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

Subject: 42 CFR Parts 412, 413, 431, 482,485, 495, and 512; [CMS–1808–P]; RIN 0938–AV34; Medicare and Medicaid Programs and Children's Health Insurance program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Program Requirements; and Other Policy Changes

Attention: File Code CMS-1808-P

To Whom it May Concern:

I am writing on behalf of the Alliance of Safety-Net Hospitals, a group of private community safety-net hospitals that serve diverse and economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2025 Medicare inpatient prospective payment system regulation that was published in the *Federal Register* on May 2, 2025 (Vol. 89, No. 86, pp. 35934-36649).

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

- Medicare inpatient rates
- Medicare DSH
- the Medicare area wage index
- graduate medical education
- social determinants of health diagnosis codes
- the proposed Transforming Episode Accountability Model
- payments for essential medicines

We also offer the perspective of community safety-net hospitals in response to the request for information about CMS's proposed updating of the hospital and critical access hospital infection prevention and control and antibiotic stewardship programs' conditions of participation that involve the reporting of data on COVID-19 and other respiratory illnesses.

We address each of these subjects individually below.

Medicare Inpatient Rates

In the proposed rule CMS calls for a 2.6 percent increase in Medicare inpatient prospective payment system rates. ASH believes this proposal seriously understates the effect of increases in hospitals' input prices and fails to reflect the effects of similarly inadequate rate increases in recent years.

ASH recommends instead that CMS increase inpatient rates 8.81 percent for FY 2025. This amount consists of two parts: a 4.51 percent net increase that better reflects the true increase in hospitals' inpatient input prices and a 4.3 percent forecast error adjustment increase to reflect three consecutive years during which hospital costs clearly exceeded Medicare's annual inpatient prospective payment system increases. We base this recommendation on three considerations:

- the failure of this proposed increase to match the increase in hospital inpatient costs;
- the current methodology's failure to capture hospitals' true labor costs; and
- the absence of an appropriate forecasting error adjustment to compensate for past inadequate increases.

The Proposed Increase Does Not Accurately Reflect the Rise in Hospital Inpatient Costs

ASH disagrees with CMS's decision to propose a 2.6 percent net increase in Medicare inpatient rates based on the current methodology the agency uses to calculate rate increases. MedPAC, for one, estimates that hospital input prices rose 4.8 percent in FY 2023 – far more than the 2.6 percent CMS proposes.

This underestimation of the annual increase in hospital inpatient costs is part of a recent, unfortunate trend. For FY 2021 the final inpatient rate increase fell 0.6 percent below actual cost increases; for FY 2022 it fell 3.0 percent below actual cost increases; and for FY 2023 it fell 0.7 percent below. Thus, in three years, actual rate increases have fallen 4.3 percent below the actual increase in costs – a significant amount. Now, CMS appears to be prepared to repeat this underestimation for FY 2025. ASH urges CMS to reconsider.

The Failure of the Current Methodology to Capture Hospitals' True Labor Costs

At the heart of what ASH believes to be CMS's underestimation of increases in hospital input costs in recent years is how the agency has been treating and continues to treat increases in one specific aspect of those costs: their labor costs.

The Bureau of Labor Statistics' Employment Cost Index used by CMS to calculate the labor portion of hospital costs only considers the salary costs of hospitals' employed staff; it does not reflect the portion of labor costs associated with contract labor – and as is widely known, that cost has risen astronomically in recent years. This has proven to be a significant problem – and a major shortcoming of the current approach to calculating rate increases.

In 2019, prior to the COVID-19 public health emergency, contract labor – mostly for contract nurses – accounted for about two percent of hospitals' allowable hours worked and hospitals paid $61.96 an hour for these services. In 2021, by contrast, contract workers account for approximately four percent of hospitals' allowable hours worked and hospitals paid $98.83 an hour for their services – an increase of 52 percent; this

increase is far greater than the nine percent rise in hospitals' fully loaded average hourly wages for employed workers from 2019 to 2021. The result of these changes: contract labor rose from less than four percent of hospitals' total allowable labor costs in 2019 to more than nine percent in 2021. The proposed rate increase does not reflect this cost increase at all; in fact, it does not even consider it – something CMS acknowledges in the proposed rule.

While the public health emergency has ended, hospitals' reliance on contract staffing, and in particular contract nurses, has not – nor will it anytime soon. While the need for such supplemental staffing has declined to a degree, it is not going away: in addition to the many professionals who left nursing during the pandemic, a recent study found that more than 600,000 nurses currently working in the field have indicated that they expect to leave the profession by 2027. This suggests that the dramatic increase in the demand for contract staffing that was so prominent during the public health emergency was not an aberration and will continue for the foreseeable future.

ASH believes CMS's calculation of Medicare inpatient rates should reflect this. For this reason, we ask the agency to find new or additional data sources that capture this aspect of hospitals' labor costs when calculating future inpatient rate increases – including the final rate increase for the coming 2025 fiscal year.

The Lack of a Forecasting Error Adjustment

ASH recognizes that there is an element of risk, and chance, in annual forecasts: sometimes costs rise more than expected and sometimes they rise less, driven by unpredictable factors like the inflation and pandemic we have experienced in recent years. Three years of underpaying hospitals for the inpatient care they provide to their patients, however, have taken a financial toll on hospitals – and especially on community safety-net hospitals, which are far more dependent on public payers than the typical American hospital.

ASH believes CMS now should help compensate hospitals for that toll by including a forecasting error adjustment in the final FY 2025 inpatient prospective payment system increase. As noted above, the final FY 2021 inpatient rate increase fell 0.6 percent below actual cost increases; for FY 2022, it fell 3.0 percent below actual cost increases; and for FY 2023 it fell 0.7 percent below. For this reason, ASH urges CMS to include a 4.3 percent increase – the sum of those three shortfalls – over and above the regular annual increase as a forecasting error adjustment to help compensate hospitals for the harm caused by three consecutive years of inadequate Medicare inpatient rate increases. CMS has made forecasting error adjustments for other types of providers in the past and ASH believes it would be appropriate to do so for inpatient hospital providers as well. MedPAC, too, recommended a rate increase greater than the market basket increase for FY 2025 as a means of protecting access to inpatient care for Medicare beneficiaries and other hospital patients.

ASH's Request for Inpatient Rates

ASH requests that CMS withdraw its proposed net inpatient rate increase of 2.6 percent and raise that increase to 4.51 percent, which we believe better reflects hospitals' actual growing costs as a result of inflation and the contract staffing challenge outlined above, and then add to that 4.51 percent another 4.3 percent as a forecast error adjustment, to compensate hospitals for three years of insufficient rate increases, for a total Medicare inpatient prospective payment system rate increase of 8.81 percent for FY 2025.

Medicare Disproportionate Share

In the proposed regulation CMS calls for increasing the Medicare DSH uncompensated care pool by approximately $560 million. ASH recognizes that the size of this pool is calculated based on a formula established by Congress and not one developed by CMS and appreciates this increase, but at the same time we believe this proposed increase is insufficient for meeting the challenges that lie ahead.

The Uninsured Rate is Higher Than the Assumption Underlying the Proposed Increase in the Uncompensated Care Pool

One part of that challenge is that there is evidence to suggest that the proposal to increase the Medicare DSH uncompensated care pool is based on an understatement of the uninsured rate.

While ASH appreciates the Office of the Actuary's effort to account for the effects of the end of the Families First Coronavirus Response Act's continuous Medicaid enrollment requirement in its 2023-2024 projection of uninsurance rates, we are concerned that its methodology does not accurately reflect the abrupt nature of the change. Its model appears to show the rate of uninsurance abruptly deviating from what the Office of Actuary refers to as the population residual as the continuous enrollment requirement was observed in the last year of actual data (2021) and then further declining in its projections as the continuous enrollment policy continued throughout the public health emergency. The model then projects a gradual increase in the rate of uninsurance beginning in 2023-2024 and continuing until rates of uninsurance return to pre-pandemic levels around calendar year 2026. In fact, the end of the continuous enrollment requirement and its associated disenrollments from Medicaid much more abruptly altered the rate of uninsurance. Based on extrapolation of state data on Medicaid disenrollment, ASH believes there will be 32.5 million uninsured individuals in FY 2024, yielding a rate of uninsurance of 9.6 percent – a much higher rather than the 8.7 percent presumed in the proposed rule. This, in turn, should result in a $670 million increase in the Medicare DSH uncompensated care pool over and above what is suggested in this proposed regulation.

Reduced Medicare DSH May Jeopardize Federal Health Equity Efforts

Another aspect of the challenge posed by insufficient Medicare DSH uncompensated care payments is that it threatens to slow CMS's health equity efforts. In recent years almost every new CMS program has had a strong health equity component and many existing CMS programs have had equity components added to them. Failing to keep pace with the need for Medicare DSH uncompensated care resources can only detract from CMS's and the administration's health equity efforts because it would, without question, hit hardest the same safety-net hospitals – including ASH hospitals – that serve the most patients who are challenged by social drivers 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 depriving it of adequate resources with another. To the contrary, it should be consistent, and in this case that consistency, that walking the talk, means not starving of resources the very hospitals that serve populations the administration and CMS have so publicly and repeatedly and, we believe, entirely appropriately, declared their intention to serve more effectively and with greater equity.

Please Increase the Medicare DSH Uncompensated Care Pool More Than Proposed

This year's proposed increase of approximately $560 million in the Medicare DSH uncompensated care pool does not even restore hospitals, and especially community safety-net hospitals, to where we were when the current fiscal year began because from FY 2021 through FY 2024 that pool was cut by $1.9 billion. While an argument might be made that the COVID-19 public health emergency resulted in a temporary reduction in hospital admissions, that period is over, medical problems deferred during the pandemic are now being

addressed, admissions have once again risen and are expected to rise even more for the remainder of the current year and FY 2025 as well, and community safety-net hospitals will need adequate Medicare DSH uncompensated care payments if they are to continue to fulfill their mission of service to their communities.

Based on the more credible uninsurance rate for FY 2025 described above, the recent increase in hospital admissions, and the expectation that this increase will continue for at least the coming year, ASH urges CMS to increase the Medicare DSH uncompensated care pool another $670 million, thereby raising it from the proposed $560 million $1.23 billion.

This increase is merited because hospitals in general, and community safety-net hospitals in particular, are caring for more uninsured patients than any of us anticipated and are therefore providing more uncompensated care than any of us anticipated – and are struggling financially more than any of us anticipated as a result. Medicare DSH uncompensated care payments constitute a major part of the financial foundation of community safety-net hospitals' ability to serve the low-income, economically and socially disadvantaged residents of their communities, and the $1.23 billion increase in the Medicare DSH uncompensated care pool that we seek is absolutely critical to such hospitals' continued ability to serve their communities as all of us have come to expect. This is what it is needed to ensure quality care for the uninsured, including so many more people who lost their Medicaid coverage than any of us anticipated, and this is what is needed to help community safety-net hospitals play their role in providing such care. Community safety-net hospitals need this help because the demands of the vital role they play continue to outpace the limited resources available to them. Ultimately, the size of the Medicare DSH uncompensated care pool needs to more accurately reflect the number of people who have lost their health insurance: both those who have lost their Medicaid coverage and those who have lost their commercial insurance.

ASH's Request for the Medicare DSH Uncompensated Care Pool

For the reasons presented above, ASH asks CMS to recalibrate its calculations based on more appropriate Medicaid enrollment and disenrollment numbers and the resulting uninsured numbers and increase the Medicare DSH uncompensated care pool by $670 million more than the $560 million it has proposed, for a total increase of $1.23 billion for FY 2025.

Medicare Area Wage Index

ASH would like to bring to CMS's attention several concerns we have with proposed changes in the Medicare area wage index.

Ameliorate the Impact of the Use of Updated CBSAs

CMS's proposed changes in the Medicare area wage index – the revised labor market areas and changes in core-based statistical area (CBSA) delineations by the Office of Management and Budget based on 2020 census data resulting in some counties and hospitals moving from rural to urban and others moving from urban to rural – are quite extensive. These changes will result in significantly reduced Medicare payments for some hospitals. While we appreciate that current Medicare policy caps such changes at five percent in any one fiscal year, we suggest that CMS implement a much-needed interim step to help hospitals adjust to changes that in many cases will be significant by permitting them, on a one-time basis only, to spread out a potential reduction of five percent over a three-year period rather than being forced to absorb such a reduction in a single year. Because of the potential size of such a loss, we believe an interim step like this would be appropriate.

Raise the Labor-Related Share

As noted above, recent years have seen a significant change – a significant increase – in hospitals' labor costs. In addition to the changes we suggest for CMS payment policy to reflect these changes, ASH also recommends that CMS raise the labor-related share of hospitals' wage index from the current 67.6 percent to at least 72.8 percent, which is the figure CMS calculated for the updated labor share for long-term-care hospitals for FY 2025.

Discontinue Use of the Low Wage Index Hospital Policy

ASH disagrees with CMS's decision to continue the low wage index hospital policy it introduced for FY 2020. Under that policy, hospitals with wage indexes in the bottom quartile for all wage indexes received increases, and so that Medicare can implement this policy in a budget-neutral manner, it takes the money to increase those payments away from hospitals in the highest quartile, doing so with no policy basis or rationale. When CMS introduced this policy for FY 2020 it said it intended to employ it for four years only, and now, those four years are expiring. We refrained from objecting more strenuously than we did at the time because we were assured this policy had a clear expiration date, so we are disappointed that CMS has not followed through with its expressed intent. We urge you to reconsider this change of heart – especially in a year during which, because of the revised labor markets, many of these very hospitals in high wage areas are already seeing some of their payments unfairly and, in ASH's view, inappropriately reduced. These hospitals now face the prospect of significant wage index reductions as a result of the revised labor markets without relief from the reductions they were previously assured were only temporary and would end after the 2024 fiscal year.

Do Not Change How Much Time Hospitals Have to Withdraw From a Wage Index Classification

Finally, the proposed rule calls for changing how much time hospitals have to withdraw from a wage index classification from within 45 days of official publication of the proposed rule to within 45 days of publication of the preview version of the proposed rule. ASH believes it is unfair to give hospitals less time to make such an important decision and urges CMS to withdraw this proposed change.

Graduate Medical Education: The Focus on HPSA Scores in the Allocation of New Residency Slots

As we have in the past, ASH would like to convey its opposition to what we believe is CMS's overreliance on *Health Professional Shortage Area* (HPSA) scores in the distribution of new graduate medical education slots. CMS accepts applications for new slots from hospitals that qualify under any of four categories: rural hospitals and hospitals treated as rural hospitals (category one); hospitals over their otherwise-applicable resident limit (category two); hospitals in states with certain new medical schools and medical schools with additional locations and branch campuses (category 3); and hospitals that serve HPSAs (category 4). Despite having these four distinct categories, however, the agency continues to give its highest priority in the distribution of new residency slots to just one of them: hospitals that serve areas designated as HPSAs (category 4).

ASH disagrees with this approach; we believe it has no foundation in the enabling legislation and that it is inherently unfair to deserving hospitals that may qualify for new residency slots in the other three (non-HPSA) categories. CMS stated in the past that its methodology does not intend to exclude hospitals that do not serve HPSAs from receiving new residency slots, but regardless of this intention, it is an entirely

predictable result of continuing to rely so heavily on HPSAs. ASH's own past analysis found that giving exclusive priority to applications from hospitals with high HPSA scores would have precisely this effect and time has proven that analysis to be accurate; this has made vast parts of the country virtually ineligible for new residency slots. Again, this outcome does not reflect Congress's intention when it authorized the new residency slots.

ASH views the use of HPSAs in this manner to be a problem. The HPSA construct is antiquated. Gaining HPSA status starts with a costly undertaking by state governments, and increasingly, state governments are proving reluctant to make this investment – and even when they do, the process is burdensome. HPSA status depends in part on an area's level of poverty, but this is an uneven playing field because it costs more to live in high-cost areas. Using HPSAs as a major part of the criteria consequently favors – unfairly – some areas over others and therefore should be used sparingly, if at all, and it significantly undermines the other three criteria for additional residency slots.

For these reasons, ASH urges CMS to withdraw this proposal and develop an alternative methodology for distributing residency slots that does not rely so heavily on HPSAs and gives greater weight to the other three criteria for new slots.

Social Determinants of Health Diagnosis Codes

In the proposed rule CMS calls for changing the severity designation of seven ICD-10-CM diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity to complication or comorbidity based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes. ASH supports this proposed change with enthusiasm and thanks CMS for proposing it.

The Proposed "Transforming Episode Accountability Model"

In the proposed rule CMS calls for introducing a new, mandatory "Transforming Episode Accountability Model" (TEAM) to advance the agency's work on episode-based alternative payment models. Participation in TEAM would be required for hospitals located in any of the geographic areas CMS chooses to participate in this program.

ASH has a number of concerns with the program as proposed.

The Program Should Not Be Mandatory

As a proof of concept, ASH believes participation in TEAM should be voluntary. While we recognize that CMS may be concerned that TEAM may not have enough participants unless it mandates participation, ASH believes many hospitals that perform a significant volume of at least some of the involved surgical procedures would not be at all intimidated by the program's requirements and would welcome the opportunity to pursue TEAM's upside financial risk. Meanwhile, the voluntary participants can test the program's viability and usefulness and, if evaluation proves its effectiveness, TEAM can be made mandatory in the future based on an understanding that the program works, that it saves money, and that it improves quality of care.

Safety-Net Hospitals Should Not be a Disproportionate Number of TEAM Participants

CMS proposes oversampling CBSAs for mandatory participants in TEAM, citing its desire to include high concentrations of safety-net hospitals because such facilities have not participated in large numbers in other CMS payment models.

In ASH's view, the lack of safety-net hospital participation in past models reflects directly on how CMS has defined and shaped those models, making it very difficult for safety-net hospitals to participate. On numerous occasions in recent years ASH has encouraged CMS to develop models in which safety-net hospitals can fairly participate – participate if not on an equal footing as other hospitals then at least on a fair footing.

TEAM does not rise to this standard. By failing to consider and incorporate many of the costs that do not appear in Medicare claims – costs that reflect safety-net hospitals' investment in the delivery of services that address the social drivers of health for so many of their patients – CMS proposes a program that will almost automatically cost community safety-net hospitals more to execute than it will other hospitals. If CMS absolutely must make participation in TEAM mandatory for some hospitals, ASH urges it not to specifically target safety-net hospitals for such participation.

Mandating Participation for All of the Proposed Surgical Procedures is Inappropriate

ASH objects to the unusual combination of surgical procedures included in TEAM. The DRGs are highly diverse, and one of them – for coronary artery bypass graft – was proposed as part of a similar effort several years ago but abandoned because so few hospitals perform enough of these procedures to merit a program dedicated to them. We believe a package of procedures more closely related from a surgical perspective would be more appropriate because they can draw from common medical specialties and care teams and share professional care coordinators. Absent such a restructuring of the program, we believe, for reasons described below, that participating hospitals, whether mandatory or voluntary, should be able to choose among the surgical procedures for which they will be TEAM participants.

TEAM Underestimates the Resources it Will Demand of Hospitals

ASH believes CMS has underestimated the resources that would be required to establish the care teams needed to lead and participate in TEAM. Most of the procedures are so completely different that they would require different physicians to administer them and oversee the cases and care; different care teams; their own, dedicated care coordinators; and different post-acute-care options. In many cases this will necessitate establishing large and complex infrastructures for alarmingly few cases to engage in such tasks as patient registration, case management, monitoring bundle compliance, and more.

The requirement that participating hospitals must perform a collective 31 operations featuring the procedures that are part of TEAM is an alarmingly low threshold and would not even exclude a hospital from participating in the model; it would only bring it under a different level of risk for episode spending reconciliation purposes. Pursuing surgical excellence depends to a significant degree on volume and repetition but requiring only a collective 31 cases of seven distinct, in some ways very, very different procedures assures neither.

As noted above, ASH believes a better approach is to permit participating hospitals to select which of the surgical procedures for which it will function within TEAM parameters. Creating and investing in care teams to perform low volumes of surgery is a waste of resources that community safety-net hospitals, with their low margins and high dependence on public payers, simply cannot afford.

The Proposed Compensation for Participants is Inadequate

For TEAM, CMS proposes reducing Medicare's payments for the involved episodes by three percent of a calculated target price. This is an approach CMS has employed in other payment models in the past. Those models, however, covered a period of 90 days, not the 30 days proposed for TEAM. In a 90-day episode, only between 30 percent and 50 percent of the episode cost comes from the events immediately surrounding the surgical procedure; the rest comes from post-acute care and other services. Thus, the greatest opportunity for the kind of savings CMS seeks from TEAM typically comes after the procedure, through better early care that results in fewer post-surgical complications and reduced need for post-acute care. The TEAM model, with its abbreviated episode period, would deprive participants of this vital cost-reducing opportunity that is one of CMS's major objectives in launching this program. For this reason, ASH urges CMS either to reduce its proposed payment by less than the proposed three percent or increase the program's performance period to 90 days.

In addition, because the cost risk is so much greater for safety-net hospitals, ASH urges CMS to permit mandatory TEAM participants that are safety-net hospitals to remain in track 1 for payment purposes.

TEAM Overlooks a Major Cost Component for Some Hospitals

The TEAM model calls for hospitals to be paid a three percent discount for model episodes. Implicit in this discount is that hospitals control all aspects of their costs, but in many cases they do not. Specifically, some states do not permit hospitals to employ physicians. While CMS certainly has the right to impose a payment reduction on hospitals and it similarly has the right to reduce payments to physicians, independent physicians are under no obligation to accede to a hospital request that they accept reduced payments for their services. It is not difficult to envision circumstances under which physicians who perform the very types of procedures covered by TEAM either refuse to accept a reduced payment or even take their patients elsewhere. When this happens, some hospitals – especially those located in states that do not permit hospitals to employ physicians but not necessarily limited to that circumstance – may either be unable to meet their volume requirements for the program or would be forced to accept a financial penalty for their participation in the program: they would need to subsidize an important program cost out of their own revenue. We do not believe this is CMS's intention and believe this possibility needs to be addressed so that participation in TEAM does not become a financial hardship – especially if, as proposed, some hospitals, and especially safety-net hospitals, are required to participate in the program.

The Target Prices Are Not Set Appropriately

ASH believes CMS's approach to calculating target prices does not adequately reflect many of the variables that go into the care of patients on a case-by-case basis. Some of the surgical procedures included in TEAM are technically elective but needed while others are performed on an emergency basis; some may be performed in an acute-care hospital while others may be performed in an acute-care hospital's in-house outpatient surgical unit or an entirely separate outpatient facility; and some may have specific comorbidities and complications while others have complex needs that are particularly common among safety-net hospitals because of the nature of the patients they serve, such as hip replacements performed on patients with an orthopedic sarcoma or a joint replacement performed on a patient posing one of the many complications commonly associated with social determinants of health such as long-term heart disease or diabetes; and DRGs in general have limited value in predicting post-acute needs and spending. CMS knows that providers invest different types and quantities of resources in the care of such patients, so ASH believes the agency should develop a more representative plan for a series of variable target prices that better reflect true medical circumstances – especially considering the low case volume proposed for participation

in the program, which means that one case could potentially have an outsized influence on overall costs when a participating hospital is not performing a significant volume of a given procedure.

TEAM Overlooks Today's Shortage of Post-Acute-Care Services

Creating bundles of care that rely on post-acute-care settings as part of less costly delivery of care poses a tremendous challenge at this time. Across the country, acute-care hospitals are retaining patients long after they can safely be discharged into post-acute care for the simple and unfortunate reason that there are no vacancies in the post-acute-care settings those patients need when they need them. How, for example, can an acute-care hospital be expected to discharge a surgical hip femur fracture patient to a skilled nursing facility or an inpatient rehabilitation facility when it cannot find a skilled nursing facility or inpatient rehabilitation facility with an available bed when the need arises? This is a challenge that hospitals across the country are facing almost every day, and failing to overcome almost as often, so creating a program that mandates such transfers will not, in and of itself, lead to additional, available beds materializing overnight or even in the near-term future. CMS's current proposal to mandate staffing levels in skilled nursing facilities, moreover, will almost certainly exacerbate this problem, at least in the short term if not longer. Often, hospitals cannot even discharge such patients to their homes, with instructions for professional home care, because the home care agencies in their regions, including in many cases the hospitals' own home care organizations, are operating at capacity and simply cannot serve any additional patients at any given time.

ASH's Recommendations

In response to these and other challenges, ASH recommends the following changes if CMS wishes to move forward with TEAM:

- Make participation in TEAM voluntary, not mandatory.
- If participation remains mandatory for some hospitals, do not target CBSAs with disproportionate numbers of safety-net hospitals.
- Permit participating hospitals to choose involvement in only some of TEAM's designated surgical procedures.
- Reduce the size of the payment discount CMS requires to reflect that this model has a shorter time span than previous CMS payment models – or at least do so for community safety-net hospitals and rural hospitals.
- Establish a broader range of target prices to reflect the different circumstances under which some of the procedures would be performed.
- In setting target costs, give greater consideration to the supply of post-acute-care services and consider exempting individual episodes when lack of such services can be adequately documented.
- Permit safety-net hospitals and rural hospitals to remain at risk track 1 if they wish to avoid the prospect of downside risk. Their importance to their communities and the damage such losses could cause are too great a risk to those communities.
- Increase the number of procedures mandatory participants must perform to participate in the program's downside risk to ensure excellence in care and reasonable economies of scale that the program as currently proposed does not ensure.

Payments for Essential Medicines

ASH appreciates CMS's proposal to make separate supplemental payments to small, independent hospitals so those providers can establish and maintain a buffer stock of essential medicines for use during future shortages. We think this is an excellent idea and thank you for proposing it.

At the same time, ASH also encourages CMS to consider expanding the pool of hospitals eligible for such assistance to other providers that operate on especially narrow and precarious financial margins because of their unusual reliance on public (Medicare and Medicaid) payments: providers such as safety-net hospitals. Like the small, independent hospitals for which these payments are now proposed, many community safety-net hospitals continue to survive at the very edge financially, and if the purpose of providing these payments is to ensure that financially vulnerable hospitals have the wherewithal to deal in the future with the kind of prescription drug shortages that have arisen in the recent past, then these safety-net hospitals are in very much the same situation and, we believe, very much deserving of similar consideration for appropriate financial assistance.

Response to Request for Information About Data Reporting

In the proposed rule CMS seeks stakeholder perspectives on its plan to update the hospital and critical access hospital infection prevention and control and antibiotic stewardship programs' conditions of participation to extend a subset of the current COVID-19 and influenza data reporting requirements because it believes sustained data collection and reporting of respiratory illnesses outside of emergencies will help hospitals gain important insights on their evolving infection control needs. Specifically, CMS proposes replacing the COVID-19 and seasonal influenza reporting standards for hospitals with a new standard that addresses acute respiratory illnesses. It also proposes that in the event of a declared national public health emergency for an acute respiratory illness, reporting may be needed for additional measures.

ASH urges CMS to continue strengthening the alignment between federal, state, and local agencies to reduce data reporting complexity, duplication, and strain on hospitals. The CDC's National Syndromic Surveillance Program (NSSP) would be an excellent tool for reducing reporting mechanisms and improving efficient data reporting. Before requiring use of the NSSP for hospitals, though, public health agencies need to address some of the challenges of the NSSP receiving data, such as public health authorities using other ways to collect syndromic surveillance data from hospitals that are not connected to the NSSP; community safety-net hospitals have found this to be true. We urge CMS to work with the CDC to build the infrastructure to connect the NSSP with state and local public health authorities so hospitals that already submit data to state and local entities can meet future data reporting requirements without the need for duplicative reporting to multiple agencies.

ASH supports data reporting as a means of tracking potential infection problems but believes weekly data reporting, in the absence of a public health emergency, is overly burdensome and unnecessary. Instead, we recommend that CMS seek such data monthly, with the option of increasing this frequency if and when it declares a public health emergency. Because of the cost of such data reporting, ASH also believes CMS should provide additional funding to community safety-net hospitals for this purpose.

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The Alliance of Safety-Net Hospitals appreciates the opportunity to comment on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director