WISCONSIN HOSPITAL ASSOCIATION

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June 28, 2021

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: Comments on Proposed Rule CMS-1752-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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program

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.

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 will unfairly manipulate the wage index to benefit only 3 states. We understand that they purposely did not apply budget neutrality to the restoration of this policy, in order to hold other states harmless. However, we still feel that this policy is unfair; 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 87% 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.

"Market-based" MS-DRG Data Collection and Weight Calculation

In WHA's 2021 IPPS comment letter, we noted concerns with CMS's proposal to require hospitals to include on their Medicare cost report the median payer-specific negotiated charge for Medicare Advantage organizations, and utilize this information to weight what CMS called "market-based payment rate information." Given that hospitals were already required to report similar information in the Hospital Price Transparency Final Rule, the additional requirement would have created additional burdens on hospitals without benefiting consumers. There was also insufficient explanation of why CMS was proposing to utilize this new method instead of the past cost-based method. We appreciate that CMS has listened to concerns expressed and decided not to go ahead with these proposals.

Graduate Medical Education

Wisconsin, like many other states, is projecting a workforce shortage particularly in the physician field. By 2030, the number of people age 65 and older is projected to double in every county in our state. This demographic change means many baby-boomers will be leaving the medical field and we will need new physicians to replenish them. While WHA has worked with the Wisconsin Legislature to create a successful GME grant program at the state level, Medicare should be shouldering more of the GME costs at the federal level, particularly when considering that Medicare significantly under-reimburses hospitals for their cost of care.

WHA was very pleased to see Congress recognize for the first time in more than 20 years that Medicare needs to shoulder its share of the load in ensuring we have enough physicians to adequately care for our growing Medicare population. WHA has long supported legislation that would increase the number of GME slots, and while the 1,000 that will be funded over the next five years is far short of what is needed, it is a vast improvement over adding no new slots.

CMS proposes to largely follow the federal statute in ensuring at least 10% of these positions are distributed in rural areas, states with new medical schools, serving health professional shortage areas or HPSAs, and hospitals below their reference resident limits. However, CMS appears to be giving perhaps undue influence to the HPSA criteria by proposing to first fill hospitals with the highest HPSA scores. WHA urges CMS to instead more closely follow the statute by giving equal weight to the four criteria rather than undue weight to HPSA scores, which have had long-standing concerns about their accuracy. Additionally, WHA is concerned about CMS's proposal to only allow for one FTE per-hospital per-year. This is narrower than the statute, and would mean that a hospital that gains an additional slot will only train a new physician once every three years (if that is the length of the residency). Instead, we support at least allowing the slot to last the length of the residency,

so that the hospital that gains a slot can fully realize the ability to continue that added training capacity. In other words, the policy should allow that slot to add one new physician every year, rather than every three years.

WHA is pleased that CMS recognizes Wisconsin's as one of 35 states that have created new medical school locations and thus meets criteria for additional slots. Wisconsin has worked collaboratively with partners in the state legislature and executive branch, spanning two administrations, to grow a highly successful public-private partnership that has added 125 residency slots across our state. The demand for these slots has been far outpacing the slots available. For example, one program in northwest Wisconsin had over 300 applicants for their single new slot. WHA recommends that when distributing final slots, CMS also give priority to states like Wisconsin that have shown an ability to successfully expand their programs and are thus most likely to be able to quickly fill additional slots.

Rotator Cap Fix

WHA was also very pleased to see Congress address the long-requested fix for the rotator cap issue that was created by Congresses capping GME under the Balanced Budget Act of 1997, based on hospitals' 1996 residencies. Two hospitals in Wisconsin inadvertently triggered Medicare's GME cap when they hosted resident "rotators" for very brief periods of time, leading their caps to be set at less than 1.0 FTE. While Wisconsin has worked to grow training opportunities in Green Bay since then, this artificial cap has been a significant barrier. WHA is pleased that CMS is finally implementing this fix and appears to intend to give hospitals adequate time to plan for this policy to take effect.

Hospital Quality Reporting

The COVID-19 pandemic created significant strains on hospitals that led to equally significant variations in data and measures. WHA applauds CMS for recognizing the uniqueness of the pandemic and giving hospitals flexibility to deal with the reality of this hopefully once-in-a-lifetime event by proposing to suppress data measures. Because of CMS's waiver for Q1 & Q2 2020, hospitals were not required to submit this quality data, as reporting was optional. Some hospitals still decided to enter data, and we support CMS in its decision not to use that data to calculate an incentive or penalty in the pay-for-performance programs.

As a result of these suppressions, CMS recognizes it would not have sufficient data to calculate performance on hospital value-based performance (HVBP), nor would it be appropriate to base hospital performance on the remaining clinical outcomes measure domain. WHA supports CMS in its decision to therefore provide neutral payment adjustments under the HVBP for FY 2022.

WHA also supports CMS in its proposal to suppress the pneumonia mortality measure for FY 2023, as well as excluding patients from the HVBP's other mortality measures. As CMS has noted, a significant number of patients with pneumonia had COVID-19 as a secondary diagnosis, which could distort measure performance. WHA believes CMS should examine additional areas where exclusions would make sense, due to the uniqueness of the pandemic, and the additional data corollaries we are learning about as time goes by.

Likewise, WHA supports removing the Patient Safety Indicator (PSI 90), due to its unreliability and inability to pinpoint objective measures that hospitals can improve on. We are pleased CMS recognizes the lack of usefulness of this measure, and applaud CMS for taking this step at reducing hospitals' administrative burden.

While we support CMS in suppressing and removing these measures, we caution them against prematurely going forward with the additional measures listed below.

CMS should not go forward with reporting of Maternal Morbidity Structural or Health Equity Measures

While WHA agrees the Maternal Morbidity Structural and Health Equity Measures are important areas to focus future improvement efforts, we do not believe either measure has been adequately designed or contemplated by CMS. Like the PSI 90 measure that CMS proposes to remove, these measures include too many factors that, when aggregated, do not provide meaningful information on how hospitals can actively improve their scores and attain the desired policy goals CMS has set forth. WHA believes more work needs to be done to ensure these become outcome-based measures that can actually drive improvement.

Reporting of Health Care Personnel (HCP) COVID-19 Vaccination Should be Optional, not Mandatory

WHA and its members have gone to great lengths to both encourage and administer vaccinations for health care staff and the general public. However, it is premature for CMS to require the reporting of this measure for HCP. CMS relies heavily on its experience with influenza vaccinations as rationale for the reporting of COVID vaccination status. However, it is not yet known whether the COVID vaccines will follow the same path as the flu vaccines have. In fact, there are still many unknowns about the future course COVID-19 will take and how that will impact vaccines and their availability. It is also important to note that none of the vaccines have yet been fully approved via the FDA, and are yet under the emergency use authorization.

CMS should keep the reporting of this measure optional for FY2022 while it continues to study these unresolved questions and while the vaccines undergo full FDA approval.

Promoting Interoperability Program

Because regulatory burden creates additional healthcare costs and limits provider productivity, reducing EHR-related burden on hospitals and clinicians in the Medicare Promoting Interoperability (PI) Program is a priority for WHA. We believe that in its regulations for these programs that mandate specific uses of EHR technology, CMS should minimize EHR-related regulatory burdens and ensure that any additional EHR investments, additional time spent using EHR technology, or adjustments to workflow that are necessary to comply with regulatory requirements are outweighed by healthcare cost-savings and improvements in patient outcomes. We offer the following comments in regard to CMS's proposals to update the PI program.

Reporting Period

WHA does not support CMS's proposal to increase the electronic health record (EHR) reporting period from the long-standing continuous 90-day period to a continuous 180-day period. Recognizing EHR software upgrades, system downtime, vendor capacity and delays and other factors, a 90-day reporting period provided a meaningful and accurate representation of the hospital's EHR performance. Creating a 180-day reporting will give hospitals less time to modify their EHR to meet new requirements, resulting in rushed implementations that could degrade quality and efficiency, and provide a less accurate picture of the EHR system's capabilities.

"Query of PDMP" Measure

WHA supports CMS's proposal to retain the query of PDMP measure under the electronic prescribing objective as optional and increase the bonus points from five to ten. As previously noted by CMS, there is a lack of standards-based interfaces between certified EHR technology and the PDMPs. As a result of the lack of national IT standards for state PDMPs that aligns with certified EHR technology standards, hospitals too often are required to resort to manual data entry into the EHR to document completion of the PMPD query and manual calculation of this measure. We are pleased to see CMS recognizes these concerns and has retained this measure as optional.

Public Health and Clinical Data Exchange Measure

Similar to hospitals' concerns with the PDMP query measure, there are a lack of standards-based interfaces between public health agencies' IT systems, resulting in significant challenges in certified EHR technology receiving or incorporating data electronically. The ongoing Public Health Emergency has highlighted the importance of the ability for national, state, and local public health IT systems to have common interface standards with certified EHR technology. Thus, while we support the proposal to allocate five bonus points for attesting to the Public Health Registry Reporting or the Clinical Data Registry Reporting measures, we believe the remaining four measures are currently infeasible given the current IT capabilities of public health agencies.

Protect Patient Health Information Objective

We do not support CMS' proposal to require hospitals to attest to the completion of an annual assessment of the nine SAFER guides. Implementing safety practices for planning or unplanned EHR downtime is important, but this is out of scope for the promoting interoperability program. Further, it is unclear if the 2016 SAFER Guides are still relevant and best practice, and thus would create significant burden on hospitals to update and assess their practices to a guide that may no longer be a best practice.

Prevention of Information Blocking Attestation

To eliminate confusion for hospitals, we support CMS' proposal to remove attestation statements 2 and 3 from the prevention of information blocking attestation requirement.

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

Sincerely,

Eric Borgerding
President & CEO