Alliance of Safety-Net Hospitals

June 16, 2022

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, 482, 485, and 495; CMS-1771-P; RIN 0938-AU484; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Attention: File Code CMS-1771-P

To Whom it May Concern:

I am writing on behalf of the Alliance of Safety-Net Hospitals (formerly the National Alliance of Safety-Net Hospitals), a group of private community safety-net hospitals that serve economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2023 Medicare inpatient prospective payment system regulation that was published in the *Federal Register* on May 10, 2022 (Vol. 87, No. 90, pp. 28108-28746).

The Alliance of Safety-Net Hospitals (ASH) would like to bring to your attention our views on seven aspects of the proposed regulation:

- proposed inpatient rates
- area wage index
- Medicare DSH
- hospital readmissions reduction program
- health equity
- graduate medical education
- Medicare conditions of participation

We address each of these issues individually below.

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Proposed Inpatient Rates

ASH finds CMS's proposal to raise Medicare inpatient rates 3.2 percent in FY 2023 to be insufficient. We believe it fails to account adequately for the serious challenge of rising health care delivery costs. We also believe it reflects a continuation of a long-running trend of market basket updates that have failed to keep pace with increases in the costs hospitals incur when caring for their patients.

Hospital costs are rising for a number of reasons and ASH believes CMS has underestimated them in its FY 2023 rate proposal.[1] Labor costs have been the greatest driver of rising hospital costs. In 2019, prior to the pandemic, 3.99 percent of the hours worked by nurses in hospitals were worked by contract or traveling nurses, accounting for a median of 4.7 percent of hospitals' nurse labor expenses. By January of 2022 contract and travel nurses accounted for 23.4 percent of all nursing hours worked in hospitals, which translated into a median of 38.6 percent of hospitals' nursing labor costs. The rise in the proportion of care provided by contract and travel nurses has been driven by the combination of a persistent shortage of nurses and the recruitment of staff nurses away from hospitals by nurse staffing agencies.

The greatly disproportionate rise in the share of contract nursing costs (65 percent) relative to the increase in contract nursing hours (18 percent) has been driven by the enormous – and, in ASH's view, unconscionable – hourly fees those staffing agencies charge to hospitals for nurses: one study found that the hourly rates for contract nurses rose 213 percent between January of 2019, before the pandemic, and January of 2022, just a few months ago.

One of the challenges this poses is that the employment cost index used in the calculation of the market basket increase includes only hospital-employed staff and not the contract staffing that hospitals have been forced to rely on more than ever during the past two years. Using such expensive staffing is not a choice: it is a necessity, and without it many hospitals would not be able to continue serving their communities as they always have because they would not have the staff to do so.

Other hospital costs have been rising as well. Prescription drug spending, for example, rose 7.7 percent in 2021 alone. Costs for supplies, too, have been rising, led by the necessity of unprecedented but essential spending on personal protective equipment (PPE). Hospitals have experienced rising costs in the parts of their facilities that are most involved in serving COVID-19 patients: intensive care units and respiratory care departments, where supply costs have risen 31.5 percent and 22.3 percent, respectively, from 2019, before the pandemic began, through the end of 2021.

On top of all this has come an increase in the cost of doing business – inflation – to a degree not seen since the late 1970s and early 1980s. The Bureau of Labor Statistics reported that as of April of 2021, the CPI-U had experienced its greatest 12-month increase since September of 2008. It also found that the CPI-U hit a 40-year high in February of this year and that consumer prices in March of 2022 rose 8.5 percent on an annualized basis in that month alone.

Not all of CMS's Medicare partners have faced the prospect of such an inadequate update. Unlike the proposed market basket update included in this rule, for example, rate increases for Medicare Advantage plans appear to be increasing along with those rising costs. In its recently released Medicare Advantage rates for FY 2023, CMS announced that those plans would receive a payment increase of 8.5 percent – two-and-a-half times greater than the proposed rate increase for inpatient services.

We do not begrudge Medicare Advantage plans the increase CMS has given them but believe hospitals deserve at least the same consideration, if not more. The numbers tell the story: the cost increases hospitals have incurred during the pandemic are real, they were unavoidable, and they are hurting hospitals. Median hospital operating margins declined 3.8 percent by the end of 2021 compared to where they stood before the pandemic.

Health insurers, on the other hand – including Medicare Advantage plans – are faring well. According to a recently published account, [2]

> The analysts' report finds that the average growth in earnings before interest, taxes, depreciation and amortization (EBITDA) was 3.7% in the first quarter among seven major national payers. When excluding investment income and realized gains and losses, however, EBITDA was up 10.3% on average.
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> What was driving this performance? Strong enrollment growth in Medicare Advantage and Medicaid as well as improvements in the commercial book, analysts said. Enrollment gains were partially offset by higher costs, largely due to the spread of the omicron COVID-19 variant alongside growing non-COVID utilization.

We understand the methodology CMS employs to determine the change in the market basket but believe that methodology has failed this year by not recognizing the true extent of the financial and medical challenges hospitals currently face and by not proposing an appropriate rate increase that reflects the severity of those challenges. We also understand that CMS has the authority to employ a different methodology, if it wishes, to develop a more appropriate rate proposal for FY 2023.

ASH finds the productivity adjustment particularly troubling. Such an adjustment assumes hospitals can increase overall productivity in a manner comparable to other sectors of the economy. They cannot. Providing acute hospital care is a labor-intensive, hands-on undertaking that must be performed on site: automation cannot help and work cannot be sent off-shore. In fact, productivity has fallen during the current public health emergency because of unusually high staff turnover and the use of temporary staff, especially temporary nurses, who need more time, not less, to do their jobs because while they bring to their job their considerable nursing skills they almost always have a significant learning curve for adjusting how to employ those skills within individual hospitals' systems and workflows. ASH believes inpatient productivity adjustments are always inappropriate but that they are especially inappropriate amid the challenging hospital environment in the middle of a pandemic.

For these reasons ASH urges CMS to reconsider this year's proposed update in the face of the challenges its partners in serving the Medicare population face, the sacrifices they have made, and the obstacles they will encounter if they must enter yet another fiscal year knowing that the additional resources Medicare will give them will be inadequate to ensure their ability to continue serving their Medicare patients as they have for so many years. A 3.2 percent rate increase does not begin to cover the increased cost of caring for Medicare patients in hospitals over the past year, or what it can reasonably expect to cost to care for them in FY 2023, so ASH urges CMS to take a different approach to determining a fair rate increase for hospitals for providing inpatient care to Medicare patients in the coming fiscal year.

It also is worth noting that past rate decisions that affect the FY 2023 rate proposal continue to harm hospitals. Specifically, when CMS concluded in 2014 that it needed to recover $11 billion in payments associated with improved documentation and coding, it chose to do so through a temporary adjustment to the payment rates that was slated to be fully restored after the $11 billion was recovered in 2017. Congress intervened, however, and converted this recoupment into a payment cut, directing CMS

to restore the adjustment incrementally through FY 2023 rather than all at once. The incremental approach of this restoration, however, has had the net effect of reducing hospital inpatient payments during this period beyond what CMS originally intended and also has deprived hospitals of much-needed revenue in recent years, and particularly during the pandemic, when the financial challenges they have faced have been unprecedented. Because FY 2023 is the last year adjustments are to be made to restore rates, ASH urges CMS to analyze the impact of the incremental restoration of rates to determine:

- how much this approach cost hospitals during period from 2018 through 2023 during which CMS was required to make 0.5 percent increases compared to what payments would have been during that period if the documentation and coding adjustment had been fully restored in a single year; and
- whether the congressionally-mandated increases in the rate resulted in a permanent reduction of inpatient prospective payment system payments compared to what they would have been if the documentation and coding adjustment had been fully restored in a single year.

Once such an analysis is completed, we urge CMS to work with Congress to increase FY 2023 (and potentially future) rates to make hospitals whole for this unfortunate withholding of much-needed Medicare payments.

Finally, in light of all of the factors presented above, we ask CMS to increase the inpatient prospective rate increase in the final rule. Specifically, we ask CMS to consider using the growth rate in allowable Medicare costs per risk-adjusted discharge for inpatient prospective payment system hospitals between fiscal years 2019 and 2020 to calculate the FY 2023 final market basket update. The data needed for these calculation can be found in Worksheets D-1, Part II, lines 48 and 49 and S-3, Part 1, column 12 of the Medicare cost report. This would yield an unadjusted market basket update of 7.99 percent for FY 2023. Such an update would better reflect the actual input price inflation ASH hospitals expect to face in the coming year – far better than the 2.7 percent CMS has proposed. Again, we also ask that CMS eliminate the productivity adjustment for the coming year and work with Congress to make that elimination permanent.

These steps – increasing the market basket adjustment to 7.99 percent and eliminating the productivity adjustment – are essential for more than the financial health of hospitals: they are essential for access to care; they are essential for the ability of hospitals to continue providing a broad range of care – the services their communities need; and they are essential to health equity because in the case of ASH hospitals, these providers are the vital and in many places the only link to access to care for the medically, socially, and economically vulnerable and disadvantaged.

Area Wage Index

When changes in labor market areas were introduced in FY 2021 that would have resulted in major annual wage index reductions for some hospitals, ASH joined with others in urging CMS to limit hospitals' wage index losses to five percent, and in the final rule CMS did exactly that: it limited hospitals' wage index reductions for FY 2021 to that five percent. In the proposed FY 2022 rule CMS again asked stakeholders to comment on whether it should continue to limit the decrease of any hospitals' wage index. ASH supported such a limit but suggested taking it one step further, urging CMS to hold hospitals harmless from wage index reductions of more than five percent every year because a five percent reduction in wage index is a dramatic and unpredictable reimbursement change regardless of the

cause. We were pleased that CMS adopted the five percent cap in the final 2022 inpatient prospective payment system rule but were disappointed that the policy was slated to expire at the end of the current fiscal year.

In the proposed FY 2023 rule CMS calls for taking this hold-harmless concept a step further, proposing to apply a five percent cap on any decrease of a hospital's wage index from its index in the previous year regardless of the circumstance causing the reduction. ASH supports this proposal and thanks CMS for introducing it.

Labor-Related Share

In the FY 2023 proposed regulation CMS calls for keeping the labor-related share of Medicare payments at the current 67.6 percent for hospitals with a wage index greater than 1.0. This labor-related share was finalized and made effective for payments beginning in FY 2022, yet in light of the greatly increased cost of hospital labor – described in detail above – and decreased hospital inpatient utilization, both resulting from the COVID-19 pandemic, ASH believes this level is already outdated and needs to be reviewed and most likely increased.

In addition to requesting that CMS update the labor share we also ask the agency to modify its methodology so it reviews the labor costs only of hospitals in wage areas greater than 1.0 because hospitals in areas with a wage index lower than 1.0 receive a statutorily defined labor-related share of 62 percent. We request this because our analysis comparing hospitals' average hourly wages calculated from data reported on schedule S-3 of their FY 2019 to their 2020 cost reports found that the average hourly wage rose 4.14 percent among hospitals with a wage index greater than 1.0 while hospitals with a wage index of 1.0 or less experienced an increase of only 2.38 percent during that same period of time.

We understand that changes of the labor share are budget-neutral, but updating the share would ensure that a more appropriate amount of money goes to hospitals in areas with a wage index greater than 1.0 – which are those experiencing the greatest increases in labor costs.

For these reasons, ASH urges CMS to review hospital labor costs and how they have changed in recent years and consider raising the labor-related share for hospitals with wage indexes greater than 1.0 for FY 2023.

Medicare DSH

ASH is extremely disappointed to see that at the same time the federal government has so very publicly focused new attention and greater energy on addressing health equity challenges it is proposing a significant reduction of its Medicare DSH uncompensated care pool. Such a cut can only detract from its health equity efforts because it would, without question, hit hardest the very safety-net hospitals – including ASH hospitals – that serve the most patients who are challenged by social determinants of health and the most patients who have suffered, and who continue to suffer, from inequitable access to care. The federal government should not reach out to a specific population with one hand while taking resources away from it with the other; it should be consistent, and in this case consistency means not taking much-needed resources away from the very hospitals that serve a population the administration has so publicly and repeatedly declared its intention to serve more effectively and with greater equity.

The Proposed Decrease in the Medicare DSH Uncompensated Care Pool

In the proposed FY 2023 rule CMS shares its intention to reduce the Medicare DSH uncompensated care pool by $654 million, to $6.5 billion. ASH opposes this reduction. If anything, we believe this pool should be larger, not smaller, in the coming year, to meet the needs of safety-net hospitals that expect to continue serving large numbers of uninsured and underinsured patients in the coming year.

We are concerned about how CMS calculated Factor 1, which is 75 percent of the estimated Medicare DSH payments that would otherwise be made under the old (pre-Affordable Care Act) methodology, because we expect hospital uncompensated care to increase in the coming year, not to decrease. As was the case last year, ASH hospitals and others like them find themselves continuing to serve patients who have put off addressing some of their medical problems because of the pandemic and their desire to avoid doctors' offices and hospitals. With the pandemic appearing to wind down we now are seeing these patients returning in growing numbers. When CMS calculated its Medicare Advantage payments for FY 2023 it included a risk score increase of 3.5 percentage points, suggesting that the agency agrees that Medicare Advantage patients who have put off seeking medical care because of COVID-related risks will continue to turn to hospitals to address their needs and that hospitals will continue to see more challenging patients because of delays in seeking care because of COVID-19 and Long COVID. We are hard-pressed to understand why the same assumption does not appear to have been given comparable weight in the calculation of Factor 1, which assumes a one percent reduction in case mix from 2021 to 2022 and from 2022 to 2023.

As described above, we expect health care costs to continue rising in the coming year as the country battles labor shortages, rising labor costs, supply chain challenges, and inflation. This means that a given unit of care will cost more to provide in the coming year – and a given unit of care provided without reimbursement to uninsured patients will cost more as well.

We expect hospitals, and especially community safety-net hospitals, to serve more of those uninsured and underinsured patients in the coming year, too, and this should increase how much uncompensated care they provide. A Kaiser Family Foundation report[3] estimates that between 5.3 million and 14.2 million people will lose their Medicaid coverage in FY 2023 when the public health emergency ends and states begin reviewing the eligibility of their current Medicaid participants and eliminating many from their Medicaid rolls. We understand that the Office of the Actuary accounted for this in estimating the percentage change in uninsurance, but given the severe financial challenges faced by many hospitals and the individuals they serve, we support use of a different estimate to calculate Factor 2. Specifically, the use of the percentage change in uninsurance is intended as a proxy for the amount of uncompensated care hospitals provide, but we believe it would be appropriate to apply a case-mix adjuster to the percentage change in uninsurance for FY 2023 to recognize increases in resource consumption required to provide care to uninsured individuals at this time when many were forced to make the difficult decision to wait to receive care rather than risk exposure to COVID-19 over the past two years.

ASH urges CMS to take a closer look at data on the number of uninsured Americans, the expected acuity of the patients hospitals will serve in FY 2023, and the number who are likely to lose their Medicaid coverage in the coming year. Then, we ask that you recalculate Factor 1 and come to a more realistic conclusion about what DSH-eligible hospitals like those that belong to ASH can expect to provide in uncompensated care in the coming year and adjust the Medicare DSH uncompensated care pool accordingly – with more resources, not less.

Methodology for Calculating Hospitals' Share of the Medicare DSH Uncompensated Care Pool

In the proposed regulation CMS calls for using the two most recent years of audited data on uncompensated care costs from Worksheet 10 of hospitals' FY 2018 and FY 2019 Medicare cost reports. For FY 2024 and future years CMS proposes using a three-year average of the uncompensated care data from the three most recent fiscal years for which audited data is available.

ASH supports this proposed methodology. We requested it in our comments on the proposed FY 2022 inpatient prospective payment system and thank you for proposing to adopt this methodology for FY 2023 and beyond.

As we have conveyed to CMS in the past, however, ASH remains deeply concerned about year-to-year volatility in uncompensated care costs reported on the S-10. We believe that using multiple years of S-10 data will reduce the impact of this volatility on safety-net hospital finances. ASH thanks CMS for taking this step to provide additional financial certainty for hospitals that care for at-risk populations.

ASH continues to believe that all hospitals should be subject to identical audit protocols of their S-10 reporting and that auditor education is paramount. Because a fixed amount is available for Medicare DSH uncompensated care payments, ASH does not believe it is equitable to subject some hospitals only to desk reviews while others undergo a more customary audit. In addition, we encourage CMS to work with the MACs to improve the S-10 audit process to foster greater clarity, consistency, and completeness in the audits. For example, CMS should establish a standard process across auditors, including standard timelines for information submission and acceptable documentation to meet information requirements. We also urge CMS to develop a transparent time frame for audits, with adequate lead time and communication to providers about expectations, and to establish a process for timely appeals. ASH believes the Medicare wage index audit process could be a model for S-10 audits.

Also as we have in the past, ASH 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, ASH 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.

Another Way to Address 1115 Uncompensated Care Waiver Days

In the proposed rule CMS calls for excluding from the numerator of a hospital's DSH fraction any days associated with care provided to individuals under an uncompensated care pool under a section 1115 waiver if that waiver does not provide the individual with insurance coverage. While ASH hospitals do not receive reimbursement from an 1115 uncompensated care pool, ASH 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 care.

We are concerned that the ramifications of this proposal 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 would in turn lower overall the traditional DSH payments used to determine the amount of funds available for uncompensated care DSH payments in all states. We do not believe Congress anticipated the administration enacting policies that would reduce the total amount of DSH payments that would otherwise have been made when it linked those payments to the uncompensated care pool in the Affordable Care Act. We also think now is not a good time to be reducing Medicare DSH payments to hospitals – not at a time when they can almost certainly be expected to see more uninsured and underinsured patients, not fewer such patients, in the coming year.

Instead, ASH believes the appropriate avenue to address these waivers is in the uncompensated care portion of Medicare DSH payments. ASH has long objected that some compensation hospitals receive for providing care to uninsured individuals is not subtracted from the cost of providing care to the uninsured on worksheet S-10 of the Medicare cost report prior to the calculation of Factor 3.

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 with 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. Community safety-net hospitals should not be asked to sacrifice on behalf of hospitals that are reporting their uncompensated care in this manner.

While ASH 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, ASH 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 – and at the expense of others, including private community safety-net hospitals.

Hospital Readmissions Reduction Program

In the proposed rule CMS explains that it is considering additional approaches to reflect social determinants of health in the Hospital Readmissions Reduction Program and requests comment on ways to revise the program to incorporate performance for socially at-risk populations.

ASH has long been very interested in the Hospital Readmissions Reduction Program and was one of the most vocal advocates of a change in the program that CMS ultimately adopted: using dual eligible patient percentages to establish peer groups so hospitals' performance in the program could be compared to similar types of providers. Until that time safety-net hospitals, serving the most challenging and medically vulnerable patients with the support of minimal resources, were compared, often unfavorably, to hospitals with significant resources caring for adequately insured patients who faced few barriers, if any, to obtaining quality health care in a timely manner. The result of this comparison was, more often than not, that safety-net hospitals were penalized significantly more than other hospitals under this program.

In general, ASH and safety-net hospitals are pleased with this change in the Hospital Readmissions Reduction Program. The flaws in the program's original design were, in our view, successfully addressed by the creation of hospital peer groups.

As safety-net hospitals, we are not averse to CMS exploring further refinements of the program and would welcome an opportunity to work with you to ensure that those changes are based on good data and do not restore the disadvantages for safety-net hospitals that previous revisions of the program corrected. Community safety-net hospitals must not be harmed by any future changes, so we encourage CMS to proceed carefully and cautiously and to consult with stakeholders before proposing any changes in the Hospital Readmissions Reduction Program.

Health Equity

Before addressing the specific health equity concepts addressed in the proposed rule, ASH 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 more to serve 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 is an unquestionably important aspect of addressing health 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 identifying social determinants of health and analyzing Z code reporting and defining disparities will 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 communities across the country. Safety-net hospitals are committed to addressing health inequities, but absent a federal partner committed to working with us to address those inequities, all we will be doing is collecting data for its own sake.

It is from this perspective that ASH responds in the rest of this section of our letter to various requests for information (RFI) included in the proposed FY 2023 Medicare inpatient prospective payment system rule about various health equity matters.

Social Determinants of Health Diagnosis Codes

In the proposed rule CMS solicits comment on how the reporting of diagnosis codes in categories Z55-Z65 may improve its ability to recognize severity of illness, complexity of illness, and utilization of resources under Medicare's MS-DRGs. CMS believes that reporting social determinants of health Z codes in inpatient claims data could enhance coordination within hospitals across their clinical care and discharge planning teams, including post-acute partners.

ASH appreciates CMS's recognition that patients adversely affected by social determinants of health may require more resources to treat effectively and we support adjusting payments in response to these needs. Such payment adjustments, however, cannot be made in a budget-neutral manner because then all we would be doing is redistributing resources within a system in which many payments already do not cover the cost of care. Adjusting payments to facilitate better care for patients challenged by social determinants of health by reducing other payments would only exacerbate existing payment inadequacy and access problems.

While ASH does not oppose reporting Z codes if implementation is undertaken based on the suggestions we offer below, we are concerned that if reporting becomes mandatory it may crowd out other medical diagnoses that would affect the assignment of a case to an MS-DRG that carries either a complication or comorbidity (CC) or a major complication or comorbidity (MCC) when used as a secondary diagnosis. Before CMS considers any policy requiring the mandatory reporting of Z codes, we ask the agency to analyze Medicare inpatient hospital claims to determine what percentage of these claims use 20 or more of the diagnosis field locators.

We recommend that CMS, if it elects to require such reporting, make it optional for at least three years to give providers and the agency time to gain experience reporting and collecting this data. We also believe CMS will need to know the number of patients experiencing the condition reported and the number of patients who were screened so the agency can better gauge the scope of the problem within the Medicare population and the extent to which it increases resource utilization within a given population.

ASH encourages CMS to begin with screening and reporting only of homelessness (Z59.00, Z59.01, and Z59.02) as a catch-all category for homelessness and housing instability. Otherwise, we are concerned that use of more granular codes would introduce a degree of subjectivity that may render the collection of this data meaningless for risk adjustment and other purposes. Before considering expanding to other Z codes related to social determinants of health we strongly encourage the agency to engage hospitals and other stakeholders to determine the one or two additional codes CMS should consider collecting given its potential to affect both resource utilization and patient outcomes.

If CMS elects to begin with voluntary screening for homelessness and reporting of Z59.00, Z59.01, and Z59.02 on inpatient claims, we encourage the agency to develop a stakeholder advisory group to provide the agency with feedback on the guidance that hospitals and other providers will need to capture accurately this data and report it to CMS in a consistent manner. An example of an issue this group should help CMS resolve is the documentation standards required to support that a Medicare beneficiary screened positive for homelessness.

Disparity Measurements in Medicare Quality Programs

The proposed rule asks stakeholders to address how the agency might develop future policies that use disparity data as a quality measurement tool in addressing health disparities and advancing health equity in its Medicare quality programs. Among the measures CMS outlines in the proposed rule are prioritizing existing clinical quality metrics and metrics for selected social and demographic factors associated with disparities. ASH cautiously supports this approach and encourages CMS to explore additional measures that reflect access to care to go along with outcomes measures that can, when examined together, better identify causes of disparities and provide the kind of information needed to facilitate informed program development to address disparities and improve access to care.

We addressed potential changes in the Hospital Readmissions Reduction Program above, in a separate section of this letter.

CMS also asks in an RFI about the selection of social risk factors and demographic data in inpatient quality reporting that might be useful in measuring disparities. Among CMS's stated interests are identifying new social risk factor and demographic variables to use to stratify measures and the possible use of imputed and area-based social risk and demographic indicators for measure stratification when patient-reported data is unavailable.

ASH acknowledges the value of dual eligibility as an indicator of financial distress; it is a defining characteristic of many of the patients community safety-net hospitals serve. At the same time, however, we also recognize that financial distress can occur outside of that definition; it may not be as great, perhaps, but it can be significant nonetheless. For this reason, we urge CMS to look beyond the narrow parameter of dual eligibility as a defining characteristic of financial distress.

To do so we suggest several possible data sources: Medicaid and uninsured patient population are the best indicators of care to vulnerable populations. Other potential sources are the Health Resources and Services Administration's Area Deprivation Index; the Centers for Disease Control and Prevention's "PLACES" data; data reported by patients themselves; Z codes reported by providers on Medicare claims under the parameters outlined above; and Logical Observation Identifiers, Names, and Codes (LOINC) codes.

ASH is skeptical about the use of imputed data for social and demographic indicators; we prefer that CMS use Medicaid coverage or patient self-reported data when gathering data on which to base disparity measurements.

The RFI also raises the question of how to identify meaningful differences in reported disparities. The RFI outlines several approaches that appear appropriate but ASH urges CMS to engage in more measure development and testing and to customize the measures it uses based on individual subjects and populations rather than attempt to employ measures too widely and risk producing results that are either without value or even potentially harmful.

Once CMS identifies meaningful differences in reported disparities, the RFI raises the question of how the agency should use and apply what it learns, suggesting that such use might begin with providing confidential reporting to providers. ASH supports the suggestion that at least at first disparity measures should be reported confidentially to providers well before public reporting and payment accountability. CMS has employed this approach with its other Medicare quality programs and we believe it should continue doing so for disparity measures.

Patient Access to Health Information

CMS has asked stakeholders to comment on how to further promote equitable patient access and use of their health information without adding unnecessary burden for providers.

In general, access to their own information has enabled many patients to understand their health challenges better and act more effectively to address them. It enables them to identify medical errors, better understand how and when to take their medicine, and communicate more effectively with their providers. The patients who use this tool generally like it – but too many patients continue not to use this tool at all. In general, ASH members support their patients' use of electronic patient portals.

The process of using patient portals is not without its challenges. ASH members are all community safety-net hospitals that serve large numbers of low-income patients, many of whom lack the physical tools – computers, smartphones, adequate internet access – even to gain access to their patient portals while others lack the education or language skills to use their portals effectively.

The proposed rule also asks stakeholders to comment on potential challenges associated with patient access to their medical information such as racial bias and stigmatizing language within electronic health records and patients' resistance to using that access as a form of communication with providers and asks stakeholders to identify some of the barriers they have encountered to patient access and to address whether these challenges differ based on the nature of individual patient populations.

ASH recognizes the value of giving patients access to their medical records, but the current barriers are real and not easily overcome. Currently the greatest barriers to greater use of electronic health records among patients served by community safety-net hospitals are access to the technology needed to work

with electronic medical records and patient resistance to doing so. Hospitals cannot supply the technology some patients need even to attempt to use their patient portal and have only a limited ability to encourage those who resist the concept entirely – and the proportions of safety-net hospital patients who fall into these two categories is not insignificant. While we hope that the extensive use of telehealth during the COVID-19 pandemic will make at least some patients more comfortable with the use of technology in addressing their health care needs, it is too soon to see if this will have a meaningful impact on overall patient use of these tools. In the end, the decision on whether to use or not to use is the patient's choice, not the hospital's. For this reason, moreover, any notion of attempting to assess providers on their patients' use of their EHRs, as raised in the RFI, is premature at the very least.

Graduate Medical Education

Calculating the FTE Cap

In the proposed rule CMS calls for modifying its policy for determining a hospital's FTE residency count when the weighted FTE count exceeds the hospital's FTE cap. ASH supports this proposed methodology but requests one modification of it: we urge CMS to permit hospitals that were disadvantaged by the former policy but that do not have open Medicare cost reports to be able to reopen their cost reports solely for the purpose of recalculating their FTE cap for the period according to the new methodology. This would extend the policy's retroactive applicability to all affected hospitals instead of only those with open cost reports.

Rural Training Program Affiliation Agreements

Under current regulations, CMS permits teaching hospitals that cross-train residents to enter into "Medicare GME affiliation agreements" to share and redistribute those cap slots to accommodate the actual rotation of their residents. Current law includes a provision permitting additional cap slots for urban hospitals that establish "rural training track" as part of Rural Training Programs (RTPs), and now, CMS proposes permitting urban and rural hospitals participating in the same RTP to enter into an "RTP Medicare GME affiliation agreement" effective for the academic year beginning July 1, 2023, with certain conditions applying too the residencies involved. ASH supports this modification and we thank CMS for proposing it.

Conditions of Participation

ASH recognizes the need for the federal government to collect certain data to facilitate addressing public health emergencies. We believe, however, that the Medicare Conditions of Participation are not an appropriate vehicle for enforcing data reporting requirements.

Public health emergencies are, by nature, extremely taxing, and diverting hospital staff away from critical patient care needs to report data can be dangerous at the height of an emergency. We believe exclusion from the Medicare program – and possibly from other payers, too, by extension – is too severe a penalty for failure to respond to a request for data in the midst of a public health emergency.

ASH believes CMS responded effectively and admirably to hospitals' needs during the initial phases of the COVID-19 public health emergency, especially by waiving many oversight requirements. In so doing, the agency enabled hospitals to focus on caring for their patients. Only later in the pandemic did

data reporting become mandatory. It seems entirely plausible that the proposed change in the Medicare Conditions of Participation, if it had been in place at the beginning of the current pandemic, would have been among the provisions deserving of a temporary waiver. In light of that paradox, ASH urges CMS not to add to the Conditions of Participation a new condition that would only be applicable at a time when it would be most likely to be unachievable.

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ASH appreciates the opportunity to submit these comments and welcomes any questions you may have about them.

Sincerely,

Ellen J. Kugler
Executive Director

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