WISCONSIN HOSPITAL ASSOCIATION

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June 17, 2022

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

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

Dear Administrator Brooks-LaSure:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2022 rule related to the Medicare Program Hospital Inpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Payment Update

For FY 2023, CMS proposes an overall market basket update of 3.2%.This update, on the heels of the FY 2022 payment update of 2.7%, is woefully inadequate and is not keeping up with the true level of inflation impacting health care and the country as a whole. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. **Unfortunately, historical data is no longer a good predictor of future changes. Given the extreme levels of inflation our country is facing the market basket is inadequate.** Indeed, with more recent data[1], the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year. We urge CMS to consider the changing health care system dynamics and their effects on hospitals.

Specifically, we urge CMS to 1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023.

[1] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast.

The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on hospitals. While COVID cases have been much more manageable recently, and while the hope is we are returning to a post-covid normal, hospitals are facing mounting fiscal pressures stemming from COVID, including:

- Rising labor costs from a nationwide workforce shortage and historic inflation. Labor costs often make up 60% or more of a hospital's operating cost.
- Stagnant reimbursement from government payors like Medicare and Medicaid, which make up more than half of inpatient care for 94% of Wisconsin hospitals.
- Longer average lengths of stay due to hospitals treating higher-acuity patients and the lack of available long-term care settings for patients. These patients require more staffing resources and yet our antiquated payment structure does not take this into account.
- A return of the Medicare Sequester cuts at 1% on April 1, and 2% on July 1.
- Depletion of the COVID PRF and funding for COVID tests and treatment for the uninsured.

In addition to these challenges facing all hospitals, mid-size rural hospitals are also facing the prospect of two payment statuses set to expire by September 30, 2022. **The Medicare-Dependent hospital designation and Low-Volume Adjustment payments help support seventeen rural hospitals in Wisconsin, all of which are lifelines to their communities. If allowed to expire, these cuts could lower payments to these essential hospitals by up to $19 million in 2023 for Wisconsin hospitals alone.**

While WHA is advocating with Congress for the extension of these programs, we are concerned that CMS is ignoring congressional intent and denying a group of hospitals — those with 200 to 799 discharges — access to this critical payment adjustment. Therefore, we urge CMS to apply the 25% payment adjustment to all hospitals with fewer than 800 total discharges, as is specified under the law. This would extend the adjustment to approximately 136 additional rural hospitals. Two thirds of these hospitals have payment-to-cost ratios that are less than one. These small and isolated hospitals desperately need this additional support to cover the cost of caring for their patients.

Despite numerous financial pressures, hospitals have worked hard in recent years to keep costs down. According to data from the Bureau of Labor Statistics, hospital prices have grown an average of 2.1% per year over the last decade, about half the average annual increase in health insurance premiums. However, with the combination of historic inflation, an unprecedented workforce shortage, and sustained underpayments by federal government health care programs, hospitals are facing significant fiscal pressures going forward.

Wisconsin ranks 16th lowest in terms of per-beneficiary spending according to the Kaiser Family Foundation, and yet, is not rewarded for being a low-spending state when it comes to Medicare. Wisconsin hospitals receive, on average, around 73% of what it costs them to provide Medicare services, well below the national average. At the same time, Wisconsin is also the 16th highest state in terms of the percent of its population on Medicare. As people move off private insurance and onto Medicare, it compounds the impact of insufficient Medicare reimbursements, as Wisconsin has seen **annual Medicare underpayments to Wisconsin hospitals grow from $1.77 billion in 2016 to $2.78 billion in 2022, a 57% increase in 4 years**

Unlike other industries, hospitals cannot simply raise prices to bring in additional revenue. Hospitals can only bring in additional revenue by renegotiating higher payments with employers and health insurers, something that is increasingly difficult in the current fiscal environment. ***Given these immense challenges, CMS must recognize the need for its payment policies to correspond to the actual inflationary environment hospitals are operating in.***

<u>Disproportionate Share Hospital (DSH) Payments</u>

We are concerned with CMS' proposal to decrease DSH payments—by approximately $800 million—to hospitals for FY 2023. These payments are extremely important to our hospitals given Medicare and Medicaid

made up more than half of the inpatient days for 94% of Wisconsin hospitals in 2019. We ask for more clarity on the agency's calculations for DSH payments. Specifically, we ask CMS to provide more details on the agency's assumption of small increases in discharge volume for FY 2022 and FY 2023.

Additionally, we question the agency's estimate that the uninsured rate will decrease from 9.6% to 9.2% from FY 2022 to FY 2023 when determining DSH payments. In our communities, it is clear that an *increase* in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions begin to unwind. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.**

High-Cost Outlier Threshold

In addition, we are concerned about the dramatic scale of the proposed increase in the high-cost outlier threshold—a 39% increase from the FY 2022 threshold—that would significantly decrease the number of cases that qualify for an outlier payment. We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven the increase, but which will likely not continue fully in FY 2023. However, we urge the agency to explain in more detail the factors driving this significant increase in the IPPS high-cost outlier threshold—the largest by far in the past decade. **Specifically, we ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.** Our Wisconsin hospitals report that they are continuing to experience challenges transferring patients to both other acute care settings and post-acute settings, suggesting that a steep decrease in the outlier threshold may unfairly impact the ability of hospitals to recoup these high-cost stays.

Area Wage Index

The area wage index is designed to adjust payments based on local differences in labor costs. WHA has often noted concerns about manipulation of the Medicare Area Wage Index in the prospective payment system. CMS has echoed these concerns in recent proposed rules, noting that results of making the rural floor budget neutral on a national basis, as required by the Patient Protection and Affordable Care Act Section 3141, is that all hospitals in some states receive an artificial wage index that is higher than the what the single highest urban hospital wage index would otherwise be. WHA has previously joined with associations in other states to garner support from Congress to address this patently unfair payment manipulation, which has specifically benefited hospitals in states on the east and west coasts and has been commonly referred to as the "Bay State Boondoggle."

WHA applauds CMS for continuing policies designed to restore fairness to the wage index, such as bringing up those hospitals in the bottom quartile and excluding urban hospitals that reclassify as rural from the overall calculation of each state's rural floor.

WHA opposed efforts by Congress to manipulate the rural floor by restoring the imputed rural floor for all-urban states. It was unfortunate that Congress included this blatant earmark in the American Rescue Plan Act of 2021, as it now continues to unfairly manipulate the wage index to benefit a handful of only-urban states and territories. With the Medicare Trust Fund facing more solvency concerns than ever, states should not be artificially steering a finite amount of Medicare taxpayer dollars by manipulating Medicare payment formulas.

More than ever, this shows the need for CMS to accelerate opportunities to pay Medicare services based on outcomes and the value of care provided. Wisconsin hospitals receive only 73% of costs from Medicare while the national average is closer to 84% of cost. While Medicare should be focusing on incentivizing and rewarding states like Wisconsin, payment policies such as this all too often create perverse disincentives to provide such care. Wisconsin hospitals and health systems continue to pursue high quality, high value health

care and we continue to support CMS finding ways to correct past manipulations of the Medicare payment system in favor of incentivizing high-quality, high-value care.

Hospital Quality Reporting and Value Programs

The COVID-19 pandemic continues to create significant strains on hospital quality and the performance measures. CMS has recognized the uniqueness of the continuation of the pandemic and the variation in outcomes data. As the pandemic progresses, the data continues to be studied for the impact COVID-19 has on patient care. In some cases, data that was once under a CMS waiver for Q1 & Q2 2020, where hospitals were not required to submit data, would now be within the timeframe of being utilized to calculate performance in value-based programs. In the FY2022 rule, a number of data suppressions were adopted.

Hospital Readmission Reduction Program

The HRRP imposes penalties of up to 3% of base inpatient PPS payments for having "excess" readmission rates for six selected conditions, as compared to expected rates of readmissions. Last year, for FY 2023, CMS adopted suppression of any data affected by the pandemic that distorted a hospital's performance due to the pandemic. Because of the findings that a direct correlation and clinical proximity existed between PN readmissions and COVID-19, the PN readmission measure was suppressed. This year, CMS is proposing to reinstate the Pneumonia (PN) measure for FY 2024. CMS believes it can resume the use of the PN readmission measure because in January 2021 it adopted an ICD-10-CM code that captures pneumonia due to COVID19 as a secondary diagnosis (J12.82). WHA supports CMS waiting to reinstate this measure until after CY 2021 can be analyzed based on the use of the new ICD-10 code and data that captures the Winter 2021 surge.

WHA also supports including, for all 6 measures in this category, to include a patient's history of COVID-19 one year prior to an index admission or readmission as a co-variate in the risk adjustment models.

WHA does not support the inclusion of health equity disparities as part of the penalty program which would therefore suggest that disparity control is in the sole hands of the hospitals, rather than a community collaboration. At this point in time this does not seem feasible or fair.

Hospital Value-based Purchasing (HVBP)

CMS funds this budget-neutral program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance. Hospitals may earn back some, all, or more than the 2% withhold based on their measure performance. Several significant changes were made to this program in FY 2022 (such as suppression of HCAHPS and multiple hospital acquired infections measures) resulting in a full suppression of this program, with CMS ultimately paying back all withheld money to the respective hospitals. As a result of the continued pandemic, CMS is recommending applying the same methodology and will again make neutral payment adjustments for FY 2023. Scores will be calculated and reported, but not used in calculating performance payments. WHA agrees with this determination.

Similar to the HRRP resumption of the PN mortality measure, WHA would support reinstating this measure after another calendar-years-worth of data is captured, as stated above. WHA supports CMS' proposal to include patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models for its HVBP mortality and complication measures starting in FY 2023 and the change to the PN mortality measure when CMS resumes its use in FY 2024. WHA supports the re-baseline time periods for HCAHPS and HAI measures to use CY 2019 (pre-pandemic) instead of using CY 2021 which was impacted by the pandemic.

Hospital-acquired Condition (HAC) Reduction Program

The HAC Reduction Program imposes a 1% reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates. CMS is proposing to suppress all 6 measures under this program due to the public health emergency (as further described in other programs

above). WHA agrees with the data suppression and not penalizing hospitals based on it. WHA does not support the possibility that future performance could be tied to the PSI 90 measures which have historically been challenged as being unreliable and not connecting claims data to hospital operations.

Hospital IQR Program

CMS proposes to add ten new measures to the IQR program in addition to a new maternal health designation for hospitals and solicits input on approaches it could take to advance maternal health in its quality programs. Many of the recommended measures have been previously included on the December 2021 Measures Under Consideration (MUC) list, which WHA appreciates reading about ahead of time. However, it is difficult to see which measures are drawing the most attention. It would take hospitals and data generation sources hundreds of hours to build reports to track the status of the measures internally of which many measures may never move forward to the next level. Allowing for additional time from when the measure reaches a status of moving forward to a proposed rule, to when the rule is accepted, finalized, and ultimately included in the final rule would be appreciated. Adding measures to the MUC list is helpful, but until it is adopted likely will not be tracked by hospitals.

Changes proposed to the IQR's eCQM reporting requirements bring additional burden to hospitals, especially Critical Access and Rural Hospitals that need to engage and build infrastructure in their Electronic Health Record (EHR) systems. While having options for hospital to select on the eCQM list is helpful and allows for choices on reporting, WHA does not support the proposal to increase the number of eCQMs from four to six starting in CY2024. Reporting of eCQM should be ramped up incrementally to allow for the time between the IT and Quality staff to create the measure definitions and assist in proper training for data collection. Given the strain already existing with healthcare staff, making several mandatory changes during this time-period is unrealistic and should be deferred.

1. **Hospital Commitment to Health Equity (Measure 1).**
   CMS proposes to adopt an attestation based structural measure beginning with CY 2023 reporting for FY 2025 payment periods that assesses hospital leadership's commitment to health equity. Hospitals would be asked to attest to implementing a series of practices the agency believes would demonstrate an organization's commitment to advancing health equity across five domains. Attestation-based measure reflecting implementation of equity-related practices in five domains:

   - Equity is a Strategic Priority (4 potential elements to comply with)
   - Data Collection (3 potential elements to comply with)
   - Data Analysis (1 potential element to comply with)
   - Quality Improvement (1 potential element to comply with)
   - Leadership Engagement (2 potential element to comply with)

   WHA agrees that hospital leadership must drive this initiative by promoting a culture of quality and safety and would support this measure with a few recommendations. WHA recommends reconsidering a structural self-attested measure giving an "all or none" approach which can be a deterrent and may not adequately reflect progress that hospitals are making along this journey.

   Additionally, having only 1 response in Data Analysis and Quality Improvement leaves a wide-open interpretation that would produce inconsistent responses and will likely not help drive improvement. Also, since this measure has been endorsed by some review groups, but not yet submitted to the National Quality Forum (NQF), WHA recommends CMS continue working with the NQF to determine a suitable measure and reevaluate its effectiveness after one year of voluntary reporting before determining if it will move to a mandatory measure. Health Equity in general has taken on many forms and produced many definitions since the pandemic started, WHA recommends a more robust definition be at the premise of this measure with additional details and examples be included in each of the 5 domains of questions.

2. **Screening & Screen Positive Rate for Social Drivers of Health (SDOH) (Measures 2 & 3)** Considering the Request for Information (RFI) and screening on how CMS could encourage hospital improvement on health equity and reducing disparities, WHA would be in support of having the ability to comment on the suggestions that are brought forward from healthcare entities. Collecting and aggregating data based on disparities is extremely important, **but the root cause of the issue appears to still be how the data can be collected and collected accurately**. There are many limitations to data capture: lack of staff training who are asking sensitive questions to patients, inability for many EHR's with limited data fields to allow for space to record the Z codes on the claim form, productivity of Health Information Technology coding staff to read the record looking to capture these items, etc.

   Placing attention on resources that assist hospitals in asking the right questions (cultural competence) with a focus on implicit bias training must come before data can be accurately captured and used for making decisions on which populations are most vulnerable or disparate. A hospital's ability to capture Z codes for SDOH is in very early stages of development. Substantial work with EHR vendors to assist in the documentation and visualization in the record will still need to be completed as a first step.

   As long as it is not over-burdensome to hospitals, WHA does support screening for HRSN's (Health-Related Social Needs) and the proposed categories: (1) food insecurity; (2) housing instability; (3) transportation needs; (4) utility difficulties; and (5) interpersonal safety; as those seem to be the most prevalent according to data currently reported. WHA also supports having 5 separate rates, one for each category, instead of an aggregate measure. Please consider if this reporting should start in areas that are serving a more vulnerable population, perhaps based on the Social Vulnerability Index (SVI). WHA also recommends CMS host several sessions to help educate hospitals on the variety of collection methods available. Since this measure has been endorsed by some review groups, but not yet submitted to the National Quality Forum (NQF), WHA recommends CMS continue working with the NQF to determine a suitable measure first, before the measure becomes mandatory.

3. **Proposed addition of Cesarean Birth eCQM (Measure 4)**
   The proposed rule introduces a Low-risk Cesarean delivery measure added to a list of potential eCQMs to report in the CY2023 reporting period for the FY 2025 payment determination and making it mandatory the following year. At this point in time, there is no optimal rate established in US practice guidelines for medically necessary or unnecessary C-sections. Given that this reporting could establish such guidelines, WHA would not support making this measure mandatory at this time due to lack of evidence and an established baseline of data. WHA is also concerned about the current lack of endorsement from the NQF and encourages CMS to obtain this before finalizing it for use in the IQR.

4. **Proposed addition of Severe Obstetric Complications eCQM (Measure 5)**
   The proposed rule introduces this measure for the CY 2023 Reporting Period/FY 2025 Payment Determination with Mandatory Reporting Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years. WHA does support initiatives that reduce Severe Maternal Morbidity (SMM), by analyzing links between maternal morbidities to ultimate mortality, especially in rural areas where mortality is increased. If NQF endorsement is not sought this year, WHA would not support this measure but would recommend it as a reporting eCQM measure only.

5. **Proposed Hospital-Harm—Opioid-Related Adverse Events eCQM (Measure 6)**
   The proposed rule would begin with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years. WHA supports continuing to have valuable Opioid metrics to select on the menu of eCQMs. Having an opioid measure to track preventable opioid overdoses and subsequent reversals while in the hospital is a valuable measure.

6. **Proposed Global Malnutrition Composite Score eCQM (Measure 7)**
   The malnutrition proposal would begin with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years. Through the years this has been proposed and will be difficult to measure as people are not always forthcoming about food security/insecurity. A measure like this does directly align with creating healthier communities and directly supports collecting social determinants of health data.

   WHA supports this measure and the fact that it is tied to the primary care MIPS program. One point to consider is how low-income patients will be able to support a nutritional care plan after discharge. With this said, when a patient is in the hospital, it is typically well after they have become malnourished, so upstream flagging measures should also be implemented. WHA would however discourage mandatory reporting until after several years of validating. This measure could overlap with the SDOH/HRSN measures also being proposed.

7. **Proposed Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #3559) (Measure 8)**
   Reporting of the Patient-Reported Outcomes (PROMs) beginning with two voluntary reporting periods in CYs 2025 and 2026, followed by mandatory reporting for eligible elective procedures would impact the FY 2028 Payment Determination and for Subsequent Years. Aging adults are at greater risk of immobility after unsuccessful procedures or ones that are not properly monitored, leading directly to a poorer quality of life and increased falls. WHA supports the measure designation but without a clear mechanism for data collection (provider vs patient) it remains unclear on how the data will be aggregated and trended. Additionally, these types of procedures are moving out of the hospital to the ambulatory care setting. WHA recommends collecting and reporting this data to establish a consistent process but not make this mandatory.

8. **Proposed Medicare Spending Per Beneficiary (MSPB) Hospital Measure (NQF #2158) (Measure 9)**
   Beginning with the FY 2024 Payment Determination, this measure has been updated from the version that was removed from the IQR in FY 2020, which was identical to the one currently remaining in VBP. It appears that since the removal of the measure there has been a significant amount of research and case scenario planning, as well as NQF endorsement. However, the NQF suggests the validity is quite low. Given that the measure would permit readmissions to trigger a new episode of care and thus counted towards the calculation of the MSPB performance, this measure is not supported by WHA.

9. **Proposed Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF # 1550) (Measure 10)**
   Methodology proposals would begin with the FY 2024 payment determination with the potential to replace the current measure under the VBP program. WHA supports this revised measure and the inclusion of an additional 26 ICD-10-CM codes.

Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

WHA does agree that moving forward with a focus on maternal morbidity is very important. Simple attestation measures can be interpreted in many ways, and we feel that too many hospitals would simply attest "yes" without moving forward and identifying actual improvement opportunities. Labeling a hospital as a "birthing friendly" hospital or any similar name would not be valid or proof of any type of certification based on self-reporting; therefore, not providing much value to patients. WHA is not in support of a label such as listed above based on attestation to two questions and would recommend on holding off on a designation until more robust metrics are in place that measure the quality of care. Would like to see maternal morbidity

or mortality measures selected that address disparities in the future; perhaps the proposed eCQM measures will suffice or changes to the maternal health CoPs.

Hospital Infectious Disease Data Reporting Condition of Participation for COVID-19 and Future Public Health Emergencies

In 2020, CMS adopted a condition of participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 and other acute respiratory illnesses (i.e., influenza) to HHS. While the CoP was written to expire at the conclusion of the COVID-19 PHE, CMS suggests its need to monitor the impact of the pandemic could extend beyond the current PHE. In addition, the agency states that it and its federal partner agencies want a more permanent policy allowing it to collect data in the event of future PHEs involving infectious diseases.

In this rule, CMS proposes to revise the COVID-19 hospital data reporting CoP it adopted in 2020 so that hospital COVID-19-related reporting would continue after the conclusion of the current PHE through April 30, 2024, unless the Secretary establishes an earlier end date. The broad data reporting categories proposed in the rule align with current reporting requirements.

In addition, CMS proposes to establish a new CoP for future public health emergencies that would require hospitals and CAHs to report certain data to the CDC in the event of a PHE declaration for an infectious disease. CMS proposes several broad categories of data that it could ask hospitals to report, including:

- Suspected and confirmed cases of the relevant infectious disease pathogen among patients and staff;
- Total deaths attributed to the relevant infectious disease pathogen among patients and staff;
- Levels of personal protective equipment and other relevant supplies in the facility;
- Capacity and supplies in the facility relevant to the immediate and long-term treatment of the infectious disease pathogen, such as ventilator and dialysis/continuous renal replacement therapy capacity and supplies;
- Total hospital bed and intensive care unit census, capacity and capability;
- Staffing shortages;
- Vaccine administration status of patients and staff if a vaccine is applicable;
- Relevant therapeutic inventories and or usage;
- Isolation capacity, including airborne isolation capacity;
- Key co-morbidities and/or exposure risk factors of the patients being treated for the relevant infectious disease pathogen.

CMS also proposes that it would generally require hospitals to report person-level information on each applicable infection (confirmed and suspected) and if applicable, vaccination data at the person-level. This person-level data would need to include a medical record identifier, race, ethnicity, age, sex, residential county, zip code and relevant co-morbidities for affected patients. Finally, CMS would generally require hospitals to report requested data to the CDC on a daily basis. However, the Secretary of HHS would retain discretion over the format of data reported (including whether to ask for person-level data), as well as the frequency of data reporting.

WHA has strong concerns that this additional data reporting burden will negatively impact hospitals that are already dealing with too many complex regulations and a dwindling workforce pool to balance patient care needs and federal regulatory compliance. CMS should end the requirement hospitals report this data as a CoP as soon as possible, but certainly no later than the end of the public health emergency.

WHA continues to believe that CMS's COVID-19 data reporting CoP is inconsistent with the core intent of Medicare's CoPs, which is to set health and safety standards for the delivery of health care. Furthermore, WHA

is very concerned about the overreach of CMS's proposal to request patient-level data on each applicable infection (confirmed and suspected) and if applicable, vaccination data at the person-level.

RFI on IPPS and OPPS Payment Adjustments for Wholly Domestically Made NIOSH-approved Surgical N95 Respirators

WHA appreciates CMS seeking feedback on how to deal with supply-chain disruption such as PPE and investigating enhanced payments for resource costs associated with domestically made PPE. If the COVID-19 pandemic has exposed anything, it is how interconnected and fragile our supply-chain lines can be. Not only did we face severe PPE shortages early on, but we now face shortages for contrast media dyes, leading hospitals to have to implement conservation strategies for patients needing scans or procedures that rely on contrast IV.

We appreciate CMS investigating an enhanced reimbursement rate for obtaining domestically made products as a way of encouraging more domestic production. In addition to something like this, we believe this ongoing challenge may require a deeper, more strategic response that takes into account the complexities of modern manufacturing, business structure, suppliers and the interwoven relationships between all parties. We appreciate CMS recognizing that hospitals have had to deal with the challenges of rising costs created by these supply chain disruptions and urge them to consider other broader impacts as hospitals deal with significant increases in input costs. According to a recent report by the American Hospital Association, supply expenses for hospitals nationwide were 15.9% higher by the end of 2021 compared to the end of 2019 and 20.6% higher per patient.

WHA appreciates the opportunity to provide comments on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO