National Alliance of Safety-Net Hospitals

June 28, 2021

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Subject: 42 CFR Parts 412, 413, 425, 455, and 495; CMS-1752-P; RIB 0938-AU44; 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

Attention: File Code CMS-1752-P

To Whom it May Concern:

I am writing on behalf of the National Alliance of Safety-Net Hospitals (NASH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2022 Medicare inpatient prospective payment system regulation that was published in the *Federal Register* on May 10, 2021 (Vol. 86, No. 88, pp. 25070-25790).

NASH would like to bring to your attention our views on five aspects of the proposed regulation:

- Medicare DSH proposals
- wage index and labor-related share
- graduate medical education
- organ acquisition payment policies
- health equity

We address each of these issues individually below. After that, we address some of the issues on which CMS has invited stakeholder comment.

Areas of Agreement

Before proceeding to address the aspects of the proposed regulation with which NASH has concerns we first would like to note those on which we agree and support what CMS has proposed.

- NASH supports the proposal to repeal the requirement that hospitals include on their Medicare cost report the median payer-specific charge that they negotiated with all of their Medicare Advantage payers by MS-DRG for cost reporting periods ending on or before January 1, 2021.

- NASH supports CMS's proposal to use a "measure suppression policy" that would enable CMS to suppress the use of measure data in its quality programs if the agency determines that circumstances caused by the COVID-19 pandemic have significantly affected those measures and the resulting quality score. This policy, CMS notes, is intended to ensure that such measures neither penalize nor reward hospitals based on circumstances caused by the pandemic. The policy would be used for the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Program, and the Hospital Value-Based Purchasing Program.
- NASH supports CMS's proposal to perform its statutorily required rebasing of Medicare's relative weights based on FY 2019 data rather than FY 2020 data because the latter will be so skewed because of the effect of COVID-19 on the delivery of hospital inpatient care.
- NASH supports CMS's announcement that it will continue the 20 percent add-on payment for care provided to patients diagnosed with COVID-19.

Medicare DSH

NASH appreciates the opportunity to comment on the following issues related to the uncompensated care portion of Medicare DSH payments:

- CMS's assumptions for calculating Factors One and Two for FY 2022
- the use of a single year of data from the S-10 worksheet of hospitals' FY 2018 Medicare cost reports as the basis for calculating Factor Three
- the exclusion of Medicaid shortfalls from the calculation of Factor Three
- a potential alternative to CMS's proposed change of its policy for counting section 1115 waiver days when calculating the Medicaid ratio used to calculate empirical DSH payments

Assumptions for Calculating Factors One and Two

The Medicare DSH uncompensated care pool is the product of two factors: Factor One, which is 75 percent of the amount that CMS would have otherwise paid in Medicare DSH payments absent the implementation of the Affordable Care Act's modifications of Medicare DSH (referred to later in this letter as "traditional DSH"); and Factor Two, which is the percentage change in the rate of uninsurance in the United States. Both measures have seen unexpected changes in the past year because of the COVID-19 public health emergency and, in NASH's view, need to be treated differently from how they have in the past as a result.

Factor One

Factor One, which is largely driven by Medicare inpatient volume, has been greatly affected by the decline in hospital inpatient volume caused by COVID-19 over the past 15 months. Many Medicare and Medicaid patients put off seeking needed medical care either because of government-mandated restrictions on the provision of care in hospitals or out of a personal choice to reduce their chances of contracting the virus by deferring needed care and temporarily avoiding hospitals. Now, as vaccination rates increase and infection rates decline, these people can be expected to begin addressing their deferred medical needs in the year ahead. NASH is concerned that the historical data used to estimate inpatient

hospital utilization among Medicare and Medicaid-covered individuals understates the actual amount of inpatient care hospitals are likely to provide in the coming year.

Another major driver of Factor One is the proportion of inpatient care hospitals provide to Medicaid-eligible individuals. The federal government implemented emergency policies to ensure that no one would lose their Medicaid coverage during the pandemic and these coverage protections will not end immediately with the end of the emergency declaration. Analysts estimate that nation-wide Medicaid enrollment has grown by nearly eight million people since the beginning of the COVID-19 public health emergency. NASH believes that as the COVID-19 emergency continues to fade and people begin to address the medical problems they have now neglected for more than a year, many will be turning to hospitals with their Medicaid coverage, which should in turn lead to higher traditional DSH payments, not lower.

Factor Two

The COVID-19 emergency has resulted in many Americans losing their jobs, and with those jobs, their health insurance. We are confident that when reliable data is available, we will learn that the number of uninsured Americans has grown – and perhaps grown significantly, with preliminary estimates suggesting that about one million people have lost their health insurance since the pandemic began.

Proposed Alternative

For the reasons described above relating to past data not being predictive of FY 2022 circumstances, NASH urges CMS to freeze the FY 2022 DSH uncompensated care pool at the FY 2021 level. Without question, parts of FY 2020 and most of FY 2021 will prove to be true anomalies.

If CMS does not accept this proposed alternative, we ask that CMS provide additional description of the methodology used to derive the "other" factor influencing the agency's estimate of Factor One, which appears in the proposed rule not to adequately reflect the effects described above. We also request that CMS use the latest available data (i.e., any updates released between the analysis developed for the proposed rule and publication of the final rule) when finalizing its calculations of Factors One and Two in the hope that such data might capture more of the increases in utilization and reductions in insurance coverage that we anticipate during FY 2022.

Use of a Single Year's Data to Calculate Uncompensated Care DSH Payments

NASH disagrees with CMS's proposal to base its calculation of hospitals' FY 2022 Medicare DSH uncompensated care payments on S-10 data from only hospitals' FY 2018 cost reports. As we have expressed in the past, NASH believes that basing such an important calculation on a single year of data poses a potential problem: hospitals' uncompensated care can and does vary from year to year as they experience natural ups and downs. Basing this calculation on a single year of data can result in large fluctuations in payments from one year to the next. Such fluctuations are difficult to ride out under normal circumstances, and even more so as many financially challenged DSH hospitals are still reeling from the effects of the pandemic.

To address this challenge and even out the ups and downs, NASH recommends that CMS return to calculating eligible hospitals' Factor Three from more than one year's worth of data. For FY 2022, we recommend that DSH payments be calculated based on an average of the Factor Three figures derived

from hospitals' FY 2017 and FY 2018 S-10 reports. In the future we recommend that payments be based on a three-year average, beginning with FY 2017, FY 2018, and FY 2019 data for FY 2023 payments and continuing with three years of data thereafter, with appropriate future adjustments to reflect the unusual circumstances caused by the COVID-19 emergency.

The Exclusion of Medicaid Shortfalls from the Calculation of Factor 3

As we have in the past, NASH continues to object to use of line 30 of the Medicare cost report's S-10 worksheet as the sole source of data on the uncompensated care hospitals provide. Community safety-net hospitals, in particular, care for significant numbers of Medicaid patients, and in states that have expanded their Medicaid programs, Medicaid shortfalls can be nearly as great a financial challenge as uncompensated care. For this reason, NASH believes CMS should do more to quantify hospitals' Medicaid shortfalls by incorporating line 31 of the S-10 into its calculation of hospitals' uncompensated care used in the calculation of Factor 3.

Alternative Proposal to Address 1115 Waiver Days Under DSH Policy

In the FY 2022 proposed rule, CMS proposed to exclude from the numerator of a hospital's DSH fraction any days associated with care provided to individuals under an 1115 waiver if that waiver does not provide the individual with insurance coverage. NASH opposes this proposal. The Medicaid days in the numerator of the Medicaid fraction serve as a proxy for the amount of care provided to low-income individuals, and the cost of treating these patients can reasonably be expected to be higher than those for treating patients who face fewer barriers to accessing care. As such, NASH supports CMS's long-standing position that the days of care provided to these individuals should be counted in the numerator of the Medicaid fraction even if circumstances dictate that the Medicaid payment generally underwrites the facilities' provision of uncompensated care rather than providing explicit coverage to the individual.

Additionally, we are concerned that the ramifications of this proposed policy would extend beyond the states that currently operate under the affected waivers. By lowering the empirical DSH reimbursement to hospitals in states that employ these waivers, CMS will in turn lower overall traditional DSH payments used to determine the amount of funds available for uncompensated care DSH payments in all states. We do not believe that Congress anticipated the administration enacting policies that would reduce the total amount of DSH payments that would otherwise have been made when they linked those payments to the uncompensated care pool in the Affordable Care Act.

Instead, NASH believes the appropriate avenue to address these waivers is in the uncompensated care portion of Medicare DSH payments. NASH has long objected that some compensation that hospitals receive for providing care to uninsured individuals is not subtracted from the costs of providing care to the uninsured on worksheet S-10 of the Medicare cost report prior to the calculation of Factor Three.

This situation can arise when a local, county, or state government payment is made to a hospital but is not directly tied to the care provided to a particular uninsured individual. In this manner, the hospital has been compensated for its "uncompensated" care, but because such compensation is not directly tied to an individual patient service, the S-10 instructs such hospitals to report the costs of providing such care as uncompensated but does not offset these costs by the associated payments the hospital received.

A similar situation could arise in states that have obtained section 1115 waivers from the federal government to compensate hospitals for the care they provide to uninsured individuals rather than expanding Medicaid coverage to the individuals themselves. Payments received from the Medicaid program (such as waiver payments) would be reported on line 2 or line 5 of Worksheet S-10, while depending on the hospital's charity care policy, the costs of providing the care could be recorded as charity care write-offs on line 22.

This disconnect between the Medicaid payment and the charity care write-off (because the payment is not explicitly to cover this patient's care) results in a situation in which the hospital is essentially being paid twice for that care: once under the 1115 waiver and again because reporting it as an uncompensated cost gives it a bigger share of the limited Medicare DSH uncompensated care pool.

Medicare DSH uncompensated care is a zero-sum pool: with every eligible hospital receiving a proportional share of the pool based on its uncompensated care, one hospital's reporting of uncompensated care for services for which it has in reality been compensated enables it to increase its share of the pool – and to do so at the expense of other hospitals.

While NASH appreciates CMS's proposal to exclude uncompensated care pool days from the total of hospitals' Medicaid days in the Medicaid fraction, we do not agree with this approach. Instead, and for the reasons stated above, NASH urges CMS to require recipients of such payments to include those 1115 uncompensated care pool payments as offsetting revenue to their uncompensated care costs on their S-10 report prior to the calculation of Factor 3. This would help prevent the double-dipping from which some hospitals have benefited over the years.

Medicare Area Wage Index

NASH would like to address two aspects of the changes CMS proposes in Medicare area wage index policy.

Labor-Related Share

In the proposed rule, CMS calls for reducing the labor-related share of Medicare payments from the current 68.3 percent to 67.6 percent. NASH opposes this in large part because we disagree with some of the assumptions underlying this proposal.

First, NASH disagrees with CMS's proposal to exclude from the labor-related share the proportion of non-medical professional service fees presumed to have been purchased outside of the hospital's labor-market (for the purposed of this comment letter, "purchased from national firms"). We disagree specifically with CMS's assertion/assumption that services purchased from national firms are not affected by the local labor market. In the experience of NASH's member hospitals, national firms unquestionably adjust their rates for different reasons – including for reasons that are largely dictated by local labor costs.

Fundamentally, although a national firm's wage-related costs may not specifically vary according to the local labor market of a client hospital (although they may, depending on the contract), what the hospital actually pays for that contract labor almost certainly will. As such, the costs of services purchased from firms outside of the hospital's labor market should be included within the labor-related share of costs.

Imagine a hospital in an average wage area that is seeking bids for accounting services. The hospital receives three bids: one from a firm in a high-wage area, one from a firm in a low-wage area, and a third from a firm in the hospital's own average-wage area. Clearly each bidder must tailor its proposal to compete with the prevailing wages at the hospital if it hopes to be more appealing than simply performing the function in-house while also not undervaluing the services the firm intends to perform. This is contrary to the assumption in the proposed rule, which is that each firm would bid for the services according to its own labor costs regardless of the value that would represent to the hospital.

Second, NASH disagrees with CMS's position that labor costs associated with services provided by hospitals' or health systems' home offices do not "vary with the local labor market" in instances where the home office is in a different labor market from the labor market in which the hospital provides patient services. On the contrary, we assert that the home office's labor costs absolutely vary with "the local labor market" even when that local labor market is not the same as the main hospital's. The proposed methodology fails to consider that the home office is essentially a part of the hospital. Stated differently, the issue is not that home office labor costs do not vary with the hospital's local labor market, it is that the hospital, along with its home office, is operating in multiple labor markets. The home office's portion of the hospital's labor costs should not be excluded from the labor-related share simply because they are not in the same labor market as the hospital. Even if the wage-index adjustment applied to hospital payments is not sufficiently refined to recognize this multi-labor-market circumstance, that is no reason to completely eliminate the recognition of these costs under the inpatient prospective payment system as being affected by local labor market forces. The proposed methodology seems particularly unfair to independent hospitals in high-wage areas with no home office costs that will see their reimbursement lowered through a reduction in the labor-related share because a portion of other hospitals' administrative costs have been removed. For this reason, we request that CMS treat 100 percent of home office labor costs as being "labor related."

Although federal law requires the Secretary to update market basket weights, including the labor share, more frequently than every five years, it does not dictate the methodology for doing so. The COVID-19 emergency has had an unusual and unexpected impact on hospital wages in many places, and especially in urban areas with already higher-than-average wages (i.e., wage indexes greater than 1.0): it is driving them up to an unprecedented degree and in an unprecedented manner. This proposed reduction of the labor-related share would apply only to geographic areas with a wage index greater than 1.0 and would therefore reduce reimbursement to those very hospitals that already faced the highest labor costs just as those costs are further increasing in response to the public health emergency. COVID-19 has had an impact on hospital wages, and ultimately will on Medicare wage indexes, but it is too soon to measure that impact and impose this type of cut on so many hospitals.

For these reasons, NASH respectfully requests that CMS revise its proposed calculation of the labor-related share to include costs associated with non-medical professional service fees purchased outside of the hospital's own labor market as well as home-office labor costs.

Limit on Wage Index Losses

The current year's inpatient prospective payment system rule invites public comment on whether to include a provision to protects hospitals from the immediate and potentially damaging effects of significant reductions of their wage index by limiting any reduction in their wage index adjustment from the previous year to five percent. Because many hospitals already suffered wage index losses in the current fiscal year, including up to five percent, and face the prospect of still more losses in the coming

year, NASH urges CMS to protect them from major additional losses and retain the same five percent limit on wage index-caused Medicare losses in FY 2022. In fact, NASH urges CMS to make this five percent cap permanent, every year. More than anything else, hospitals need predictability, and a loss of more than five percent would be chaotic and potentially devastating for hospitals – and especially for community safety-net hospitals that operate on much smaller margins than the typical American hospital.

Graduate Medical Education

In the proposed rule, CMS presents its plan to implement Section 126 of the Consolidated Appropriations Act of 2021, which calls for 1,000 new graduate medical education residency positions to be distributed to certain qualified hospitals over the next five years. The legislation stipulates that these new slots should be distributed among the four following groups:

1. rural hospitals and hospitals treated as rural hospitals (referred to later as "Category One")
2. hospitals over their otherwise-applicable resident limit (Category Two)
3. hospitals in states with certain new medical schools and medical schools with additional locations and branch campuses (Category Three)
4. hospitals that serve Health Professional Shortage Areas (HPSAs) (Category Four)

The legislation calls for CMS to allocate at least 10 percent of the 1,000 slots to hospitals in each of these categories but otherwise gives CMS discretion over the distribution methodology. In addition, the legislation limits individual hospitals to receiving no more than 25 additional full-time equivalent residency positions through this effort and requires recipient hospitals to agree to increase the total number of full-time equivalent residency positions under their training programs by the number of slots they are awarded.

NASH objects to several aspects of the methodology CMS proposes for distributing these residency slots and would like to explain our objections and propose an alternative.

The Proposed Focus on HPSA Score is Inconsistent with Congressional Intent

CMS proposes accepting applications from hospitals that qualify under any of the four categories described above but says it will give its highest priority in the distribution of new residency slots to hospitals that serve areas designated as HPSAs. Specifically, the agency would award new residency positions to hospitals that meet one or more of the four qualifying categories listed above and also serve areas or populations with the highest HPSA scores (a measure of an area's provider-to-population ratio, rate of poverty, and travel time to the nearest source of care) compared to all other qualifying hospitals regardless of their category of qualification.

This proposal would distribute slots exclusively according to HPSA rank even though the use of HPSAs as a qualifying criterion is addressed in only one of the four categories that the enabling legislation stipulates. NASH disagrees with this decision because it has no foundation in the enabling legislation and

because we believe it is inherently unfair to deserving hospitals that may qualify for new residency slots in the other three (non-HPSA) categories.

In the proposed rule CMS states that its proposed methodology does not intend to exclude hospitals that do not serve HPSAs from receiving new residency slots. Regardless of whether that is CMS's intent in developing this proposal, it is undoubtedly a predictable result. As described in more detail below, NASH's analysis of the proposed methodology suggests that giving exclusive priority to applications from hospitals with high HPSA scores would have precisely this effect. Again, NASH does not believe this was Congress's intention and disagrees with this approach.

Although CMS believes "there is a strong likelihood" that the proposed methodology would result in compliance with the legislative requirement that at least 10 percent of the new residency slots go to hospitals in each of the four eligibility categories, NASH believes CMS should adopt a methodology that will better reflect the legislative intent.

The Proposed Methodology Would Exclude Rural Hospitals (Category One)

The hypothetical example of CMS's proposed methodology provided on page 25509 of the proposed rule presumes that the last of the residency slots would be consumed by hospitals serving HPSAs with a score of 19. NASH's analysis (Appendix A of this letter) confirms the reasonableness of that example, showing that there are more than 400 qualifying HPSAs across the nation with a score of 19 or above – more than enough to absorb the 200 slots that would be available under CMS's proposed methodology. Even if enough slots were to remain for some to be distributed among hospitals serving HPSAs with a score of 18, that would open up an additional 462 HPSAs, more than doubling the count for a total of more than 900 with a score of 18 or above.

Based on the information noted above, it seems reasonable to assume that there would not be any slots to distribute among hospitals serving HPSAs with a score of 17 or lower, yet many states do not have a single qualifying HPSA with a score of 18 or higher. Among them are such heavily rural states as Wyoming, New Hampshire, Hawaii, and Pennsylvania. Minnesota and Maine are each home to only a single HPSA with a score of 18 or higher. According to RUCA (rural-urban commuting area) code to zip code approximation data available from the USDA Economic Research Service, teaching hospitals in Pennsylvania, New Hampshire, and Hawaii are located in rural areas with some of the highest RUCA codes among teaching hospitals, yet these hospitals would be unlikely to be eligible to receive any additional slots under CMS's proposed methodology.

We believe this data further supports the intuitive understanding that the proposed methodology would not reasonably apportion slots to hospitals that qualify under Category One.

The Proposed Methodology Would Exclude Hospitals Currently Operating Over Their Residency Limits (Category Two)

The same is true for hospitals currently operating over their residency limits, many of which are urban teaching hospitals. The emphasis on HPSA status would, according to NASH's analysis, prevent many of these urban teaching hospitals from qualifying for additional residency slots under Category Two. In

addition to the heavily rural states identified above, Massachusetts, New Jersey, Delaware, and others also have no HPSAs with a score of 18 or higher. When we compared our national HPSA analysis with a cost-report analysis of hospitals training residents above their indirect medical education caps (Appendix B) we found 105 hospitals providing unreimbursed training to more than 2,000 residents in states with no HPSA with a score of 18 or greater.

State	Estimated Hospitals Over Cap	Estimated IME Residents Over Cap
DE	2	22.85
HI	3	37.05
MA	17	345.32
NE	5	211.46
NH	2	21.48
NJ	28	564.39
PA	44	665.32
RI	3	158.04
VT	1	41.91
WY	0	0.00
Total	**105**	**2,067.82**

Pointedly, our analysis also found that the hospital with the most unreimbursed indirect medical education residents in the 2019 HCRIS cost report file – although located in a state with high-scoring HPSAs – is not itself located in a HPSA at all and would likely not be a candidate to receive any new slots under CMS's proposal.

Urban areas distinguished by especially large numbers of uninsured and Medicaid-covered people often rely heavily on large teaching hospitals for emergency services and primary and mental health care and much of that care has long been provided by residents in training. These hospitals often are not located in high-scoring geographic or population-based HPSAs, in many cases because the hospital's own efforts to recruit health care professionals have made such a designation unnecessary. Medicare's graduate medical education program has long sought to support the efforts of urban hospitals to train physicians in high-volume, high-need community settings that will serve them well wherever they ultimately choose to practice medicine, but the proposed methodology does not support this objective. For this reason, NASH again objects to the undue influence HPSA status would have on the ability of urban teaching hospitals to obtain any of the 1,000 new residency slots.

The Proposed Methodology Would Exclude Hospitals in States with New Medical Schools (Category Three)

Even though the enabling legislation specifically calls for hospitals in states with certain new medical schools and medical schools with additional locations and branch campuses to receive new residency slots, the decision to give priority to hospitals serving HPSAs would prevent hospitals in some states from receiving new residency slots. There are new or expanded medical schools in New Jersey, for example, but *that entire state has no qualifying geographic or population HPSAs.* Using the conservative estimate that only hospitals serving HPSAs with a score of 18 or above would likely qualify to receive any new

slots, we estimate that every hospital located in four of the 35 Category Three states would effectively be excluded from consideration under the proposed methodology – more than 140 in all.

The affected states are:

- Delaware
- Massachusetts
- New Jersey
- Pennsylvania

NASH does not believe the legislation called for CMS to make this kind of policy decision and again objects to the outsized influence CMS proposes giving HPSA consideration.

NASH Recommends an Alternative Approach to Equitable Distribution

NASH recommends that CMS take another approach to distributing the 1,000 new residency slots: an approach that respects Congress's desire to distribute some slots to providers that serve HPSAs but that does not make HPSA representation the overriding consideration in the distribution of all 1,000 slots.

We request that CMS finalize a modified version of its alternative slot distribution methodology for FY 2023 while revisiting the distribution for subsequent years. Specifically, we support a one-year implementation of the alternate distribution model put forth by the Association of American Medical Colleges.

For future distributions, NASH asks CMS to establish separate distribution methodologies for each eligibility category and to allocate a portion of the available slots to each category. We also suggest that hospitals should be assured by CMS that their investments in these new residents will not result in their ending up closer to breaching or going further beyond their caps than they were before these slots were awarded and that the distribution will enable programs to grow in a meaningful rather than symbolic way. To that end, we suggest that CMS impose "tie-breakers" rather than dividing slots among eligible applicants to avoid distributing partial slots. We also suggest that hospitals be invited to submit an application under each category under which they qualify but with the understanding that they can only be approved under the application that would award them the most slots and they would only receive slots under that one category. Finally, applications should be as simple as possible to limit the administrative burden associated with the process – especially given the limited number of available slots.

NASH believes that there are available methods for ranking applicants within each category and suggests the following metrics for consideration in future rulemaking:

- Category One: Latest Goldsmith Modification of the RUCA codes of the highest area served by the hospital in which the resident(s) would be trained.
- Category Two: Number of residents over cap (indirect medical education and graduate medical education).
- Category Three: Distribute slots among eligible states proportionately according to the number of residents being trained in the state's new programs relative to the total number of residents being trained at new programs nationwide. Within each state, distribute slots

first among those applicants operating new programs ranked by the total number of residents they are currently training in those new programs and second, according to the number of residents the applicant is training beyond its existing residency cap.

- Category Four: HPSA score of the area served by the hospital where the resident(s) would be trained.

Prioritizing applications within each category of eligibility would assure a distribution of slots that would meet Congress's mandate to allocate at least 10 percent of the aggregate number to hospitals in each of the categories and would directly benefit hospitals that qualify under the criteria as written rather than unevenly benefiting hospitals that serve HPSAs.

Conclusion

NASH believes CMS proposes giving too much weight to HPSA status in the distribution of the 1,000 new residency slots that Congress authorized. Using such a methodology, moreover, would place at a disadvantage many of the types of providers that Congress clearly hoped would benefit from the 1,000 new slots. To address this problem, NASH urges CMS to implement its alternative distribution methodology (modified according to the public comments submitted by the Association of American Medical Colleges) for one year while the agency and industry work to develop a model that more specifically addresses the legislative mandate and intent.

Organ Acquisition Payment Policies

Background

CMS's proposal to change its methodology for calculating the ratio that identifies Medicare's share of total usable organs represents a fundamental change in a Medicare reimbursement policy that has stood for more than 30 years and that has helped develop and support our nation's robust organ donation and transplant system.

Transplant hospitals acquire organs from deceased donors. Such organs may subsequently be "matched" with a recipient at a different transplant hospital. In many cases, this process is facilitated by the efforts of an organ procurement organization. Currently, CMS instructs hospitals to assume that acquired organs that are passed on to an organ procurement organization are Medicare organs and that any acquisition costs that are not reimbursed by the organ acquisition company are Medicare reimbursable costs. Under CMS's proposal, the hospital initially acquiring the organ from the deceased would have to determine the insurance status of the individual who ultimately received the organ in a different hospital and only record organs that ultimately ended up in a Medicare patient as Medicare-usable organs.

NASH opposes this proposed change and asks CMS to withdraw its proposal until it can complete further study of the change's impact.

The Proposed Change Would be Administratively Burdensome

Within the rule, CMS makes what we believe to be an incorrect assertion that transplant hospitals procuring organs from deceased individuals either already have or could easy obtain access to an existing source for the insurance status of the procured organ's ultimate recipient. To the contrary, we have found that in many cases organ procurement organizations and transplant hospitals do not have access to such information and that the current restrictions on their access to this information are by design.

This lack of payer information is intentional: it is needed to ensure patient privacy. In addition, it ensures that decisions about prioritizing organ allocation cannot be influenced by the recipient's ability to pay. Even if a path to identifying this information were readily available, the requirement would impose a significant new administrative burden and would force hospitals to report information on their cost reports that they themselves would not be in a position to validate.

NASH believes a separate but administratively accountable entity would need to develop a real-time, secure, navigable, HIPAA-compliant, national information clearinghouse before transplant hospitals would be in a position to make the proposed change in their cost report filings.

CMS is Understating the Costs, Both Financial and Human

CMS has estimated the financial impact of the proposed change to be a $230 million cut in payments to transplant hospitals while industry analysis estimates the effects to be far greater: closer to $380 million in cuts. The significant difference between the estimates indicates a real need for CMS and the industry to work together to further evaluate the proposal before it is finalized.

Removing such a large sum of money from the nation's organ donation system can only serve to reduce the number of available organs for transplant – an effect that is contrary to the bipartisan objective of increasing organ donation and improving the lives of the thousands of individuals currently waiting to receive an organ. Without these available organs, the Medicare program would need to provide continued treatment to Medicare-covered individuals who would not receive an organ in as timely a manner, or at all, as a result of this policy. In addition to the tragic human cost of reduced access to transplantable organs, the additional financial costs associated with continued treatment would, in turn, offset some of the savings CMS estimates that it would achieve by cutting payments to transplant hospitals. Industry analysis estimates that a reduction of five to ten percent of usable kidneys would increase Medicare spending by $85.5 million and increase mortality among patients waiting on dialysis for a transplant.

Some Aspects of the Proposed Changes May Require Additional Refinement

If implemented as proposed, we believe this change in guidance would inappropriately result in an instruction to hospitals to offset payments relating to organs transplanted into non-Medicare beneficiaries from the Medicare share of costs instead of offsetting them against total organ acquisition costs (as would be more appropriate). Transplant hospitals currently record as Medicare-usable organs the number of organs sold to organ procurement organizations and they subtract from their acquisition costs associated

with such organs any associated payments they receive. CMS's proposal appears to require that hospitals no longer record some of these organs as Medicare organs but would still require hospitals to record the payments received for those organs as if they were still regarded as Medicare organs.

NASH suspects this is an unintended oversight rather than an intentional consequence of the proposed policy but this speaks to the complicated nature of Medicare reimbursement for organ acquisition costs and the need for further stakeholder engagement before any changes are finalized. If CMS chooses to implement this provision in the final rule, NASH asks the agency to revise its instructions to reflect that hospitals should remove payments from organ procurement organizations from acquisition costs prior to applying the ratio used to determine Medicare's share.

NASH's Request

NASH joins with others in the industry in asking CMS to withdraw all of the proposed transplant-related provisions from the proposed rule. Instead, we urge CMS to study the potential impact of the proposals on transplantation and collaborate with stakeholders to more thoroughly evaluate appropriate methods of implementation (i.e., required changes to cost reporting forms and instructions and other guidance) and to consider alternative approaches. We hope CMS will not implement any change in policy unless such a study demonstrates that the proposed changes would not jeopardize the impartiality of the matching process and would not reduce the number of successful donations and transplants.

Health Equity

Background: The Role of Community Safety-Net Hospitals in the Health Care Safety Net

Before addressing the specific health equity concepts addressed in the proposed rule, NASH believes it is important to describe the role of community safety-net hospitals.

Generally speaking, the communities private safety-net hospitals serve are characterized by significant health disparities driven in large part by inequities in the resources that have been invested in them over the years. As a result of these inequities, these communities face significant health challenges. The role of safety-net hospitals is to work with their communities to address these health inequities. Because they primarily serve Medicare and Medicaid patients they are paid less than other hospitals that serve more privately insured patients, which is one of the most important reasons community safety-net hospitals often lack the resources of other hospitals. This same problem of lower reimbursement also hinders their ability to attract the physicians they need to work with their communities.

Because of this, these hospitals start out at a disadvantage. Community safety-net hospitals often are older facilities that have aging medical equipment, lower operating margins, and smaller endowments. Even so, they routinely offer services they know will lose money because they know their communities need those services and have few other places to get them.

Despite these many challenges, safety-net hospitals are constantly testing new ways of doing a better job of serving their communities. In their constant pursuit of health equity they want to do more and need to do more, but they need the federal government, and Medicare, to help them. While Medicare payments alone are not the root cause of some of these problems, the federal government needs to empower these

hospitals financially to serve all of their patients, including their Medicare patients, and if and when the federal government identifies areas where safety-net hospitals fall short in the pursuit of health equity it needs to work in partnership with those hospitals to change that.

Identifying health equity challenges on a hospital-by-hospital basis is an unquestionably important aspect of addressing health care disparities and the inequities that cause them but it is only part of the job that needs to be done. The federal government also needs to lead in addressing the problems it uncovers: lead in the form of direction, programs, and resources. Data collection and stratification and health equity access scores can help, but they only identify problems; working to solve the problems they identify requires leading an effort to address the inequities in resources these hospitals experience that have helped lead to the health care disparities in the communities in question.

Recent events saw these communities again bear a disproportionate brunt of a nation-wide problem. These communities suffered from COVID-19 in disproportionate numbers, and many safety-net hospitals were struggling under even greater financial stress. They were poorly served by a Provider Relief Fund distribution methodology that greatly favored wealthier hospitals in wealthier communities that served higher proportions of privately insured patients, and that same Provider Relief Fund continued to overlook these communities and their hospitals when it attempted to make additional targeted distributions to safety-net providers based on poorly drawn criteria that reflected a fundamental lack of understanding of what it means to be a safety-net hospital serving a community with major health care disparities.

It is from this perspective that NASH responds to aspects of the proposed FY 2022 Medicare inpatient prospective payout system rule that addresses health equity.

Community Safety-Net Hospitals in Pursuit of Health Equity

NASH enthusiastically supports CMS's desire to address inequities in the American health care system. Addressing inequities in health care is what community safety-net hospitals are all about: we have been doing it for many years. Community safety-net hospitals are on the front lines in the effort to address health equity. Among the many steps NASH members have taken to improve how they address health inequities, they have:

- Updated electronic health records to add a module to assess patients' social needs supported by the development and implementation of online training to engage provider partners and monitored uptake of this data, identified best practices, and analyzed workflows to determine additional training and education needs while also identifying hidden populations that have emerged through the use of new demographic data fields.
- Created LGBTQ+ patients groups and introduced of new processes to protect both patients and staff from bias.
- Developed and introduced standard practices for implementing assessments of social needs and social determinants of health at the point of care, augmented with support and referral interventions when screening suggests such needs.
- Stratified performance measure data to identify disparities in emergency department wait times between non-Hispanic white and non-Hispanic black patients from arrival time to departure (or admission), mapped the processes that led to those disparities, and developed and introduced interventions designed to address this problem.

- Establishing a dedicated program for LGBTQ health that connects patients with compassionate and skilled providers across its health care system who offer culturally competent care in a judgment-free setting.
- Presented hundreds of workshops on unconscious bias to providers and staff to raise awareness about the unintentional ways providers can be swayed by bias in the workplace. These workshops also give participants tools to address and change current practices.

Safety-net hospitals bring a good deal of experience and expertise to a dialogue about health equity, and with this in mind, NASH would like to address several aspects of the proposed regulation that fall under the broad rubric of health equity.

Improving Demographic Data Collection

NASH recognizes that CMS will need data: data to identify health inequities, data to identify challenges, data to identify hospital performance, and data to drive resources to address those challenges. Before CMS begins to introduce new data collection, NASH urges the agency to carefully review the data it already collects and make every effort to ensure that it does not duplicate any current data reporting requirements. If the agency chooses to require hospitals to submit additional data, NASH requests that such additional requirements not be overly burdensome and that this new data is collected uniformly among all hospitals.

NASH also encourages CMS to pay careful attention to the types of data it asks hospitals to collect and to the challenges associated with collecting certain types of data. Community safety-net hospitals have dealt with such challenges constantly over the years and have come to understand that collecting data is not always the simple, straightforward endeavor some might hope it to be.

Identifying at-risk populations and those who are vulnerable to long-time inequities in the health care system, experience has taught safety-net hospitals, can be a very sensitive undertaking. Providers can be directed to collect certain data to facilitate analysis and future action, but collecting some data can be difficult. It is important for hospitals to be sensitive to and respectful of patient concern of possible disclosure of certain information because hospitals are, after all, in the business of caring for people, and for care to be effective trust is essential between patients and caregivers.

While NASH supports efforts to identify and address health inequities and the collection of data to better understand these inequities, we urge CMS to make any data reporting associated with such undertakings as simple possible. NASH is particularly concerned about especially burdensome new data-reporting requirements, which can become a distraction from the work safety-net hospitals do – that is, caring for their patients. In addition, NASH hopes that before introducing new data reporting requirements CMS will consider alternatives sources of data. One such alternative could be the Community Need Index, a zip-code-based tool that aggregates five socioeconomic indicators long known to contribute to health disparities. Adoption of this or inferred data or some other comparable tool or tools could eliminate the need for major new data collection or reduce the amount of data CMS believes it needs to achieve its objectives.

One form of data collection that concerns NASH is patient-reported outcome measures of the type CMS seeks stakeholder feedback about in the proposed rule: patient feedback following elective primary total hip or knee arthroplasty. NASH is troubled by this idea because of the kinds of biases that can sometimes

be found in such surveys. History suggests that when patients respond to satisfaction surveys their responses speak to their happiness with their overall hospital experience and not to the quality of the care they received. This means that wealthier hospitals with more resources – hospitals more likely to have private rooms, more food choices, and quieter locations farther from street sounds – are more likely to get positive ratings than older hospitals with semi-private rooms. While such information may be useful for patients seeking a pleasant hospital experience, it is of little value in directing patients to where they are most likely to experience a successful hip or knee replacement and of no discernible value in identifying health equity challenges. We also have seen such data gathered in the past with the best of intentions and then used in ways that harmed community safety-net hospitals for reasons having nothing to do with the quality of care they provide. For these reasons, NASH has serious misgivings about the use of patient surveys in its current form as a means of identifying health equity issues.

NASH supports data collection; it is worthy and important. No less important, though, is ensuring that the data collected is useful, that it is not overly burdensome to collect, and that it is collected uniformly from all hospitals. NASH would welcome an opportunity to work with CMS to ensure that any new data collection meets these objectives in a way that is not burdensome to providers yet is useful to providers and policy-makers.

Future Potential Stratification of Quality Measures Based on Demographic Considerations

In the proposed rule, CMS asks stakeholders to comment on the prospect of future potential stratification of quality measures based on demographic considerations.

In general, NASH supports the concept of additional stratification of quality measures based on demographic considerations. CMS states that it would initially compare newly stratified quality scores with hospitals on a confidential basis, to show them where they stand, and then include this data on the Hospital Compare site in 2023. While generally supportive of this concept, NASH believes making the data available on Hospital Compare in 2023 is much too soon. The agency needs more time to ensure that the desired data can be collected uniformly and is reliable.

NASH recommends that the same criteria for data collection that we describe above, in the section "Improving Demographic Data Collection," apply to this effort as well: the data should be easy to collect; it should not impose additional, burdensome data-collection requirements for hospitals; and it should be collected uniformly among all hospitals.

NASH also is concerned about the nature of the comparisons. Like the revised Hospital Readmissions Reduction Program, NASH believes it is essential that data not be compared across all hospitals, that the comparisons should be between hospitals that care for similar types of patients in similar types of communities. Without this distinction, the data would not account for the greater challenges some hospitals face in caring for their communities.

To make the proposed new data stratification a truly useful tool in the pursuit of health equity, CMS also must commit resources and an accompanying effort to work with hospitals to make improvements that move toward greater health equity if the data shows quality problems or quality inequities.

Based on these qualifications and considerations, NASH conditionally supports CMS's proposal to undertake additional data stratification of quality measures based on hospital demographic considerations as a means of improving health equity across racial, ethnic, and other lines.

Creation of a Hospital Equity Score

NASH is uncertain about CMS's proposal to create hospital equity scores because in the proposed rule the agency did not share how it might calculate those scores and how such a measure might be used.

Creating such scores poses a number of challenges that CMS would need to address. As noted above, simply collecting the data needed to compile such scores would be difficult – and it would be most difficult for the very hospitals that serve the most diverse communities.

While newly collected data might identify differences in the challenges hospitals face it may say little, if anything, about health equity beyond identifying those that face more pressing challenges. Also, it is very likely that the hospitals that show the greater challenges, and that therefore face a more difficult path toward health equity, will be the very hospitals with the fewest resources with which to address those inequities: lower margins (if any), older buildings and infrastructure, aging equipment, smaller endowments, less physical space to rebuild or expand, and the challenges inherent in attempting to recruit physicians. If such data is to be collected, NASH hopes its use will go beyond identifying challenges and that it will be used instead to direct additional resources to where they are needed most.

Before NASH can state an unequivocal view on the concept of health equity scores for hospitals, however, we need to know definitively about how such scores would be calculated, how they would be used, and how such an effort would contribute to addressing the social determinants of health and pursuing health equity in the communities our safety-net hospitals serve.

* * *

The National Alliance of Safety-Net Hospitals appreciates the opportunity to share our views on the proposed FY 2022 Medicare inpatient prospective payment system regulation with CMS and welcomes any questions you may have about the ideas we have presented in this letter.

Sincerely,

Ellen Kugler
Executive Director

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they are more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive Community safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates. Private community safety-net hospitals can be found serving communities urban, rural, and suburban across the country.

Appendix A – Eligible HPSA Count By State

Primary State Name	Health Professional Shortage Area (HPSA) Score																						
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Alabama				1				2	3	6	3	6	6	17	7	6	12	4	5	2	1	1	
Alaska						1	2	3	1			3	3	12	6	5	1						
Arizona					2		6	4	7	10	15	16	10	12	16	19	21	13	13	3			
Arkansas							2	1	3	9	5	6	7	14	8	7	8	2	1	1			
California			1	2	4	2	9	14	18	27	32	23	28	32	23	49	36	25	12	1			
Colorado					1	3	1	5	4	3	6	8	9	9	6	5	5	7	2	2		1	
Connecticut									2	1	5	5	4	6	3	3	2	1					
Delaware													1		1	3							
District of												1	1	1			2	1	1				
Florida								1	1	3	3	5	11	10	27	57	42	20	6	1			
Georgia							3	2	4	2	8	10	11	14	29	30	21	19	9	7	6	2	
Hawaii											1		1	1	2	3							
Idaho							1	3	2	2	3	12	6	10	8	2	1						
Illinois					2	6	7	11	5	10	10	12	8	15	24	20	8	6	1				
Indiana				2	2	7	6	4	6	10	5	9	11	10	4	7	4	1					
Iowa					1	3	3	5	7	10	5	9	6	9	6	5	1						
Kansas				1	2	4	3	6	5	11	7	17	13	19	7	6	3	1					
Kentucky						1	4	3	6	3	15	20	9	18	16	18	12	5	3				
Louisiana					1		2	2	3	7	14	13	8	9	13	17	23	11	8			1	
Maine						1		3	2	2	2	7	4	4	3	5	1						
Maryland				2	2	1	1	3	3	3	6	5	4	5	5	2	5	2	1	1			
Massachusetts				1			2	3	1	4	4	2	1		1								
Michigan		1				3	3	3	3	8	14	12	11	16	18	21	18	4	7	1			
Minnesota					3	1	3	8	6	5	3	9	6	10	10	4			1				
Mississippi								2	1	1	2	3	3	7	6	12	14	11	13	9	6	2	1
Missouri							1		2	1	2	2	6	17	20	37	24	8	6	3			
Montana	1					2	1	6	1	4	3	4	12	8	10	12	8	4	5	1			
Nebraska				2			2	3			1	1	2	2	1	1							
Nevada						1		3	1	2		2	2	5	11	5	5	1					
New Hampshire				1	1			3	1	2	1			1		1							
New Jersey																							
New Mexico							1					1	1	1	7	7	13	14	5	3			
New York							3	3	2	4	5	3	14	24	19	27	14	9					
North Carolina						1	1	3	4	6	4	9	4	16	23	29	41	13	7	4	2		
North Dakota				1		1	1	6	2	8	7	12	12	14	3	3	1		2			1	
Ohio			3	2		4	5	1	10	9	4	12	7	3	6	13	6	5	1				
Oklahoma				1		1	1	3	3	8	9	3	10	14	13	11	8	1	1	1			
Oregon							1	3	2	5	3	2	3	12	9	13	3	7	1				
Pennsylvania			1		2	4	1	4	6	11	10	8	6	4	5	3							
Rhode Island						3		1		2				1									
South Carolina							1	1		2	1	9	7	6	11	11	3	6	1				
South Dakota						2	3	1	3	4	2	6	4	14	4	9	5	2	3	2	1		
Tennessee						3		8	2	12	6	7	9	8	14	18	11	6	3	2			
Texas				3	1	12	4	15	26	26	38	49	58	48	69	58	51	27	6		1		
Utah					4	1	1	2	5	3	5	3	1	5	4	4	2	2					
Vermont						1			1		1	1											
Virginia			1		3	4	2	9	10	6	12	4	4	8	11	8	7	2					
Washington									4	3	4	6	5	25	27	22	6	4					
West Virginia						1	1	2	4	4	10	4	9	6	11	20	11	6	1	2			
Wisconsin			2		4	5	2	4	10	9	14	15	7	9	7	10	3						
Wyoming							3		2	2	2	5	4	3	5	3							
Total	**1**	**1**	**8**	**19**	**35**	**79**	**93**	**169**	**194**	**270**	**312**	**381**	**369**	**514**	**539**	**631**	**462**	**250**	**125**	**46**	**17**	**8**	**1**

Appendix B – Indirect Medical Education Hospital and Residents Over Cap Count By State

State	Estimated Hospitals Over Cap	Estimated IME Residents Over Cap
Alaska	1	7.94
Alabama	6	288.10
Arkansas	6	132.65
Arizona	11	299.40
California	77	1,836.43
Colorado	12	221.05
Connecticut	7	45.17
District of Columbia	4	226.27
Delaware	2	22.85
Florida	33	863.90
Georgia	16	333.85
Hawaii	3	37.05
Iowa	12	245.90
Idaho	3	8.94
Illinois	26	509.70
Indiana	14	246.68
Kansas	5	215.15
Kentucky	7	461.11
Louisiana	14	428.93
Massachusetts	17	345.32
Maryland	12	557.35
Maine	2	22.43
Michigan	31	677.55
Minnesota	12	136.68
Missouri	17	419.40
Mississippi	6	226.66
Montana	2	1.19
North Carolina	13	1,012.66
North Dakota	3	50.13
Nebraska	5	211.46
New Hampshire	2	21.48
New Jersey	28	564.39
New Mexico	3	70.77
Nevada	9	115.66
New York	36	744.42
Ohio	37	946.72
Oklahoma	8	163.57
Oregon	9	241.65
Pennsylvania	44	665.32
Rhode Island	3	158.04
South Carolina	11	408.45
South Dakota	3	50.67
Tennessee	10	491.01
Texas	45	1,605.55
Utah	5	126.60
Virginia	13	462.29
Vermont	1	41.91
Washington	13	411.35
Wisconsin	15	223.60
West Virginia	8	186.49
Wyoming	0	0.00
Total	**682**	**17,791.84**