSH program to support hospitals serving high numbers of low-income patients and providing proportionally high amounts of UC, CMS should ensure essential hospitals are shielded from these payment cuts.**

As described in section 1 of this letter, essential hospitals are at the forefront of providing care to marginalized patients and combating health inequity. Given the patchwork of funding on which they rely and the instability inherent in these payment sources, it is critical these hospitals have a steady, predictable funding source through the Medicare DSH program. **Using its Section 1886(d)(5)(I) exceptions and adjustment authority, CMS should cap year-to-year losses in UC-based DSH payments for essential hospitals (using the definition we have provided in our response to the safety net RFI) but do so in a way that does not reduce Medicare payments for other hospitals.**

CMS proposes for a second year to make PR and IHS hospitals whole for DSH cuts related to changes in the factor 3 methodology through a supplemental funding stream under its exceptions and adjustment authority. Similar to the methodology used for PR and IHS hospitals, CMS can calculate the amount of UC-based DSH an essential hospital would receive using the finalized factor 3 for the upcoming year and compare it with the amount of UC-based DSH the hospital would have received had the UC-based pool remained steady. Using its exceptions and adjustment authority, CMS then could provide an additional payment to

²⁷ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 15, 2023.

essential hospitals equal to the difference between these two values. For example, CMS would calculate an essential hospital's UC-based DSH amount using its FY 2024 factor 3 multiplied by the UC-based pool in FY 2020, which was the last year before UC-based DSH payments began to decrease. The difference between this amount and the proposed UC-based payment for the upcoming fiscal year would be the additional payment amount. **This policy would serve to protect essential hospitals from year-to-year variability in DSH payments while still targeting these payments based on relative amounts of UC, allowing these hospitals that disproportionately serve marginalized patients to continue their critical work.**

d. 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 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 2024, CMS proposes to use three years of data—in this case, from the audited FYs 2018 to 2020 worksheets S-10. As CMS relies solely on the S-10 for calculating UC costs, the accuracy and reliability 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 FYs 2020 through 2022 cost report data that will adversely impact UC-based DSH payments in future years.*

During the COVID-19 PHE, hospitals—at the prompting of federal guidance and state orders—suspended their regular operations, including by postponing non-emergent and elective procedures. In addition to these actions by hospitals, patients were reluctant to seek care, whether in the emergency department (ED) 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-19.²⁸ This disrupted hospitals' day-to-day operations and changed the types of patients and cases they normally see. For some, this meant 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 to prepare for a possible surge. Therefore, hospitals saw 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. The drop in volume could affect the amount of UC many hospitals provided in 2020 to 2022, compared with what they typically provide. This trend has already started to appear in the data, with aggregate UC across all hospitals \$1.3 billion less than the amount of UC provided in 2019.²⁹ These changes in

²⁸ Lawrence E. Nearly Half Of Americans Delayed Medical Care Due To Pandemic. Kaiser Health News. May 27, 2020. <https://khn.org/news/nearly-half-of-americans-delayed-medical-care-due-to-pandemic/>. Accessed May 15, 2023.

²⁹ Analysis of uncompensated care data in FY 2023 NPRM DSH Supplemental Data File.

UC will vary by geographic region and differences in the severity of COVID-19 in these locations.

CMS should begin to consider policies that will mitigate any atypical drops in UC that some hospitals likely will experience due to the pandemic. Cost report data from FY 2020 that coincide with COVID-19 will be used for FY 2024 rulemaking, and cost report data from FY 2021 will be used for FY 2025 rulemaking. **CMS should begin considering steps to dampen the effect of large downward swings in UC attributable to COVID-19 that will have large redistributive effects on UC-based payments.**

- ii. *CMS should provide clear guidelines on its audit protocols and ensure S-10 reviews impose minimal burden and are equitable and uniform across all hospitals.*

CMS has yet to make public its audit protocols; it is imperative the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. **We urge the agency to disclose the criteria it uses to identify hospitals for audits. Given the relative and redistributive nature of DSH payments, it is important to ensure audits are conducted consistently and equitably.** Under the methodology of CMS' 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 DSH payments across the board. Further, CMS must minimize burden associated with audit documentation requests and conduct the audits well in advance of using 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 DSH payments 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.

CMS can avoid these issues by providing more transparency for its audit protocols. Publishing the audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address findings. Due to 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 are accurate and final. The accuracy and uniformity of audits across DSH hospitals are critical to ensure 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 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 cost-to-charge ratio (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.
- 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. 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 teaching hospitals incur. By excluding these costs, CMS' proposed CCR for determining UC costs will penalize teaching 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 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.**

- iv. 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.*

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, the worksheet also should reflect 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' DSH calculations, should be an accurate representation of a hospital's UC and other costs. Data on Medicaid shortfalls is useful for informational purposes as previously uninsured low-income individuals gain access to health coverage through Medicaid. Further, 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 revenue 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 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 non-reimbursed 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 non-reimbursed 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 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 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.**

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

CMS notes it will consider revisions to the S-10 through the Paperwork Reduction Act process. **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 begins to incorporate multiple years of S-10 data. The S-10 has assumed increased importance as it becomes the sole basis for UC-based DSH payments; as such, it is critical 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 through agency conference calls, webinars, FAQs, 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.

4. CMS should finalize a 90-day reporting period in the Promoting Interoperability Period for calendar years 2024 and 2025.

In the FY 2023 final rule, CMS finalized a 180-day reporting period for the Medicare Promoting Interoperability Program beginning in calendar year (CY) 2024. CMS now proposes a 180-day reporting period for CY 2025 and suggests it could lengthen the reporting period beginning in CY 2026. **CMS should finalize a 90-day reporting period for CY 2024 onwards, which will offer much-needed relief as providers continue to work toward interoperability.** America's Essential Hospitals strongly supports a 90-day reporting period, which gives providers flexibility to develop their reporting infrastructure and make necessary updates to their electronic health record (EHR) systems to comply with evolving Promoting Interoperability Program requirements. As CMS makes changes to the measures and scoring methodology of the Promoting Interoperability Program, 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 or vendor changes and upgrades. **Accordingly, CMS should finalize a 90-day reporting period for CYs 2024 and 2025.**

5. CMS should continue refining the Hospital Inpatient Quality Reporting (IQR) Program measure set to contain only reliable, valid measures that accurately represent 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 creating and implementing measures that lead to quality improvement. However, CMS must verify the measures are appropriately constructed and do not lead to unintended consequences.

We appreciate CMS' continued commitment to its Meaningful Measures initiative, which aims to identify high-priority areas for quality measurement and improvement and reduce provider burden. The proposed removal of three measures, including Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC-01), is greatly appreciated.

Chart-abstracted measures, such as PC-01, can impose a substantial administrative burden on safety net hospitals, which have leaner staff than at other hospitals. The manual process associated with chart abstraction can pull staff away from broader quality improvement and patient care initiatives.

We urge CMS to finalize the proposal to remove PC-01, as it aligns with the agency’s Meaningful Measures initiative and reduces administrative burden on essential hospitals, enabling them to prioritize patient care and quality improvement initiatives more effectively.

- a. CMS should revise its proposed COVID-19 vaccination among health care personnel (HCP) measure by reducing its reporting frequency and refrain from publicly reporting it.**

CMS proposes modifying the COVID-19 Vaccination Coverage among HCP measure. Specifically, it proposes replacing the phrase “complete vaccination course” with “up to date” regarding recommended COVID-19 vaccines beginning with the CY 2023 fourth quarter reporting period/FY 2025 payment determination for the IQR Program. “Up to date” would include individuals who received an updated bivalent booster dose, those who received their last booster dose less than two months ago, or those who completed their primary series less than two months ago. CMS also proposes updating the measure’s numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses.

Hospitals would report the percentage of health care personnel considered up to date with recommended COVID-19 vaccines for at least one self-selected week during each month of the reporting quarter, starting with the CY 2023 fourth-quarter reporting period for the Hospital IQR Program.

America’s Essential Hospitals supports revising the current measure, which captures up-to-date vaccination information as recommended by the Centers for Disease Control and Prevention. However, the proposed reporting frequency of one week a month might pose an undue burden on hospitals, which would have to regularly, on an employee-by-employee basis, access an “up to date” status and parse out those granted medical and religious exemptions, as well as newly hired employees. **We urge CMS to revise the proposed reporting requirements for the COVID-19 Vaccination Coverage among HCP to a single annual reporting.** Shifting to an annual reporting frequency will alleviate burden, enabling hospitals to efficiently track employee vaccination statuses, exemptions, and new hires comprehensively.

America’s Essential Hospitals firmly believes vaccination is a critical part of the nation’s continued strategy to combat COVID-19, and our members continue to promote widespread vaccination within their organizations and communities. But it is unclear whether CMS plans to address factors contributing to variation among hospitals’ reported vaccination rates and the potential for confusion among consumers if rates are publicly reported. For example, some hospitals have a vaccination requirement for all employees, while others have limited their requirement to those with specific job functions. Others require only two of the initial doses recommended under the previous policy. **We urge CMS to refrain from publicly reporting this data, given potential variation in hospital policies regarding employee vaccination requirements, which might confuse consumers.**

Finally, this revised measure has not been endorsed by the CMS’ Consensus-Based Entity (CBE), Battelle, an organization that endorses quality measures through a transparent, consensus-based process that incorporates feedback from diverse groups of stakeholders to foster accountability and consistency. Measures endorsed by a CBE are considered the gold

standard for quality measurement. **We urge CMS to seek CBE endorsement of the COVID-19 vaccination coverage among HCP measure.**

- b. CMS should ensure that the Acute Kidney Injury and Hospital Harm–Pressure Injury electronic clinical measures (eQMs) in the IQR Program are valid and meaningful and improve outcomes.**

America’s Essential Hospitals supports CMS’ efforts to address gaps in quality measurement for those with impaired kidney function and those with hospital-acquired pressure injuries. Through focus, consistency, and organization, measures can help drive overall effectiveness in improving health system performance and patient outcomes.

CMS proposes two eQMs, Acute Kidney Injury (AKI) and Hospital Harm–Pressure Injury, in the Hospital IQR Program measure that hospitals can self select to report, starting in the CY 2025 reporting period and impacting 2027 Medicare reimbursement.

We support the agency’s efforts to enhance care quality by creating electronic measures. But even CMS leaders have noted hospitals can face a significant burden when mapping data from the EHR to the appropriate Quality Reporting Data Architecture (QRDA) format, as some vendors might lack the capability to collect and transmit such data via the CMS portal.³⁰

The AKI measure is an outcomes eQOM that assesses the proportion of inpatient hospitalizations for patients 18 and older who have an AKI (stage 2 or greater) that occurred during the encounter. The measure aims to improve patient safety and prevent patients from developing moderate to severe AKI during hospitalization.

We appreciate CMS’ initial efforts related to risk stratification associated with this measure. The measure’s numerator specifies that only patients who develop AKI stage 2 or greater during the hospitalization are included. AKI is classified into three stages, based on increased serum creatinine and decreased urine output.³¹ Therefore, CMS’ proposed measure would include only patients who have developed moderate to severe AKI.

We also have concerns regarding the use of serum creatinine levels as a measure of renal function. Serum creatinine levels can be influenced by various factors, such as muscle mass, age, race, and medical conditions, that cause overproduction of creatinine. **Therefore, we urge CMS to refrain from adding the Hospital Harm–Acute Kidney Injury measure to the IQR program, as it requires further refinement and study.**

If CMS decides to incorporate the measure, **we urge it to receive endorsement from the agency’s CBE.** The Measure Applications Partnership (MAP) issued conditional support for rulemaking pending endorsement by the CBE.³² MAP is an advisory body that helps CMS

³⁰ Schreiber M, et al. Balancing value and burden: The Centers for Medicare & Medicaid Services Electronic Clinical Quality Measure (eCQM) Strategy Project. *J Am Med Inform Assoc.* 2021 Oct 12;28(11):2475-2482.

³¹ Allen J, et al. Definition of Hourly Urine Output Influences Reported Incidence and Staging of Acute Kidney Injury. *BMC Nephrol.* 21. Article number: 19 (2020).

³² Map 2019 Considerations for Implementing Measures in Federal Programs: Hospitals. National Quality Forum. December 21, 2018. http://www.qualityforum.org/Projects/im/MAP/Hospital_Workgroup/2019__Considerations_for_Implementing_Measures_Draft_Report.aspx. Accessed May 30, 2023.

identify high-priority areas for quality measurement and improvement, while the CBE ultimately endorses measures.

The Hospital Harm–Pressure Injury measure is an outcome electronic clinical quality measure (eCQM) that assesses the proportion of inpatient hospitalizations for patients 18 years and older who suffer harm due to a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. During its review, the MAP expressed concern about the measure specifications and cautioned about potential bias against facilities that lack the expertise needed to stage pressure injuries accurately (e.g., facilities without certified wound care nurses).³³ The MAP noted that risk adjustment might be necessary to ensure the measure does not disproportionately penalize facilities that treat more complex patients.³⁴

Currently, the only risk stratification CMS proposes is that the denominator exclude hospitalizations for patients diagnosed with COVID-19 during the encounter. CMS has stated it is proposing this measure adjustment because hospitals have been reporting a wide range of skin manifestations of COVID-19 as pressure injuries, due to a lack of clear coding guidance and evidence related to the pathophysiology of COVID-19–related lesions. However, CMS notes that the proposal to exclude COVID-19 is transitional.

We appreciate this initial risk stratification strategy. **But we urge CMS to reconsider adding the Hospital Harm–Pressure Injury measure to the IQR program, as it requires further refinement and study.** The concerns expressed by the MAP regarding measure specifications, potential bias against certain facilities, and the need for risk adjustment to avoid disproportionate penalties for hospitals treating complex patients, highlight the need for additional evaluation and clarification before implementing the measure.

America’s Essential Hospitals is concerned that implementing the measure without appropriate risk adjustment will disproportionately impact safety net hospitals that treat more complex patients.

c. CMS should validate the Hybrid Hospital-Wide All-Cause Mortality and Readmission Measures if it begins to include Medicare Advantage data in the measure populations.

CMS proposes to include both Medicare FFS patients and Medicare Advantage (MA) patients in the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) and the Hybrid Hospital-Wide All-Cause Readmission (HWR) measures for the FY 2027 payment determination and subsequent years. CMS notes this change could improve hospital performance under both measures. Agency officials looked at data from July 1, 2018, through June 30, 2019, including 6,883,980 unique admissions extracted from the CMS Integrated Data Repository for FFS claims, hospital-submitted MA claims, and Medicare Advantage Organization (MAO)–submitted MA inpatient encounter claims. It found MA enrollees tended to have lower hospital admission rates, and the prevalence of comorbidities was generally lower among MA beneficiaries. These findings were echoed in a 2022 *Journal of the American Medical Association (JAMA)* article that noted enrollment in Medicare Advantage, compared with traditional Medicare, was associated with significantly lower adjusted 30-day mortality

³³ Ibid.

³⁴ Ibid.

rates.³⁵ The study also found MA patients were more likely to receive guideline-recommended medication prescriptions, less likely to be admitted to an intensive care unit (ICU), and more likely to be discharged to home rather than a post-acute facility.³⁶ A separate 2021 *JAMA* article found many hospitals would not have faced penalties under the HRRP had data from MA patients been included.³⁷

Including MA data also might lead to more accurate mortality and readmission rates as enrollment in these private plans continues to rise. As of 2022, more than 31 million people, almost half of all Medicare beneficiaries, were enrolled in MA plans.³⁸ This number is expected to increase in the coming years.

While America's Essential Hospitals supports including MA data in these measures, we have some concerns about the validity, reliability, and feasibility of incorporating MA data. In its 2022 report to Congress, MedPAC stated that the incomplete encounter data has made it difficult to describe the quality of care in MA accurately.³⁹ To address this issue, MedPAC recommended that Congress improve the accuracy and completeness of encounter data in MA plans to better serve as a source of quality data and facilitate comparisons with fee-for-service Medicare.⁴⁰

Given the concerns MedPAC raised regarding the incomplete data and the need to improve the accuracy and completeness of encounter data in MA plans, it is crucial to ensure MA data is accurate before including it in these measures. **We urge CMS to confirm the validity, reliability, and feasibility of incorporating reliability of MA data and have these proposed measure revisions undergo CBE review.**

d. CMS should not finalize the proposed quality measures related to geriatric care.

America's Essential Hospitals acknowledges the importance of team-based care to improve patient outcomes, especially for older individuals. **However, we do not support including the Geriatrics Surgical Measure and the Geriatrics Hospital Measure in the IQR program, as attestation measures are subjective in nature and might not accurately capture the quality of care offered at hospitals.**

The Geriatric Hospital and Geriatric Surgical measures are structural measures that assess a hospital's commitment to improving outcomes for patients 65 or older. The Geriatric Hospital measure focuses on improving outcomes for all older patients admitted to the hospital or being evaluated in the ED, while the Geriatric Surgical measure focuses on improving surgical outcomes for older patients. Both measures include attestation-based questions across multiple

³⁵ Landon B, et al. Association of Medicare Advantage vs Traditional Medicare with 30-Day Mortality Among Patients With Acute Myocardial Infarction. *JAMA*. 2022;328(21):2126-2135.

³⁶ Ibid.

³⁷ Panagiotou O, et al. Association of Inclusion of Medicare Advantage Patients in Hospitals' Risk-Standardized Readmission Rates, Performance, and Penalty Status. *JAMA Netw Open*. 2021 Feb 1;4(2):e2037320.

³⁸ P Minemyer. CMS Data: Medicare Advantage enrollment now more than 31M. Fierce Healthcare. February 21, 2023. <https://www.fiercehealthcare.com/payers/cms-data-medicare-advantage-enrollment-now-more-31m>. Accessed May 30, 2023.

³⁹ Medicare Advantage Encounter Data. Medicare Payment Advisory Commission. September 1, 2022. <https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf>. Accessed May 30, 2023.

⁴⁰ Ibid.

domains. A hospital must affirmatively attest to each statement within a domain to receive credit for that domain.

While both these measures aim to improve outcomes for patients 65 or older, they have faced limited testing, and there is no evidence they will lead to improved patient outcomes. Collecting data from the attestation-based questions across all the domains outlined is labor-intensive, and CMS has not appropriately shown how these statements and domains improve patient outcomes. Additionally, it is not clear what value these measures add for patients, as care quality metrics, such as CMS' Overall Hospital Star Ratings and condition-specific quality metrics, are already available to help consumers to make informed care decisions.

CMS also has stated it is considering establishing a publicly reported hospital designation for geriatric care based on data from these measures. We are concerned about the accuracy of the data these measures generate and the potential administrative burdens the measures pose. Inaccurate data ultimately could undermine public trust in all reported quality data.

We urge CMS to reconsider including the Geriatrics Surgical Measure and the Geriatrics Hospital Measure in the IQR program, given that these measures lack sufficient testing and evidence to demonstrate improved patient outcomes, and the labor-intensive data collection process through attestation-based questions does not appear to be directly linked to improved care.

6. CMS should ensure measures in the Hospital VBP Program are risk stratified and minimally burdensome, and accurately track quality of patient care.

Under the VBP program, CMS proposes a series of new and revised quality measures it says will further equity goals by rewarding hospitals for providing high-quality care to underserved populations. However, we are concerned some proposals might unfairly penalize essential hospitals, **and we encourage CMS to modify some of its proposals.**

a. We urge CMS to postpone adding the Severe Sepsis and Septic Shock: Management Bundle measure to the VBP program, until it can be appropriately revised.

The Severe Sepsis and Septic Shock: Management Bundle measure has been adopted for the Hospital IQR Program, and public reporting of performance results began in 2018. CMS now proposes to adopt the measure in the VBP program's safety domain, beginning with the FY 2026 program year. **We oppose this change unless the measure is risk stratified and approved by the agency's CBE.**

The Severe Sepsis and Septic Shock: Management Bundle measure is intended to improve the quality of care provided to patients with severe sepsis and septic shock. The measure is based on the Surviving Sepsis Campaign guidelines, the international guidelines for managing severe sepsis and septic shock. The measure includes four components: timely initiation of antibiotics, fluid resuscitation, vasopressor therapy, and blood cultures. The measure is scored on a binary scale (0 or 1), with a score of 1 indicating all four components were met.

Our primary concern with the measure is that it lumps together septic shock and non-shock patients, yet it might not be appropriate for all these patients to receive each of the bundle elements, such as antibiotics, lactate measures, and fluid.

In the proposed version of the measure included in the VBP, all patients 18 years and older admitted to the hospital with sepsis, severe sepsis without septic shock, or severe sepsis with septic shock would be included. Required interventions include performing an initial lactate measurement within three hours of the presentation of severe sepsis and then repeated lactate measurement during treatment. Likewise, CMS highlighted concerns hospitals raised during the measurement development process, which included that the measure could lead to the overuse of antibiotics. The overuse of antibiotics is a concern because the measure requires that all patients with severe sepsis or septic shock receive antibiotics within one hour of presentation. But not all patients with severe sepsis or septic shock need antibiotics. We note the concern raised during an April 2022 Appeals Board Cover Letter to the National Quality Forum that the measure should not be re-endorsed until revised.⁴¹

This measure could be refocused on a subset of patients most likely to benefit from rapid and aggressive interventions—those with septic shock—and exclude those without shock. This approach would minimize antibiotic overuse and eliminate bundle elements that do not contribute to improved patient outcomes for patients not in shock, such as measuring serial lactates. A 2021 research article in the *American Journal of Respiratory and Critical Care Medicine* found that frequent use of lactate for sepsis screening and diagnosis might trigger unnecessary broad-spectrum antibiotic use in some patients.⁴²

America's Essential Hospitals also remains concerned about the burden of abstracting data to comply with the measure and **urges it to be revised to an outcomes measure**. Outcome measures focus on the results of care, which is ultimately what matters to patients and their families. In complex cases, the chart abstraction process can take up to three hours, requiring the skills of an experienced registered nurse. This can quickly become burdensome for high-volume hospitals, such as essential hospitals. Moreover, more than 50 percent of the cases do not qualify for Severe Sepsis or Septic Shock, yet an abstractor can still take up to three hours to determine that the clinical indicators were never met.⁴³ These challenges make it difficult for hospitals to comply with the measure and can lead to inaccurate reporting, due to either undercounting or overcounting the number of eligible cases under the measure.⁴⁴ We also are concerned about including this measure, given the findings of several research articles in the past four years that show hospitals with more limited financial resources and a higher proportion of low-income patients of color, such as essential hospitals, are more likely to perform poorly under the sepsis measure.^{45, 46, 47, 48, 49} To that end, **we urge CMS to refocus the measure only for patients in septic shock to ensure the sickest patients receive**

⁴¹ Ibid.

⁴² Weinberger J, Klompas M, Rhee C. What Is the Utility of Measuring Lactate Levels in Patients with Sepsis and Septic Shock? *Semin Respir Crit Care Med*. 2021 Oct;42(5):650-661.

⁴³ File Code: CMS-1694-P. Memorial Hermann Health System. <https://www.regulations.gov/comment/CMS-2018-0046-1378>. Accessed May 30, 2023.

⁴⁴ Ibid.

⁴⁵ Wang J, et al. Driving Blind: Instituting SEP-1 without High Quality Outcomes Data. *J Thorac Dis*. 2020 Feb;12(Suppl 1):S22-S36.

⁴⁶ Corl K, et al. Racial and Ethnic Disparities in Care Following the New York State Sepsis Initiative. *Health Aff (Millwood)*. 2019;38(7):1119-1126.

⁴⁷ Weinreich M, et al. Sepsis at a Safety Net Hospital: Risk Factors Associated with 30-Day Readmission. *J Intensive Care Med*. 2019 Nov-Dec;34(11-12):1017-1022.

⁴⁸ Barbash I, Kahn J. Sepsis Quality in Safety-Net Hospitals: An Analysis of Medicare's SEP-1 Performance Measure. *J Crit Care*. 2019 Dec;54:88-93.

⁴⁹ Liao J, et al. Association of Hospital Characteristics with Early SEP-1 Performance. *Am J Med Qual*. 2020 Mar/Apr;35(2):110-116.

the highest-intensity treatment and to reduce the data abstraction burden on hospitals by reducing the number of individuals monitored under the measure.

b. We urge CMS to finalize its revisions to the Medicare Spending Per Beneficiary (MSPB) Hospital measure.

CMS proposes substantive changes to the MSPB Hospital measure, which will take effect in the FY 2028 program year. The proposed refinements include allowing readmissions to trigger new episodes, introducing a new indicator variable in the risk adjustment model, and changing the MSPB amount calculation methodology. CMS made these changes partly to ensure it was evaluating circumstances within a hospital's influence. **We support this measure proposal for the HVBP Program.** We thank CMS for acknowledging our previously stated concerns that the MSPB lacked risk adjustment for factors outside the control of hospitals and might unfairly penalize essential hospitals that serve a disproportionate share of patients with complex and costly needs—both clinically and socially.

c. CMS should adopt a health equity adjustment and consider alternative approaches to identify hospitals that disproportionately serve marginalized patient populations, such as including a formal definition of an essential hospital.

CMS proposes the Health Equity Adjustment (HEA) bonus for hospitals under the VBP program. Under this proposal, bonus points would be awarded based on a hospital's performance and the proportion of patients dually eligible for Medicare and Medicaid who received inpatient services. A similar health equity adjustment was finalized for Medicare Shared Savings Program ACOs last year.

The HEA is calculated using a measure performance scaler and an underserved multiplier. The multiplier would be the number of inpatient stays for patients with dually eligible status out of the total number of inpatient Medicare stays during the calendar year two years before the start of the respective program year. CMS considered using the ADI as the multiplier, but the agency could not obtain the necessary patient neighborhood-level data.

We support CMS' proposal to provide a health equity adjustment for hospitals disproportionately serving marginalized patient populations. **We encourage CMS to examine other approaches beyond the ADI and dual eligibility to identify hospitals that disproportionately serve the underserved.** As outlined above, in Section 1, **we urge CMS to create a formal designation for essential hospitals, which could be applied to the health equity adjustment to more accurately identify hospitals serving marginalized patient populations.** Essential hospitals play a unique role in reducing disparities and promoting health equity, and a formal designation would recognize their mission to integrate health equity into care delivery and address social determinants of health. This designation would ensure hospitals serving a high proportion of underserved individuals receive appropriate support and recognition.

Relying solely on dually eligible patients to serve as the proxy for identifying safety net hospitals could lead to the incomplete identification of essential hospitals. Relying on the number of patient days of dual-eligibles also could drive longer lengths of stay for those patients. Beyond dual eligibility status, the bonus should eventually incorporate metrics identifying those facilities with high volumes of Medicaid, uninsured, and underinsured patients.

The underserved multiplier, as outlined in the proposal, holds the potential to appropriately reward hospitals that provide care to underserved populations. **We also would ask that CMS consider a ramp-up period for its proposed performance scaler. Without a ramp-up period, the scaler might inadvertently penalize hospitals that are actively striving to improve their performance.** While we acknowledge the importance of holding hospitals accountable for their outcomes, we believe it is essential to provide a transition period that allows hospitals to adjust their practices and work towards achieving better performance scores.

By granting a ramp-up period, hospitals would have the opportunity to implement strategic initiatives, improve care delivery processes, and enhance performance in the designated domains. This period would facilitate a smoother transition and allow hospitals to fully understand the implications of the performance scaler. It also would ensure a fair evaluation of hospitals' progress by accounting for the efforts made to improve performance over time.

7. CMS should finalize its revalidation proposals for the Hospital-Acquired Condition (HAC) Reduction Program.

Under the HAC Reduction Program, CMS has two proposals to add a validation reconsideration process, allowing hospitals to request reconsideration of their final validation scores. The process would be similar to the current validation reconsideration processes of the Hospital IQR Program. CMS also seeks to modify the validation targeting criteria for extraordinary circumstances exceptions (ECEs) beginning with the FY 2027 program year, affecting CY 2024 discharges.

a. CMS should finalize the proposal to add a validation reconsideration process to the HAC Reduction Program.

Under the proposed process, hospitals that fail validation would be notified by CMS and have 30 days to request reconsideration. The request must include the basis for the request and all documentation and evidence supporting the hospital's request. CMS would review the request and decide within 90 days. If CMS grants the request, it would recalculate the hospital's confidence interval and determine whether the hospital passed or failed validation. The proposed validation reconsideration process would align data validation processes with the Hospital IQR Program reconsideration process, which hospitals are familiar with. **We thank CMS for this proposal and urge that it be finalized,** as it allows hospitals to correct any errors in their reporting that might have led to a validation failure.

b. CMS should finalize the proposal to modify the validation targeting criteria for ECEs.

CMS proposes to update the targeting criteria for validating hospitals granted an ECE in the HAC Reduction Program. Specifically, CMS proposes to modify the validation targeting criteria to include any hospital with an estimated reliability upper bound less than 75 percent and that received an ECE for one or more quarters, beginning with the FY 2027 program year. This change would affect the validation of CY 2024 discharges. Further, the proposed update to the targeting criteria would align the HAC Reduction Program with the Hospital IQR and Hospital Outpatient Quality Reporting programs.

We urge CMS to finalize this proposal. CMS notes that updating the targeting criteria is necessary to ensure hospitals are not penalized for errors beyond their control. For example, a hospital might receive an ECE due to a natural disaster or other unforeseen event. We thank CMS, as it recognizes it would be unfair, in these cases, to penalize a hospital for failing to meet the validation requirements.

8. CMS should finalize proposed changes to the severity level designation for Z codes describing homelessness.

CMS is proposing to reclassify the severity level designation for three diagnosis codes describing homelessness from “non-complication or comorbidity” (NonCC) to “complication or comorbidity” (CC) for FY 2024.

We support this proposal as a critical step toward supporting health care access for underserved and under-resourced communities. This change acknowledges the impact of homelessness as a social determinant of health, including increased resource utilization and costs associated with providing care to this specific patient population. A 2021 article in *British Medical Journal* (BMJ) estimated that as many as 90 percent of individuals experiencing homelessness seek care at a safety net hospital.⁵⁰ America’s Essential Hospital’s 2020 annual member data report estimated that 370,000 patients that sought care at one of our member hospitals experienced homelessness that year.⁵¹ The proposal clarifies that housing insecurity is a valid secondary diagnosis leading to increased hospital resource use. **We urge CMS to finalize this proposed change as it recognizes the significance of addressing health care access in underserved and under-resourced communities, particularly by acknowledging the impact of homelessness as a social determinant of health and its implications for resource utilization and costs.**

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,

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President and CEO

⁵⁰ Miyawaki A, Khullar D, Tsugawa Y. Processes of Care and Outcomes for Homeless Patients Hospitalised for Cardiovascular Conditions at Safety-Net Versus Non-Safety-Net Hospitals: Cross-Sectional Study. *BMJ Open*. 2021;11:e046959.

⁵¹ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America’s Essential Hospitals 2020 Annual Member Characteristics Survey*. America’s Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed May 12, 2023.