Minnesota Hospital Association

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

Submitted electronically through www.regulations.gov.

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 Reporting 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 Ms. Brooks-LaSure:

On behalf of our 129 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments and suggestions regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rules for 2022 Inpatient Prospective Payment Systems for Acute and Long-Term Care Hospitals (Proposed Rule).

MHA generally supports the recommendations and detailed comments submitted by the American Hospital Association (AHA). Rather than duplicating AHA's analysis and suggestions, MHA's comments will focus on the topics of most concern to Minnesota's hospitals and health systems. Some of MHA's comments may differ or be more nuanced positions from those conveyed by the AHA.

Specifically, we are providing comments and recommendations in the following areas:

1. Price Transparency: Market-Based MS-DRG Relative Weights Proposed Policy Changes
2. Hospital Readmission Reduction Program Modifications
3. Disproportionate Share Hospital (DSH) Payment Changes
4. Wage Index Decrease Cap
5. Indirect and Direct Medicare Graduate Medical Education.
6. Organ Acquisition Payment Provisions
7. Quality Reporting Programs
8. Health Equity Request for Information

1. Price Transparency: Market-Based MS-DRG Relative Weights Proposed Policy Changes

In response to Executive Orders on price transparency and Medicare Advantage (MA), in its FY 2021 IPPS final rule, CMS reported that it would begin collecting median payer-specific charges for MA organizations on the Medicare cost report in Jan. 1, 2021. CMS also finalized in its FY 2021 IPPS final rule using these data to calculate new relative MS-DRG weights beginning in FY 2024. **CMS now proposes to repeal the requirement that hospitals report their median payer-specific charges for MA organizations and to repeal its use in calculating new market-based MS-DRG relative weights. CMS proposes to continue using the existing cost-based methodology for calculating MS-DRG relative weights for FY 2024 and subsequent years.**

Given the repeal of both market-based data collection and market-based MS-DRG relative weight methodology, CMS requests comments on alternative approaches or data sources that could be used for Medicare fee-for-service rate-setting for FY 2024 and subsequent years.

MHA applauds CMS' proposal to repeal the requirement that hospitals and health systems disclose privately negotiated contract terms with payers on the Medicare cost report. We have long said that privately negotiated rates take into account any number of unique circumstances between a private payer and a hospital and their disclosure will not further CMS' goal of paying market rates that reflect the cost of delivering care. We once again urge the agency to focus on transparency efforts that help patients access their specific financial information based on their coverage and care.

As MHA and its members have commented in response to prior CMS proposed rules, we remain committed to ensuring patients have the information they need to make informed health care decisions, including timely, accurate estimates of their out-of-pocket costs. In particular, MHA members have made considerable investments in price transparency, including on-line interactive tools for patients. However, we firmly believe that insurers, including MA plans, are in the best position to provide the price transparency information CMS seeks. The market-based MS-DRG transparency requirements placed an additional administrative burden on hospitals and also impacts hospitals' ability to meaningfully negotiate with health plans. This adversely impacts competition in the market, while frustrating ongoing efforts for hospitals to adapt and comply with prior requirements.

We again ask CMS to re-think the price transparency requirements under the larger goal of moving away from an FFS payment mechanism to one that focuses on value. While we appreciate that CMS seeks comments on alternative approaches or data sources that could be used in FFS rate setting, additional burdens, including the forthcoming surprise billing regulations, take away from the time and investment in improving care and health outcomes, directly impacting the value and quality of the care we provide.

Finally, as we continue to combat the COVID-19 pandemic, MHA and its members' focus has squarely been on the health, safety, and well-being of our patients, clinicians, and community. Hospitals and health systems in Minnesota and across the country have incurred significant losses and increased expenses due to COVID-19, forcing them to redirect and reprioritize

resources to ensure we can continue to provide high quality care to our patients. **Therefore, we urge CMS to recognize that hospitals will not "recover" from the pandemic once the public health emergency (PHE) ends and sorely need additional flexibilities in order to prioritize treating patients, not to address administrative burdens.**

2. Hospital Readmission Reduction Program Modifications

MHA supports the agency's work to consider the impact of the COVID-19 pandemic on hospital operations and on the Hospital Readmission Reduction Program measures in particular.

Suppression of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization measure

MHA supports suppressing the HRRP pneumonia measure. We agree that due to the nature of COVID-19, some respiratory diagnoses may have been affected by the pandemic. Our readmission rates for pneumonia show an abnormally high rate in 2020 compared to 2019. Pneumonia was the main diagnosis that shows impacts from the pandemic.

Recommendation: We support further suppression of readmission rates from Q3 2020, Q4 2020, and Q1 2021

We appreciate that Q1 and Q2 2020 will not be counted in the HRRP program. However, we also saw an increase in our readmissions rate with our Medicare Fee for Service population in Q3 and Q4 2020, as well as Q1 2021. We support suppression of these quarter as well. Further, we note that one MHA member was not alone in that experience as there was a broad reduction of patients seeking care in the first half of the year followed by an increase in care in the latter half of the year.

Modification removing COVID-19 diagnosed patients from the denominator of five condition specific metrics in FY 2023

We support removing the COVID-19 diagnosed patients from the denominator of all five conditions (AMI, CABG, COPD, HF, Pneumonia, THA/TKA) in the HPPR program. This aligns with other CMS initiatives – such as the ACO model – that remove patients hospitalized with COVID-19 from hospitals' overall evaluations. Our facilities, much like many other care systems, saw a decrease in patients seeking care in the first half of the year, only to have rates pick up substantially in the latter half of the year.

Recommendation: We support further suppressing COVID-19 patients from the denominator of all HRRP measures until the Public Health Emergency (PHE) ends

We have seen an increase in COVID-19 patients at the end of the first quarter, beginning of the second quarter of 2021 and would support the removal of all COVID-19 patients from the denominator of all HRRP measures while the PHE remains in effect.

3. Disproportionate Share Hospital (DSH) Payment Changes

For FY 2022, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $14.098 billion. Accordingly, CMS

proposes that hospitals would receive 25% of these funds, or $3.524 billion, as empirically justified DSH payments.

The remaining $10.573 billion would flow into the 75-percent pool, which is then adjusted to reflect changes in the percentage of uninsured. CMS determined that the percentage of uninsured for FY 2022 would be 10.1%; thus, after inputting that rate into the statutory formula, it proposes to retain 72.14% – or $7.628 billion – of the 75-percent pool in FY 2022. This would result in a decrease of about $660 million in uncompensated care payments in FY 2022 compared to FY 2021.

As in previous years, to distribute the 75-percent pool, the agency would continue to use the share of uncompensated care provided by each DSH hospital. For example, if Hospital A accounts for 1% of the total uncompensated care provided by all DSH hospitals, it would receive 1% of what remains of the 75-percent pool.

Uncompensated Care Payments (UCC) – Factor 3

Fiscal Year 2022 will be the fifth year utilizing uncompensated care and bad debt costs on Worksheet S-10 of the cost report to allocate UCC payments for eligible DSH hospitals. While the accuracy of S-10 reporting seemingly has improved over time and annual CMS audits reduce the likelihood of aberrant data, MHA members still have concerns about the integrity of the overall UCC distribution. Members also question the fairness of UCC allocations to specific hospitals which result in UCC distributions in excess of DRG payments.

Annual Worksheet S-10 auditing, especially if performed on a high percentage of hospitals, is effective in rooting out charity and bad debt cost levels that are outliers. However, the high degree of impact sensitivity to S-10 adjustments – about 23% - leaves a lot of room for bad data to skew UCC allocations to individual hospitals. A $1M S-10 adjustment affects UCC distribution to that hospital by roughly $230,000.

MHA members encourage CMS to use a statistical trim threshold, e.g. S-10 costs > 40% Worksheet A expenses, which would apply to all hospitals.

In terms of fairness, MHA calls attention to three member hospitals whose proposed 2022 UCC distributions are at least 20 standard deviations from the population mean. These three hospitals have proposed UCC amounts of greater than $100M and UCC distributions greater than 300% of estimated DRG payments. One member has a proposed UCC allocation of $144M, which is nearly 1000% (one thousand percent) of its estimated DRG reimbursement.

All three hospitals in question are true safety net hospitals and provide vast amounts of charity care to their respective communities. We believe that such hospitals should be adequately remunerated for high levels of uncompensated care. But we question the fairness of using Medicare funds to cover non-Medicare populations, especially when the subsidies are spectacularly excessive.

Prior to the establishment of the UCC fund via passage of the Affordable Care Act, Medicare DSH funding was based on fractional inpatient Medicaid utilization and Medicare/SSI eligibility. This historical DSH reimbursement methodology paid an add-on to the DRG payment based on a formula utilizing the two ratios mentioned above. Under what is now dubbed "Empirically Justified" DSH, the highest DRG percentage add-on payment was 254.2% [((((1.00 + 1.00) - .202) x .825) + .0588) + 1], where (1.00 + 1.00) in the equation represents 100% inpatient Medicaid utilization and 100% SSI eligibility. Of course, in reality, this scenario couldn't possibly play out, but the formula would be a reasonable upper limit on UCC distributions for eligible hospitals. Using 254.2% as a cap, one member would receive a UCC distribution of $36M on top of approximately $14M of base DRG payments.

UCC payments in excess of the cap should be redistributed to all other eligible providers.

Although the statutory language controlling UCC payments is silent on a cap or upper limit for individual hospitals, we believe that a generous upper limit, as described above, would allow for adequate Medicare payments to high charity care hospitals while redistributing some of the largesse to remaining eligible facilities. We cannot imagine Congress intended for such a cross-subsidization from the Medicare trust fund for non-Medicare purposes. Safety net hospitals receive subsidies through numerous means, including Medicaid DSH payments, Intergovernmental Transfers (IGTs), supplemental payments, Upper Payment Limit transfers (UPLs), grants, and state and local indigent care pools. **MHA and its members encourage the agency to consider an upper limit or cap on UCC payments to provide a more equitable and fiscally sound distribution of funds.**

4. Solicitation of Comments Related to Wage Index Decrease Cap

In the Proposed Rule at pages 25397, CMS seeks comments on whether to continue to apply a transition to the FY 2022 wage index for hospitals negatively impacted by CMS' adoption of the updates in OMB Bulletin 18-04. For FY 2021, CMS adopted a policy to place a 5 percent cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2020. This 5 percent cap policy has been in place for the last two years.

MHA urges CMS to continue applying the 5 percent decrease cap to the FY 2022 wage index. By extending this transition, CMS can help reduce the wage index volatility hospitals face year after year and provide the relief hospitals need to navigate the lingering impacts of the pandemic. Continued application of the 5 percent cap will provide more stability for Medicare payments and more certainty in the payment system – when the healthcare system needs it most.

In light of the importance of reducing wage index volatility for providers, MHA urges CMS to consider in future rulemaking a permanent extension of the 5 percent floor on wage index decreases. Because this relief provided by this permanent extension should not come at the expense of health care providers, MHA believes that continuing this transition should not be budget neutral.

5. Indirect and Direct Medicare Graduate Medical Education.

Pursuant to Division CC of the Consolidated Appropriations Act, 2021 (CAA), CMS proposes regulations to distribute additional residency positions to qualifying hospitals beginning in FY 2023. The CAA requires that CMS take into account the demonstrated likelihood of each hospital filling the positions made available within the first five training years beginning after the date the increase would be effective and that at least 10 percent of the total positions be distributed to the following hospital categories:

1. Hospitals in rural areas or treated as located in a rural area;
2. Hospitals in which the reference resident level for the most recent cost reporting period ending on or before enactment is greater than the resident limit;
3. Hospitals in states with new medical schools (Candidate School or Pre-Accreditation status on or after January 1, 2000) that have achieved or are progressing toward full accreditation; or in states with additional locations and branch campuses established on or after January 1, 2000, by accredited medical schools; and
4. Hospitals that serve health professional shortage areas (HPSAs).

In addition, the CAA places the following limitations on the distribution of residency positions: (1) a hospital may not receive more than 25 additional FTE residency positions; and (2) no increase in the otherwise applicable resident limit of a hospital may be made unless the hospital agrees to increase the total number of FTE residency positions under the approved medical residency training program of the hospital by the number of positions made available.

CMS proposes to distribute 200 FTE residency positions per year for five years, limiting the distribution to 1.0 FTE per hospital per year. In addition, CMS proposes to use health professional shortage area (HPSA) scores to differentiate hospital applicants, prioritizing among distributions to those hospitals with the highest HPSA score. As part of this, a hospital would be limited to one application, which CMS believes will incentivize hospitals to choose to apply for a program that serves the HPSA with the highest score among its programs.

While we understand the statutory limitations on CMS's ability to distribute these additional FTE positions and CMS's desire to ensure equitable distribution (i.e., no more than 1.0 FTE per year per hospital), we are disappointed in the mechanisms by which CMS proposes to distribute these extremely limited and highly valuable positions. The proposed prioritization based on HPSA scores is well-intentioned, but we do not believe is the best approach. When reviewing the national data on HPSA scores,[1] it is not clear that this prioritization will result in a meaningful distribution of these limited residency positions and may not achieve the desired maximum benefit.

MHA offers the following recommendations:

[1] See, https://data.hrsa.gov/topics/health-workforce/shortage-areas.

- The CAA clearly contemplated more than 1.0 FTE distributed to hospitals by setting the cap at no more than 25 additional FTEs. We urge CMS to rethink this self-imposed cap as it would be more meaningful to distribute a higher number of positions where the need is greatest and where those FTEs would be best utilized.
- As noted, it is unclear whether prioritization by HPSA score is the best representation of where positions should go and whether that one FTE will make a meaningful impact in that HPSA. While we are well aware of how valuable an additional FTE is, we question whether the cap of 1.0 FTE in conjunction with prioritizing based on HPSA score will result in meaningful change.
- CMS considered an alternative approach that would prioritize those applications from hospitals that qualify in multiple of the four eligibility categories. We believe that this approach is a better option for a limited time period while CMS works with stakeholders to develop a more refined approach beyond prioritizing by HPSA score. Further, we believe this will assist in ensuring 10 percent or more of the residency positions are distributed in each of the four categories.
- If CMS is limiting distributions to hospitals and not programs, CMS should place a greater weight and emphasis on the hospital's training program in HPSAs and rural areas. We believe that a demonstrated commitment of limited resident positions to such areas should outweigh the situation when a hospital devotes a small amount of resources to one program with a high HPSA score.

6. Organ acquisition payment provisions

CMS supports a number of organ acquisition services by providing payment for organ transplantations. CMS excludes organ acquisition costs from the inpatient PPS payment, and instead separately reimburses for organ acquisition on a reasonable cost basis. In the proposed rule, CMS proposes to codify into Medicare regulations some longstanding Medicare organ acquisition payment policies, as well as and some new policies, including clarifying definitions for "transplant hospital," "transplant program" and "organs." The agency also would clarify when medical complications are considered organ acquisition costs. In addition, CMS proposes that transplant hospitals and organ procurement organizations count and report Medicare usable organs to ensure such organs are accurately allocated to Medicare. Lastly, the agency also proposes several provisions for donor community hospitals, including reducing its customary charges to its costs.

MHA recommends that CMS conducts a comprehensive study of the potential impact of the transplant-related provisions in the 2022 IPPS Proposed Rule on patient access to transplantation and to delay implementation of these provisions of the Proposed Rule until that study is completed.

Over the past several years, CMS has made it clear that it recognizes the significant clinical and cost effectiveness and advantages of kidney transplantation over other forms of treatment for ESRD-eligible Medicare beneficiaries. To highlight this fact, CMS has instituted major regulatory changes to increase access to transplantation. The substantial limitations on Medicare payment

for the costs associated with procuring organs for transplantation that are now proposed are completely inconsistent with these initiatives: **These extraordinary payment cuts threaten to significantly disrupt the organ procurement programs operated by Transplant Centers, which currently procure 36% of deceased donor organs. Such disruption will undercut CMS efforts to increase access to transplantation and rather will increase wait times, waitlist mortality and morbidity for ESRD-eligible Medicare beneficiaries.**

MHA is concerned about the proposed change that would require a Transplant Center that procures an organ that is subsequently transplanted elsewhere to determine the insurance status of the recipient. The current rule, which essentially assumes that the recipient is a Medicare beneficiary, was intended to incentivize hospitals with Transplant Centers to institute effective organ procurement programs.

Also, under this proposal, administrative costs would increase, because hospitals and health systems would be responsible for obtaining evidence of the Medicare status of the recipients of all of the organs that are procured and are transplanted elsewhere. Contrary to the assertions in the Proposed Rule, there is no established system for obtaining this information, and obtaining evidence of Medicare liability-- especially when Medicare is functioning as a Secondary Payer (MSP) will be time consuming and complex.

Finally, unlike other changes proposed in the IPPS Proposed Rule, the proposed limitations on payment of organ acquisition costs were not included in the hospital-specific analysis that most hospitals rely on in assessing IPPS proposed changes. For this reason, many hospitals that operate Medicare-certified Transplant Centers still may be unaware that these changes could significantly impact their patients and their transplant programs.

MHA urges CMS to study the potential impact of all of the proposed changes that would limit Medicare payment for the costs of acquiring organs for transplantation on access to transplantation and to refrain from implementing any of these changes pending the completion of the study.

7. Quality Reporting Programs

Hospital Inpatient Quality Reporting (IQR) Program – COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure

CMS is proposing to adopt five new measures to the IQR program, including the COVID-19 Vaccination Coverage Among HCP measure, which would begin October 1, 2021. The new measure would assess the proportion of a hospital's health care workforce that has been vaccinated against COVID-19. The proposal would exclude staff with a contraindication to the COVID-19 vaccines. CMS also is proposing to publicly report each quarterly COVID-19 HCP vaccination coverage rate for each hospital. According to the Proposed Rule, CMS believes it is important to incentivize and track HCP vaccination in acute care facilities through quality measurement to protect health care workers, patients, and caregivers, and to help sustain the ability of hospitals to continue treating patients during the pandemic and beyond.

While we agree that all Americans should be vaccinated, in particular HCPs, we are concerned with tying this to a publicly reported quality program measure. Many employers, including hospitals, are contemplating or have mandated, the vaccination of their employees. In some cases, these mandates have led to litigation.[2] This measure may lead hospitals to feel pressure to mandate their employees to become vaccinated in order to report high vaccination rates, which will require a significant financial investment in terms of documenting HCP vaccination status, coordinating with the Human Resources department and each individual employee to obtain proof of vaccination. This is an enormous undertaking and diverts resources away from continuing to treat and serve our patients.

As this measure is defined, HCP includes all persons receiving a direct paycheck from the hospital *regardless of clinical responsibility or patient contact.*[3] While we agree that it is important for all staff members to be vaccinated, those with direct patient contact and clinical responsibilities have been prioritized. Subsequently, many of the clinical personnel received vaccinations from the hospital, while non-clinical staff may have received vaccinations from third parties or their own preferred provider. Other than an unverifiable survey of staff, MHA members would have no way of obtaining this information for those employees who did not receive the vaccination from a member.

While we do not oppose the new measure, we urge CMS to consider the ramifications of finalizing this measure by October 1, 2021. Specifically, publicly posting this information could be extremely misleading to the public. Some employees may opt not to provide this information (or refuse to receive a vaccination), skewing the publicly reported vaccination coverage rate. In addition, unless the data is broken down by patient-facing and non-patient-facing employees, we are very concerned that our patients may be reluctant to come to a hospital to obtain needed treatment. Further, we are very concerned that misrepresentations of the data about vaccination rates at hospitals may further drive vaccine hesitancy among the general population.

Hospital Readmissions Reduction Program (HRRP) – Addressing the Impact of COVID-19

The Proposed Rule recognizes that the COVID-19 PHE has had a significant impact and that HRRP quality scores may be distorted, impacting payment for hospitals. Therefore, CMS is proposing to adopt a policy for the duration of the PHE that would suppress the use of certain quality measures via adjustment to the HRRP's scoring methodology, if necessary. Under the proposal, if CMS determines that the suppression of a measure is warranted, it would calculate the measure's rates for that program year but then suppress the use of those rates to make changes to hospitals' Medicare payments. Effectively, this would allow certain measures to have a zero percent weight.

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[2] *117 staffers sue over Houston hospital's vaccine mandate, saying they don't want to be 'guinea pigs.'* Washington Post. May 29, 2021. Available here: https://www.washingtonpost.com/nation/2021/05/29/texas-hospital-vaccine-lawsuit/. See also Plaintiffs' Original Petition here https://assets.documentcloud.org/documents/20792874/methodist-lawsuit-1.pdf

[3] See, https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpcoverage-508.pdf.

We support this proposal as the COVID-19 pandemic has truly impacted our health care delivery system, severely distorting the HRRP measures. CMS should have the tools to suppress severely impacted measures, such as the 30-Day Pneumonia Readmission Measure due to external factors like the COVID-19 pandemic. This can help avoid negative financial consequences for hospitals for circumstances that are beyond their control. **We urge CMS to finalize this policy as proposed and to allow CMS to have this authority for future pandemics**.

8. Health Equity Request for Information

MHA and its members support CMS's efforts to close health equity gaps for all individuals. MHA is prepared to assist CMS by working with members to collect and report on specific sets of data elements when appropriate, including race, ethnicity, sex, sexual orientation and gender identity, primary language, tribal membership, and disability status. We agree that collecting this type of patient data can help track health outcomes, which will be critical in identifying and closing health equity gaps. We also note that as hospitals and health systems overcome this unprecedented pandemic, it is important to work with hospitals and health systems with the understanding that health care workers and staff are facing extremely high levels of burnout. MHA notes that hospitals and health systems may need flexibilities while reporting any type of data elements.

Furthermore, we support creating the Health Equity Score that would be used to synthesize results across multiple social factors and disparity measures. We believe this confidential score could identify low-performing hospitals and encourage them to develop appropriate interventions to ensure that all patients are receiving the highest quality of care possible.

We support these efforts and applaud CMS for taking this preliminary step. MHA looks forward to working with CMS in the future to address inequities and ensure that all patients receive a high level of care.

As always, we appreciate the opportunity to comment on CMS' proposed rules. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
Vice President, Finance Policy & Analytics