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June 9, 2023

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-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 PhysicianOwned Hospital Requirements; and Provider and Supplier Disclosure of Ownership: Proposed Rule (Vol. 88, No. 83), May 1, 2023.

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 2024, CMS proposes an overall market basket update of 2.8%, which is even lower than last year's 2.7% increase. This update is woefully inadequate and is not keeping up with the true level of inflation impacting health care and the country as a whole. It fails to account for the record-high inflation and persistent labor, supply and drug costs the hospital field has experienced in the last two years and continues to face. **Given the extreme levels of inflation our country is facing the market basket is inadequate.** Indeed, with more recent data, the market basket for 2022 is 5.7%, more than double CMS's estimate.

An April 2023 report released by the American Hospital Association highlights some of the cost increases hospitals are bearing right now:

- From 2019-2022 hospital expenses grew by 17.5% compared to IPPS increases of 7.5%.
- Meanwhile, hospitals have had little choice but to turn to contract labor to fill shifts, which led to an increase on contract labor costs by 258% over the same time period.
- Drug costs increased by 37% from 2019-2021, and by even more for 340B hospitals who are no longer receiving the full level of discounts for patients served by community contract pharmacies.

- The average Critical Access Hospital has seen drug costs increase by $500K annually while the average disproportionate share hospital has seen costs increase by $3M annually due to the contract pharmacy issue alone.

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.

Unfortunately, CMS's payment system does not reward Wisconsin hospitals for keeping costs down: Wisconsin ranks 16th lowest in terms of per-beneficiary spending according to the Kaiser Family Foundation, and yet, Wisconsin hospitals receive, on average, around 73% of what it costs them to provide Medicare services, well below the national average of about 84% of costs. 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 for WI hospitals grow from $1.77B in 2016 to $2.53B in 2021 – a 42% increase. This trend is only projected to increase given that Wisconsin is an aging state. In fact, as of 2018, Wisconsin was tied for 16th among states with the highest percent of their population covered by Medicare, at 20%.[1]

What's more, hospitals are increasingly are not being reimbursed for long patient stays and post-acute care they are providing. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019, leading hospitals to have to devote more staff time and expenses per patient episode. On top of this, Wisconsin hospitals lost an estimated $465 million in uncompensated care from patients they have not been able to discharge due to the lack of available nursing home beds – patients hospitals are not receiving reimbursement for after their hospital care concludes.

These factors have created a perfect storm of circumstances where hospitals are being significantly underfunded by the nation's safety-net Medicare and Medicaid programs. When one considers that Medicare and Medicaid make up more than half of inpatient care for 94% of Wisconsin hospitals, it shows just how challenging this dynamic is becoming.

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. Likewise, unlike other businesses, hospitals do not have the luxury of closing down the overnight shift when operating becomes unprofitable. If hospitals are unable to grow revenue from other sources, they must make cuts to important service lines just like any other business to remain financially viable, and indeed, many are already exploring this reality.

With these historic fiscal challenges facing hospitals, **we urge CMS to use its special exceptions and adjustments authority to implement a retrospective adjustment in the FY2024 rule to account for these differences, and more accurately reflect the costs hospitals must bear.** ***CMS must recognize the need for its payment policies to correspond to the actual inflationary environment hospitals are operating in in order to preserve the safety-net care it intends hospitals to provide.***

Disproportionate Share Hospital (DSH) Payments

We are concerned with CMS' proposal to decrease DSH payments—by approximately $115 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 question the

[1] Wisconsin Department of Administration. Percent of Projected Population Ages 60 and Older. [Online] 2017. https://www.dhs.wisconsin.gov/publications/p01803.pdf

agency's estimate that the uninsured rate will be only 9.2% for FY 2023 when determining DSH payments. The payment rule does not appear to take into consideration the fact that states are currently undergoing Medicaid redeterminations and will be doing so through the rest of 2023 and into 2024. Given that Medicaid rolls had previously been frozen during the public health emergency, it seems only logical that the uninsured rate will climb as states remove people who no longer qualify for state Medicaid programs. Even in the most optimistic estimates that the lion share of this population successfully transitions to other insurance, there is likely to be a noticeable increase in the overall uninsured rate.

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.

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

As the Public Health Emergency for the COVID-19 pandemic unwinds, we continue to see significant strains on the healthcare workforce and hospital quality performance outcomes. The FY 2024 IPPS proposed rule, mirroring the Biden Administration's Health Equity Milestones, has a strong focus on health equity with special emphasis on health-related social needs as well as patient safety, of which our Wisconsin hospitals remain in a good position to reinforce the necessary tools and approaches to support quality improvement. The proposed rule would recommend no measure suppressions as in the current FY 2023 final rule, but data collected from the pandemic should continue to be watched and evaluated in cases where measures were and are likely impacted during the past 3+ years.

Hospital Value-based Purchasing (HVBP)

CMS is proposing modifications to the Medicare Spending-per-Beneficiary (MSPB) measure beginning with FFY 2028 that include:

- "An update to allow readmissions to trigger new episodes to account for episodes and costs that are currently not included in the measure but that could be within the hospital's reasonable influence;
- A new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to episode start date; and
- An updated MSPB amount calculation methodology to change one step in the measure calculation from the sum of observed costs divided by the sum of expected costs (ratio of sums) to the mean of observed costs divided by expected costs (mean of ratios)." These same modifications were finalized for the MSPB measure in the Inpatient Quality Reporting (IQR) program in the FFY 2023 final rule and the updated measure will be posted to Care Compare in January 2024.

WHA requests additional clarification around what is a hospital's reasonable influence for a readmission. Hospitals currently work with community organizations and long-term care facilities to reduce readmissions. It will be difficult for hospitals to track readmissions under this new metric without understanding what CMS considers to be reasonable influence. CMS should continue to provide additional information via Care Compare and adjust this metric as necessary prior to the proposed FFY 2028 start.

HVBP Severe Sepsis Measurement

Beginning with the FFY 2026 program, CMS is proposing to adopt the Severe Sepsis and Septic Shock: Management Bundle (CBE #0500) (SEP-1) measure to the Safety domain. This measure would support the efficient, effective, and timely delivery of high-quality sepsis care and contribute towards CMS's goal of advancing health equity.

WHA's members place a high priority on improving sepsis care given how critical it is to patient outcomes. Our members are generally aware of the direction CMS has been moving in adding this to the HVBP program. However, at this time, we believe more analysis must be done to ensure CMS get this measure right prior to putting it into its pay-for-performance program. WHA does not support including year 3 of the pandemic as baseline data, given the previous concerns expressed about the use of data from the pandemic. WHA supports the aspects of this new proposal that follow the already well-established Surviving Sepsis campaign.

HVBP Hospital Consumer Assessment of Healthcare Providers and Systems HCAHPS Survey Measures

CMS is proposing the following changes to the form and manner of the administration of HCAHPS Survey measures beginning with January 2025 discharges:

- 3 new web-based modes of survey administration;
- Removing the survey's prohibition on patient proxy respondents;
- Extending the data collection period from 42 to 49 days;
- Limiting the number of supplemental survey items to 12;
- Requiring hospitals to collect language information about a patient while in the hospital and requiring the official Spanish translation for Spanish language-preferring patients; and
- Removing two administration methods that are not used by participating hospitals.

WHA supports bringing in new technology for the completion of these surveys and allowing patient caregiver proxies (instead of just the patient) to be able to take this survey. WHA also applauds CMS for offering the survey in Spanish and English encourages them to translate it into additional languages in the future.

HVBP Health Equity Bonus Points

Beginning with the FFY 2026 program, CMS is proposing a change to the VBP scoring methodology to reward hospitals for excellent care in underserved populations through the addition of Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS). CMS intends to calculate this using a methodology that incorporates a hospitals performance across all four HVBP domains and with a focus on measuring how many patients a hospital serves that are dually eligible for Medicare and Medicaid. CMS would define the "underserved multiplier" as the number of inpatient stays for dual eligible patients out of the total inpatient Medicare stays during the calendar year 2 years prior to the start of the respective program year.

Dual eligible patients would be identified using the State Medicare Modernization Act and CMS proposes to use a logistic exchange function to calculate the underserved multiplier so that there would be a lower rate of increase at the beginning and the end of the curve.

WHA encourages CMS to provide more information about this proposal, including how CMS intends to measure dual eligibility given that Medicare Advantage patients are not included in all CMS payment programs. WHA believes this program is a step in the right direction and could be modified over time to reward those serving vulnerable populations if CMS is able to develop accurate measures. For instance, CMS discusses utilizing an Area Deprivation Index instead of dual eligibility and WHA believes CMS should provide more rationale for this. It's worth noting that overly complex scoring methods have been a challenge in getting hospitals to embrace data quality measurements in the past; this underscores the need for a more transparent and consensus-driven data measurement.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital Commitment to Health Equity begins as an IQR measure in 2023. This attestation-based measure reflects the implementation of equity-related practices in 5 domains: Food insecurity, Housing Instability, Transportation problems, Utility difficulties, and Interpersonal Safety. In addition, there is an optional requirement to screen for these social drivers of health in CY 2023 that will be required in CY 2024. The screening will reflect the percentage of adult inpatients screened for Health-Related Social Needs (HRSN's) and the percentage of those that screened positive.

Building reporting requirements into the hospital's electronic health record requires significant time. WHA would recommend allowing hospitals time to build, track and report this data for several cycles before these requirements would move to the pay-for-performance programs. This would allow for additional time to work with community-based organizations and build a resource referral closed-loop program.

In 2017, the American Hospital Association came out with a report on hospitals' excessive regulatory burden and found a number of alarming examples of how regulation is harming hospitals and increasing costs for patients. It found, among other things, that:

- Health systems, hospitals and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains.
- Health systems, hospitals and PAC providers spend nearly $39 billion a year solely on the administrative activities related to regulatory compliance in these nine domains.
- An average size hospital dedicates 59 FTEs to regulatory compliance, over one- quarter of which are doctors and nurses.

Given the tremendous data entry burden hospitals already face, CMS should take every opportunity to minimize unnecessary data entry and reporting requirements. While hospitals fully support attending to their communities' social needs, this burden cannot be expected to rest solely on the shoulders of hospitals.

Updates Electronic Reporting Under the IQR Program

CMS is proposing to **adopt three measures** for the IQR program beginning with the CY 2025 reporting period/FFY 2027 payment determination:

- Hospital Harm – Pressure Injury electronic clinical quality measurement (eCQM);
- Hospital Harm – Acute Kidney eCQM; and
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) In Adults (Hospital Level-Inpatient eCQM).

While adding these additional choices to the eCQM list that hospitals can select from may be beneficial, it is important to note that the definitions and exclusions can be difficult for hospitals to utilize because they rely on prior documentation. This means a patient's disease progression must be accurately noted in the EHR. It's also worth noting that the Pressure Injury eCQM was piloted with only 18 hospitals and on 2 platforms (EPIC and Cerner).

WHA encourages CMS to include a larger population size for all additional measures considered to assess the burden of EHR report building. For instance, the Acute Kidney eCQM has brought up concerns about identifying the appropriate measurement definition and the Excessive Radiation Dose eCQM has brought up concerns about ; these questions have centered around whether existing software regarding the radiation dose is already in fact available for hospitals to integrate with their systems.

IQR Modification of Healthcare Personnel COVID-19 Vaccination Reporting

Beginning with the FFY 2025 IQR, CMS is proposing to modify the "COVID-19 Vaccination Coverage among Healthcare Personnel" measure to replace the term "complete vaccination course" with the term "up to date" in the healthcare personnel vaccination definition. CMS also proposes to update the numerator to specify the time frames within which a healthcare personnel is considered up to date with recommended COVID-19 vaccines.

Given the confusion over recent changes made by CMS, WHA encourages CMS to give hospitals maximum flexibility in this measure to account for the changing COVID-19 landscape and to give hospitals the ability to best meet the needs of their communities. Hospitals are already dealing with a severe workforce shortage, and CMS should not add to their burden with reporting requirements that are overly time consuming and may not reflect the constantly evolving state of COVID-19.

IQR Geriatric Structure Measures

CMS is considering a geriatric care hospital designation to be publicly reported on a CMS website, initially to be based on data from hospitals reporting on both Geriatric Hospital and Geriatric Surgical structural measures, and in the future develop a scoring methodology for granting this designation.

WHA agrees that moving forward with a focus on Geriatric or Age-Friendly care is very important. However, simple attestation measures can be interpreted in many ways, and CMS should recognize the need to incentivize against hospitals simply attesting "yes" without moving forward and identifying actual improvement opportunities.

WHA would be interested in learning more about the impact of the Birthing Friendly designation from last year's rule before moving towards adding a Geriatric marker. For instance, how will this structural measure be different from those that have received certification as an Age-Friendly hospital? Labeling a hospital as a "geriatric friendly" hospital or any similar name would not be valid or proof of any type of certification based on self-reporting, and therefore, does not provide much value to patients. For this reason, WHA does not support such a label based solely on the attestation of a structural measure.

Request for Information: Safety-Net Hospitals

As a result of Executive Order 13985 on "Advancing Racial Equity and Support for Underserved Communities through the Federal Government," the proposed rule includes a request for information (RFI) on how CMS can support safety-net providers. As CMS notes, "Because they serve many low-income and uninsured patients, safety-net hospitals may experience greater financial challenges compared to other hospitals."

WHA supports CMS working to provide more resources for safety-net hospitals. As previously mentioned, Wisconsin hospitals receive only 73 percent of what it costs them to provide care to Medicare patients and only 67 percent of what it costs them to provide care to Medicaid patients. Hospitals that serve more Medicare and Medicaid patients inherently face more financial challenges than those who have a higher proportion of patients insured commercially.

Hospitals are also facing one of the most challenging fiscal environments in recent memory as Medicare and Medicaid reimbursements fall even farther behind the true cost of care, particularly given the extremely high level of inflation and other cost increases like labor and prescription drugs. Data from Kaufman Hall shows that hospitals across the U.S. saw negative monthly operating margins throughout 2022 and persisting into 2023. Wisconsin is facing the same challenges; survey data from the Wisconsin Hospital Association shows Wisconsin's hospitals have experienced a net operating loss of -0.4% through the first six months of 2022, the most recent fiscal data available.

WHA cautions CMS against attempting to develop a definition for safety-net hospitals that is too complex. Policymakers and consumers are already frustrated over the seeming lack of sense that hospital billing makes. Likewise, hospitals are dealing with backlash from Congress over a payment system developed years ago that current lawmakers do not understand.

For instance, members of Congress have recently proposed expanding site-neutral payment policies without understanding that hospitals did not design such a payment policy, but nevertheless must plan their operating budgets based on it. Such proposals would cut overall payments to hospitals and threaten the very safety net of services hospitals are relied upon to provide.

Should CMS pursue a safety-net definition, it should utilize relatively simple and transparent metrics such as the mix of uninsured, Medicare, Medicaid, and commercial patients a hospital sees (or volumes of Medicaid/Medicare losses combined with uncompensated care/bad debt) in comparison to other health care providers.

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

Sincerely,

Eric Borgerding
President & CEO