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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1785–P
P.O. Box 8013, Baltimore, MD 21244–8010

Subject: [CMS-1785-P] Medicare Program; Proposed Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Federal Register / Vol. 88, No. 83 / Monday, May 1, 2023 / Proposed Rules

Dear Administrator Brooks-LaSure:

On behalf of the 134 voluntary and public hospitals that make up the acute care membership of the Greater New York Hospital Association (GNYHA), I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the fiscal year (FY) 2024 inpatient prospective payment system (IPPS).

GNYHA is particularly concerned about the proposed payment update, which does not keep pace with the massive cost increases our member hospitals have been facing as a result of the pandemic, the structural changes to the labor market that followed, and the unusually accelerated inflationary environment. Our comments suggest methods CMS could adopt to better reflect these cost pressures in the prospective payment updates. While GNYHA's comments focus on many topics in the proposed rule, we especially appreciate the opportunity to share information with CMS through its request for information on how to define and support safety net hospitals.

If you have any questions or would like further information on GNYHA's recommendations, please contact Rebecca Ryan at 212-506-5514 / rryan@gnyha.org.

Sincerely,

Elisabeth Wynn
Executive Vice President

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GNYHA Comments on the FY 2024 IPPS Proposed Rule

Market Basket Update

CMS proposes a market basket update of 3.0% for FY 2024, reduced by a 0.2% productivity adjustment required by the Affordable Care Act. **CMS's proposed update inadequately reflects the cost growth that acute care hospitals have experienced and will continue to experience in the wake of the COVID-19 pandemic and fails to account for substantial forecast errors in prior payment updates. CMS should use more recent and supplemental data from the Medicare Cost Reports to more accurately reflect the current inflationary environment and should also implement a forecast error adjustment to correct for the significant underestimate in FY 2022.**

The Current Market Basket Methodology Results in Inadequate Hospital Payments

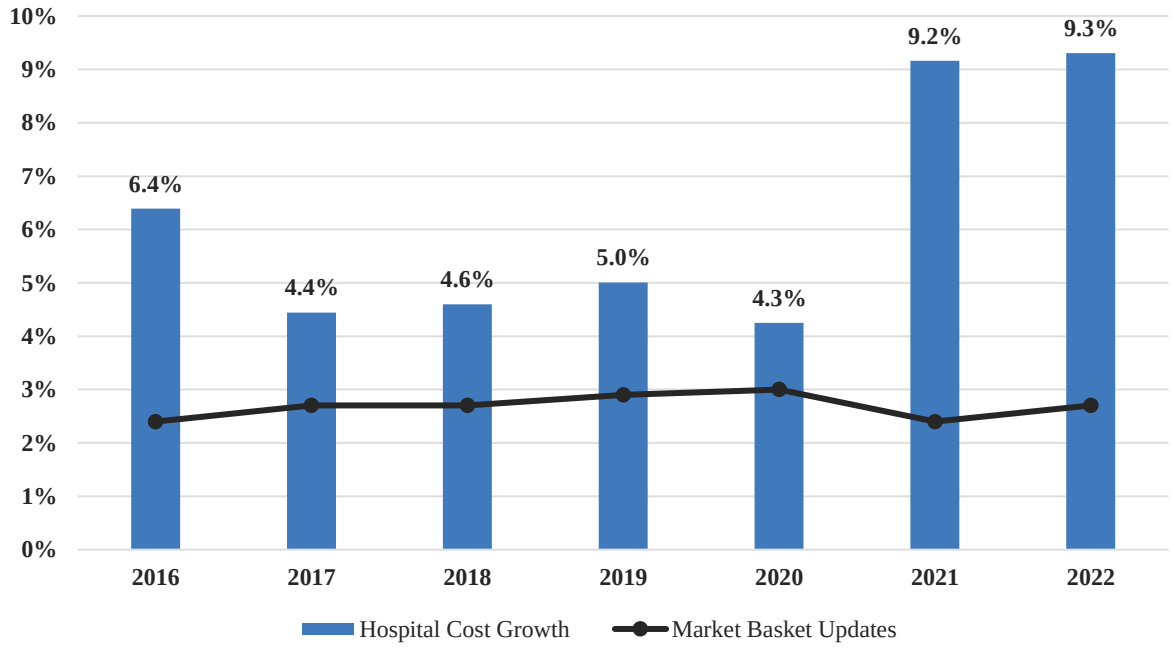
Persistent Negative Medicare Margins Threaten Beneficiary Access

Hospitals face dangerously low Medicare margins resulting from years of cuts paired with inadequate rate updates. In its March report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted an expected decrease in average Medicare margins at acute care hospitals to roughly -10% in FY 2024 and projected that the median Medicare margin for "relatively efficient" hospitals will decrease to negative margins in FY 2024. MedPAC concluded that an FY 2024 IPPS payment update based on current law would therefore be inadequate to ensure Medicare beneficiary access to hospital services and recommended an increase of one percentage point over the estimated current law update. This is noteworthy because MedPAC rarely recommends increasing payment updates over what is estimated under current law, even in years that it projects Medicare margins will be negative.

Hospitals Are Facing Unprecedented Cost Growth

To demonstrate the cost growth burden on acute care hospitals, GNYHA analyzed Medicare cost report data for those hospitals with cost report data available in each year between cost reporting years 2015 and 2022 (n=1,426). To capture the growth in costs between consistent periods, each cost report was assigned to the Federal FY with the maximum overlap. Data from the cost reports that did not span 12 months were adjusted to represent the full year, and only one cost report was included per hospital in each fiscal year (the hospital's longest cost report). Our analysis indicates that total allowable operating costs increased nationally by 9.2% between 2020 and 2021 and by an additional 9.3% between 2021 and 2022 (see Chart 1). While Medicare's payment update was lower than the actual cost growth in each year included in the analysis, this was particularly acute in 2021 and 2022, when the market basket updates were 2.4% and 2.7%, respectively. GNYHA compared the percent changes for 2016-2021 from this analysis to an analysis including all hospitals with cost report data during that time period (n=3,158). The percent changes were comparable indicating that our analysis of the limited sample through 2022 is sufficiently representative of all hospitals.

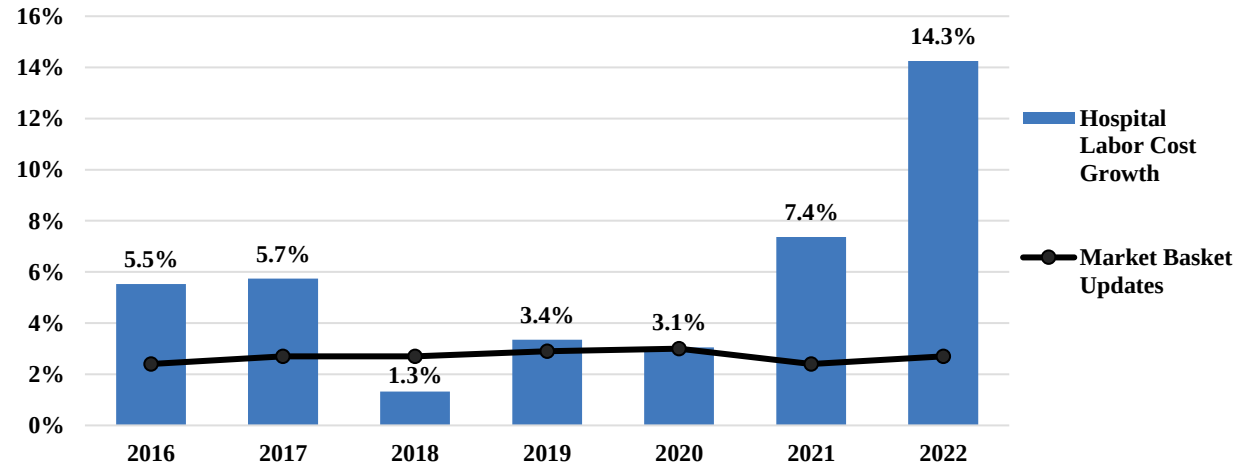
Chart 1. Hospital Total Allowable Operating Cost Growth: 2016-2022



Structural Changes Have Led to Permanently Higher Labor Costs

GNYHA has continued to find that labor cost growth is a significant component of overall cost growth experienced by hospitals, and we remain concerned that CMS's forecasts do not accurately reflect the realities of the current labor market. GNYHA's analysis of cost report data indicates that compensation costs increased nationally by roughly 7.4% between 2020 and 2021 and by 14.3% between 2021 and 2022 across the 1,426 hospitals included in our analysis (see Chart 2). Other sources support these findings, including the May 2023 KauffmanHall Hospital Flash Report, which shows that labor costs have grown by 18% since 2020.

Chart 2. Hospital Labor Cost Growth: FYs 2016-2022



These increased labor costs represent the current "new normal" labor market. The COVID-19 public health emergency (PHE) has had a lasting impact on an already strained health care labor market. Research pre-dating the PHE forecasted a shortage of over 1 million nurses by 2020. The stresses of the pandemic further deepened these shortages as significant numbers of health care workers left the labor market. These conditions led to an increased reliance on costly contract labor (discussed below), particularly for nurses, and the need to increase salaries to retain permanent staff. Due largely to widespread labor shortages, hospital negotiations with significant health care unions across the New York metropolitan area have resulted in multi-year wage increases of 7% in 2023, 6% in 2024, and 5% in 2025, increases that have continued to "ripple-through" to other hospital employees and is evidence that these increased labor costs are not transitory.

Accurately accounting for the increase in labor costs is essential to estimating an appropriate market basket. Currently, 53% of the market basket is based on the estimated growth in compensation from the base year as measured by the Employment Cost Index (ECI).[1] However, the ECI has not accurately reflected hospitals' compensation costs after the labor market changes triggered by the PHE, in large part because the ECI does not separately capture inflation in contract labor compensation. According to the Bureau of Labor's Handbook of Methods, which describes the national compensation measures produced by the National Compensation Survey (the survey that collects the source data for the ECI), the data collection is limited to individuals employed by the sampled establishment. GNYHA's conversations with Bureau of Labor Statistics economists confirmed that contract labor is not included in "Wages and salaries for All Civilian workers in Hospitals" or "Total Benefits for All Civilian workers in Hospitals," the two elements of the ECI that IHS Global Inc. uses to estimate the change in compensation prices relative to the base year.

By excluding contract labor costs, the market basket effectively assumes the price of contract labor will grow at the same rate as non-contract labor. This has not been hospitals' experience beginning with the pandemic and continuing today. Data from a recent survey of 75 New York hospitals conducted by GNYHA in partnership with several other New York-based hospital associations indicates that contract labor costs have increased dramatically in the past few years. Respondents reported that contract labor costs increased by 139% between 2019 and 2022. As contract labor costs reflect 15% of total labor costs, ignoring the trajectory of these costs contributes to CMS's inability to accurately forecast the growth in the price of labor.

Alternative Data Sources Better Capture Growth in Input Prices

CMS's current market basket methodology will lead to an underpayment again in FY 2024 because it does not accurately project cost growth during times of high inflation. **Therefore, GNYHA recommends that CMS use recent Medicare cost report data to better capture the true growth in hospital input prices for the market basket portion of the payment update. We believe CMS can use its existing authority to calculate the market basket update using these data.** Specifically, CMS should use case mix-adjusted Medicare inpatient costs per discharge from the Medicare cost reports, which represent growth in costs for Medicare beneficiaries after adjusting for both changes in intensity and changes in volume and are therefore

[1] IHS Global Inc. Prospective Payment System (IPPS) Hospital Input Price Index using IHS Global Inc. Forecast 2022 Q4.

in line with the statutory requirements for the market basket percent increase.[2] To understand the potential impact, we adjusted FY 2021 costs for case-mix by dividing the normalization factor used in Diagnosis Related Group weight development in the FY 2024 IPPS proposed rule by the blended normalization factor used in the FY 2023 IPPS final rule and the normalization factor used in the FY 2022 final rule. According to GNYHA's analysis, the percent change in case mix-adjusted inpatient Medicare costs per discharge increased by 0.96% between 2020 and 2021 and by 8.2% between 2021 and 2022. CMS could reasonably use the average percentage increase in the preceding two time periods (in this case 2020 v. 2021 and 2021 v. 2022) to calculate the FY 2024 payment adjustment, which would result in a base market basket adjustment for FY 2024 of 4.6%. GNYHA recognizes that the actual magnitude of the update would be dependent on the set of hospitals included in CMS's analysis and the method by which CMS adjusts for differences in case mix.

CMS Should Also Correct for Unusually High Forecast Errors

In its March 2023 report, MedPAC stated that CMS has underestimated the growth in hospital input prices for the market basket of operating inputs for the last two fiscal years, noting increased uncertainty as to what price growth will be in FY 2023 and raising concerns that CMS's latest forecasts indicate that it may once again underestimate price increases. GNYHA analyzed the forecasted and actualized change in prices produced by IGI from 2012 to 2022 and found that the magnitude of this forecast error has grown each quarter since the start of 2021. We found that the forecast error for the third quarter of 2022, at three percentage points, is nearly three times larger than the next largest forecast error across 2012-2022. Importantly, there is currently no mechanism to correct for forecast error in the operating portion of IPPS payments. Each year in which price growth is understated compounds the problem, as payment updates build upon the prior year's base payments. GNYHA understands that some level of forecast error is unavoidable but asks CMS to recognize that recent forecast errors have been extreme.

CMS should adopt either a one-time adjustment to its payment update of three percentage points to account for the documented FY 2022 forecast error or institute a permanent forecast error adjustment policy for IPPS operating payments that captures cases of extreme forecast error, which are only expected to occur in the wake of economic shock. CMS could take a similar approach as it does in the capital portion of the IPPS and in the Skilled Nursing Facility PPS. In both cases, CMS adjusts for forecast error associated with the most recent year with complete data when that error exceeds a threshold. In response to previous comments related to forecast error in the operating portion of IPPS, CMS has expressed its hesitance to institute such an adjustment, believing that it dilutes the prospective nature of the IPPS. GNYHA recommends that CMS structure the adjustment so that it is only triggered if the forecast error exceeds 1.5 percentage points. The forecast error adjustment would rarely be triggered and therefore would largely maintain the prospective nature of the IPPS, while protecting providers in times when accurate forecasts are difficult and avoiding persistently low payments going forward. GNYHA estimates

[2] Section 1886(b)(3)(B)(iii) of the Social Security Act states that "…*the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year."*

that implementing either a one-time or permanent forecast error adjustment would increase the FY 2024 market basket update by three percentage points.

Summary of GNYHA Recommendations

CMS should make two changes to its market basket methodology: 1) calculate case mix-adjusted Medicare costs per discharge from the Medicare cost reports and average the percent changes between 2020 and 2021 and between 2021 and 2022, which would result in a 4.6% market basket increase in FY 2024; and 2) implement a 3% forecast error adjustment to adjust for the underpayment in the prior year with the most recent actual data (i.e., correcting the FY 2022 forecast error in FY 2024). Furthermore, implementing GNYHA's recommended change to the FY 2024 market basket methodology could result in future cost avoidance if CMS chooses to implement a permanent forecast error adjustment policy, because it could eliminate the need to adjust for forecast error in two years when the FY 2024 actuals become available (i.e., CMS would adjust for FY 2024 forecast error in FY 2026). Combining these two recommendations—a 4.6% market basket update and a 3% forecast error adjustment—would result in a FY 2024 adjusted market basket increase of 7.6%.

Wage Index Policies

Rural Wage Index & Rural Floor Calculation

Through Section 401 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress amended subsection (d) of the Social Security Act to allow certain hospitals located in an urban area to be reclassified as rural (e.g., if a hospital can demonstrate that it would qualify as a rural referral center if not for its urban status), also known as §412.103 hospitals. Since 2016, urban-to-rural reclassified hospitals have also been allowed to obtain simultaneously a rural reclassification under Section 401 and an urban reclassification under the Medicare Geographic Classification Review Board (MGCRB) for wage index purposes.

CMS has changed the treatment of these hospitals over time for purposes of calculating the rural wage index and rural floor. Before FY 2020, CMS included the wage data of urban hospitals that reclassified as rural in the rural wage index and rural floor calculation except for those hospitals with a concurrent MGCRB reclassification to an urban area. In FY 2020, CMS removed the wages of hospitals that reclassify from urban to rural (i.e., §412.103 hospitals) from the calculation of the rural floor but included them in the calculation of the rural wage index, which often resulted in a state's rural floor being lower than its rural wage index. However, following the district court's decision in *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra* that CMS could not establish a rural floor lower than the rural wage index for the state, CMS reverted to its pre-2020 rural floor policy in in FY 2023 final rule. The FY 2023 policy, however, continued to exclude the data of §412.103 hospitals that also had a wage index reclassification through the Medicare Geographic Classification Review Board (MGCRB).

CMS states that in response to other pending litigation and a reevaluation of statutory language and case law, it is proposing an additional change in FY 2024 to include the data of all §412.103 hospitals (including those with a concurrent MGCRB reclassification) in both the rural wage index and rural floor calculations.

GNYHA supports this proposal. We agree with CMS's interpretation of the statutory language and case law on the treatment of geographically rural hospitals versus hospitals reclassified as rural for rural wage index and rural floor calculation purposes. The proposed policy is consistent with the statutory language under section 1886(d)(8)(E) of the Social Security Act, which requires the Health and Human Services (HHS) Secretary to treat, "for purposes of…subsection [1886(d)]" (which governs the operating PPS), The proposed policy is also consistent with recent court rulings that determined CMS regulations in which it did not treat a rural-reclassified hospital as rural were unlawful. These rulings led CMS to conclude that it needs to treat rural-reclassified hospitals—even those with a concurrent MGCRB reclassification to an urban area—as rural for all purposes of subsection (d), including when it calculates the rural wage index and rural floor. Specifically, CMS states in the proposed rule that it now interprets 1886(d)(8)(E) to mean that "a §412.103 reclassification functions the same as if the reclassifying hospital had physically relocated into a geographically rural area." We appreciate that through its FY 2024 proposal, CMS is proactively refining its statutory interpretation following the progressive litigation on how CMS treats §412.103 hospitals for purposes of its wage index and floor policies.

Low Quartile Wage Index Policy

CMS finalized a policy in FY 2020 rulemaking to increase "low" wage index hospitals—i.e., those below the 25th percentile nationally—and stated that it planned to continue the policy for at least four years. The policy was intended to provide low wage index hospitals with an opportunity to increase employee compensation without experiencing the four-year lag between when they would incur higher labor costs and when those costs would be reflected in the wage index. The policy was implemented in a budget-neutral manner through a downward adjustment to the standardized rates. CMS continued this policy through FY 2023 and proposes to extend it for a fifth year in FY 2024 to allow more time to evaluate whether the policy is having the intended effects. CMS would raise wage indices below the 25th percentile by one-half of the distance between the otherwise applicable wage index and the 25th percentile nationally (0.8615).

GNYHA has expressed concerns with the low quartile wage index policy from a legal perspective and because of the policy's seemingly open-ended timeframe and lack of formal evaluation process.

Legal Issues

CMS has faced legal challenges with the low quartile wage index policy. In *Bridgeport Hospital, et al. v. Becerra*, a group of hospitals argued that by altering the wage index for hospitals in the bottom quartile, CMS violated its statutory requirement to calculate relative hospital wage levels in each geographic area compared to the national average using hospital survey data[3]. The US District Court for the District of Columbia agreed with the plaintiffs and determined that the FY 2020 rule must be set aside. CMS has appealed this decision. CMS has also appealed a similar ruling in *Kaweah Delta Health Care District, et al. v. Becerra*.

CMS attempted to solve the statutory problems identified above by asserting its "exceptions and adjustments" authority under Section 1886(d)(5)(I), but the courts ruled this was impermissible: "Reading the general "exceptions and adjustments" provision to allow the agency to adopt the low wage index hospital

[3] "We reject [HHS's] contention that this provision, or any other in the Medicare Act, confers upon [it] the discretion to take into account all sorts of unrelated policy considerations, such as whether certain hospitals receive unwarranted advantages from other provisions of the Medicare reimbursement scheme." Bridgeport Hosp. v. Becerra, 589 F. Supp. 3d 1 | Casetext Search + Citator.

policy would gut the specific statutory provisions in place to calculate the wage index." Even if invoking this authority was deemed permissible, CMS would be required to offer corresponding regulatory changes with its proposal, which it failed to do.

Policy Intent

When CMS first implemented the policy in FY 2020, it argued that the intent of the policy was to mitigate "circularity," a theory that low wage index hospitals cannot increase compensation levels because their Medicare payments are low, but their Medicare payments are low because their wage indices are low. Since each year's wage indices are based on four-year-old average hourly wages (AHWs), CMS hypothesized that increasing low wage index hospitals' Medicare payments in FY 2020 would allow them to increase their compensation levels and thus result in higher empirical wage indices starting in FY 2024 that could be sustained into the future. If the theory was correct, the wage growth for the low quartile hospitals would be self-sustaining as it became reflected in the wage index beginning in the fourth year, i.e., FY 2023.

In the FY 2024 proposed rule, CMS acknowledges that it now has one year of wage data (FY 2020) available to evaluate the potential effects of this policy (i.e., this is the first year that CMS can evaluate whether wages increased since the low quartile policy was implemented). CMS does not discuss whether it evaluated the policy based on this single year of data but states that the currently available data is insufficient as justification to continue the policy.

GNYHA Analysis of the Low Quartile Policy's First Year Impacts

GNYHA analyzed the initial impacts of the low quartile policy by calculating the increase in the weighted AHW from FY 2019 to FY 2020 (i.e., the wage data used for the FY 2023 and FY 2024 wage indices) for hospitals that benefit from the low quartile policy and for those who do not benefit. As shown in the table below, hospitals that benefit from the low quartile policy did not increase their wages from FY 2019 to FY 2020 by nearly as much as hospitals that do not benefit from the policy (3.9% vs. 5.5%, respectively). From 2018-2019, however, before the low quartile policy was established, the group of hospitals that ultimately benefitted from the low quartile policy increased their AHWs by a similar rate as the hospitals in the top 75% of wage indices nationwide (2.3% vs. 2.7%, respectively). For both groups, the AHW growth increased by a much greater percentage from 2019 to 2020, likely due to the impact of COVID-19 on labor costs, yet the low quartile hospitals did not increase by nearly as much as the non-low quartile hospitals. Thus, there is no evidence based on these data that the policy has had its intended effect.

Table 1. Average Hourly Wage (AHW), 2022-24 (Based on FYs 2018-20 Wage Data)

	AHW FY 2022 (FY 2018 Wages)	AHW FY 2023 (FY 2019 Wages)	AHW FY 2024 (FY 2020 Wages)	% Change, 2022-23	% Change, 2023-24
US	46.52	47.79	50.33	2.7%	5.3%
Low Quartile	36.96	37.80	39.27	2.3%	3.9%
Non-Low Quartile	48.49	49.82	52.56	2.7%	5.5%

*Analysis based on CMS's wage index public use files for the FY 2023 and FY 2024 wage indices; AHWs are unadjusted for occupational mix.

Concerns & Recommendations

However, even if CMS needs more time to *evaluate* the impacts of the four-year policy, the need to continue the policy beyond four years disproves the theory that artificially increasing the wage index for the low quartile hospitals will lead to wage growth. In other words, even if CMS discontinues the policy in FY 2024, it can still evaluate the policy's effects over the prior four years as the subsequent three years of wage data becomes available on a rolling basis—i.e., wage data from FYs 2021-23, when the policy was in place, can be evaluated when it becomes available for use in the FYs 2025-27 wage index calculations. If over the next few years, it becomes clear that the policy had its intended effect of increasing wage rates, then the policy's benefit would already be reflected in hospitals' labor costs and thus in their future wage indices. If CMS instead finds that the policy did not have its intended effect and that these hospitals did not increase their wage rates by more than they might have otherwise, the policy should not continue.

Regardless of whether the policy had its intended effect, the experiment is complete, and CMS should now enter the evaluation phase. Therefore, the artificial increase in the low quartile hospitals' wage indices should end after four years. If CMS disagrees that four years of the policy is sufficient, it should better justify continuing the policy and lay out its criteria for evaluating the policy's potential success and at what point it should be terminated.

Capital DSH for Urban-to-Rural Reclassified Hospitals

Under the capital PPS, urban hospitals with 100 or more beds are eligible for capital disproportionate share hospital (DSH) payments. CMS established through FY 2007 rulemaking that a geographically urban hospital that obtains a rural reclassification under Section 401 for operating PPS purposes would lose its capital DSH eligibility.

In *Toledo Hospital v. Becerra*, the US District Court for the District of Columbia ruled against CMS's policy of not providing capital DSH payments to urban hospitals that are reclassified as rural. Specifically, it found that CMS's policy of not providing capital DSH payments to urban hospitals that are reclassified as rural under §412.103 was arbitrary and capricious because CMS did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment or account for costs at all when considering the FY 2007 rule and the policy at issue.

In response to the court's ruling, CMS is proposing that effective for FY 2024 discharges, hospitals reclassified as rural will no longer be considered rural for purposes of determining eligibility for capital DSH and would therefore be eligible for the payment. **GNYHA appreciates CMS's reconsideration of its capital DSH eligibility policy following the court's decision in *Toledo Hospital v. Becerra* and supports its proposal to allow reclassified rural hospitals to receive capital DSH payments.**

Request for Information on Safety Net Hospitals

The Institute of Medicine defines safety net providers as "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." Such providers, which include safety net hospitals (SNHs), are essential to people living in under-resourced communities, and chronic disinvestment in the form of insufficient payments from public payers, the lack of a reliable revenue source from commercial insurance, and increased costs have pushed the hospital safety net to a breaking point. Below, we detail the unique patient population that

is served by SNHs, discuss challenges that SNHs face, provide comments and critiques on how to define SNHs, and suggest ways that CMS can better support these essential providers.

Patient Population

Research demonstrates that SNHs tend to treat higher shares of patients from low-income communities, racial/ethnic minorities, and patients receiving mental health care services.[4] An analysis of the Hospital Patient Characteristic Share file confirms these findings. Table 2 provides the average share of beneficiaries that are non-white, dually eligible for Medicare and Medicaid, disabled, with a Z-code for a social determinant of health (SDH) on their inpatient claim, or with a behavioral health diagnosis by quintile of the Disproportionate Share Hospital Patient Percentage and the Medicare Safety Net Index (MSNI). In both cases, hospitals in the highest quintile have higher shares in each category as compared to those in the lowest quintile.

Table 2. Average Hospital Patient Characteristics by Safety Net Quintile

DSHPP Quintile	Average % Non-White	Average % Dual	Average % SDH	Average % Behavioral	Average % Disabled
1	15.1%	16.6%	2.1%	41.7%	21.5%
2	15.4%	21.8%	2.2%	46.0%	24.1%
3	18.3%	25.0%	2.3%	47.0%	27.0%
4	24.3%	28.7%	2.7%	46.6%	28.9%
5	42.0%	47.4%	4.5%	49.8%	35.7%

MSNI Quintile	Average % Non-White	Average % Dual	Average % SDH	Average % Behavioral	Average % Disabled
1	15.7%	18.6%	2.4%	44.5%	22.3%
2	18.1%	26.0%	2.6%	47.3%	27.4%
3	21.2%	31.6%	2.7%	48.7%	30.2%
4	24.9%	37.5%	3.3%	49.5%	33.9%
5	46.3%	54.2%	4.2%	51.4%	38.7%

Importantly, while the share of inpatient claims with a Z-code for SDH is likely understated for all hospitals, as we know hospitals have yet to fully incorporate assignment of these codes into their processes, it is likely most understated for those in the higher safety net quartiles with fewer resources to invest in social needs screening and documentation efforts. GNYHA member hospitals that serve these communities report that their patients present with significant social needs, including housing and food insecurity.

The communities served by SNHs tend to have lower rates of baseline health—often due to or exacerbated by a diminished access to community health care services and other resources—and are therefore on average more complex to treat when they present at the hospital.[5] For SNHs, this translates to preventable admissions, increased lengths of stay, and difficulties discharging patients due to homelessness, inadequate

[4] Popescu I, Fingar KR, Cutler E, Guo J, Jiang HJ. Comparison of 3 Safety-Net Hospital Definitions and Association With Hospital Characteristics. JAMA Network Open. 2019;2(8):e198577. doi:10.1001/jamanetworkopen.2019.8577.
[5] https://www.irp.wisc.edu/publications/factsheets/pdfs/PoorInPoorHealth.pdf.

resources to facilitate safe discharge to home, and/or a lack of post-acute care providers willing to accept these patients.

Safety Net Hospital Challenges

As MedPAC notes in its March 2023 report to Congress, costs per discharge for low-income beneficiaries tend to be higher than for higher-income beneficiaries with similar diagnoses. This cost burden falls disproportionately on SNHs, which treat more low-income beneficiaries. Peer-reviewed research supports this increased cost burden.[6] For example, Hoen et al. examined costs for nine surgical procedures, finding that costs per surgical procedure were greater in SNHs for all but two of the studied surgical procedures.[7] While costs tend to be higher for SNHs, revenues tend to be lower in part due to government payers (Medicare and Medicaid) reimbursing below cost. Chart 3 shows 2021 Medicare and Medicaid payment-to-cost ratios for New York hospitals.

Chart 3. NY Hospital Payment-to-Cost Ratios, 2021

Often, SNHs have insufficient commercial volume—which tends to pay above cost—to offset these public payer shortfalls. Furthermore, MedPAC has found that SNHs generally receive lower cost sharing amounts from their patients and tend to have higher patient bad debt. These factors lead to difficulty generating the financial margins necessary for SNHs to access capital markets and make capital infrastructure improvements, and challenges in recruiting and retaining talented staff, implementing quality improvement initiatives, and participating in value-based payment initiatives that may require assuming financial risk. The inability to invest in infrastructure has real implications. Safety net hospitals are at increased risk for cybersecurity attacks due to limited infrastructure and more prevalent use of older versions of electronic medical records software. Patient experience, which is in part dependent on patient perception of the condition of the physical plant in which they receive care, is likely to suffer when investments cannot be made.

[6] Nguyen NX, Sheingold SH. Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. Medicare Medicaid Res Rev. 2011 Nov 4;1(4):001.04.a01. doi: 10.5600/mmrr.001.04.a01. PMID: 22340777; PMCID: PMC4010444.

[7] Hoehn RS, Wima K, Vestal MA, et al. Effect of Hospital Safety-Net Burden on Cost and Outcomes After Surgery. JAMA Surgery. 2016;151(2):120-128. doi:10.1001/jamasurg.2015.3209.

The Importance of an Appropriate Definition

The definition used to identify SNHs is of paramount importance, with the most appropriate definition dependent on the intended application and outcome. Popescu et al., noting that several definitions of safety net status exist, examined three measures of burden: the DSH Patient Percentage (DPP), a definition based on the level of uncompensated care, and a measure based on Medicaid and uninsured caseloads. The authors found that the latter two measures identified hospitals with lower operating margins, while the DSH patient percentage generally did not. The DPP and definition based on Medicaid and uninsured caseloads generally captured more teaching hospitals that provide essential services and larger hospitals as compared to the definition based on uncompensated care costs.[8]

GNYHA does not believe that CMS should institute a single SNH definition across policies and programs. Instead, CMS should identify SNHs based on the intent of the program for which the definition will be used. For example, in some cases, CMS may be interested in those SNHs that are at risk of closure, while in other cases, CMS may want to account for the clinical complexity of providing care to underserved beneficiaries. A single, uniform definition may complicate such nuances. GNYHA also believes that CMS should avoid the use of arbitrary thresholds in defining SNHs. In cases where a threshold is necessary, GNYHA recommends that CMS determine that threshold empirically and with the intended outcome of the policy or program in mind.

Importantly, while CMS is not proposing to tie either the MSNI or the Area Deprivation Index (ADI) to supplemental payments/subsidies such as Medicare uncompensated care funding at this time, GNYHA would caution CMS against doing so. The following sections outline our methodological concerns with both the MSNI and ADI that we believe make them poorly suited for this purpose on their own.

Medicare Safety Net Index

The MSNI, which was developed by MedPAC, is a metric intended to identify the extent to which providers serve low-income Medicare beneficiaries. The index is calculated as the sum of three factors:

- The share of Medicare volume associated with low-income beneficiaries identified through receipt of the Part D low-income subsidy (LIS share)
- The share of revenue spent on uncompensated care (UC share)
- One-half of the share of total patient volume associated with Medicare beneficiaries (Medicare share)

GNYHA has several concerns with this proposed index. First, we are concerned that the index purposely attempts to specifically identify *Medicare* SNHs. That is, the index measures the extent to which a facility serves low-income Medicare beneficiaries rather than low-income patients overall. We do not believe that it is practical to make this distinction. Safety net burden affects the overall ability of a facility to fulfill its mission, reinvest in the organization, and maintain operations. Currently, the MSNI does not capture non-dual eligible Medicaid beneficiaries, a population that is essential to any definition of an SNH. Furthermore, a hospital with a low Medicare share that treats a large low-income population may still treat a large number of Medicare beneficiaries. Therefore, **focusing only on those hospitals that treat a large share of**

[8] Popescu I, Fingar KR, Cutler E, Guo J, Jiang HJ. Comparison of 3 Safety-Net Hospital Definitions and Association With Hospital Characteristics. JAMA Network Open. 2019;2(8):e198577. doi:10.1001/jamanetworkopen.2019.8577.

Medicare beneficiaries will disadvantage those Medicare beneficiaries that receive care at hospitals with lower Medicare shares. GNYHA notes that as currently constructed, the Medicare share, even when halved, is the most impactful metric in determining the MSNI.

The MSNI also significantly underweights the UC share. Notably, the UC share is the component of the index that would capture both the uninsured and underinsured, as well as any bad debts incurred on the hospital's behalf by either of these populations (e.g., unpaid cost-sharing). To illustrate this point, GNYHA modeled a scenario in which a pool of supplemental funds equal to the size of the estimated national DSH and UC payments was distributed based on the MSNI. Once supplemental payments were estimated, we converted those amounts to a per-diem amount to account for differences in hospital size. Then we regressed this per-diem payment on the three components of the index (LIS share, UC share, and Medicare share). (Note, this analysis uses payments based on MSNI rather than the MSNI itself to avoid perfect collinearity.) The results of this simple regression are provided in Table 3. Each parameter estimate represents the impact of a one percentage point increase in the model component on estimated MSNI payments and provides evidence of the wide differences in the relative importance of the three components. A one-percentage-point increase in Medicare share is associated with a roughly $14 increase in MSNI payments per day, while a one percentage point increase in LIS share is associated with a roughly $6 increase in MSNI payments per day. On the other hand, a one-percentage-point increase in UC share is associated with only a 0.00000397 increase in MSNI payments per day.

Table 3. Relative Importance of Safety Net Index Components

Variable	DF	Parameter Estimate	Standard Error	t-statistic	Pr > |t|
Intercept	1	-345.90	12.86	-26.90	<.0001
LIS Share	1	5.52	0.17	33.26	<.0001
UC Share	1	0.00000397	0.00	4.24	<.0001
Medicare Share	1	13.94	0.40	34.68	<.0001

GNYHA is also concerned that in describing how it may calculate the MSNI, CMS did not indicate that it would include outpatient volume in the calculation of the LIS share. SNHs are important providers of outpatient services, including primary care services, to low-income individuals and others that may not have access to such care otherwise. Failing to account for these services omits an essential part of the safety net mission and risks skewing the results of the MSNI. Importantly, MedPAC recognizes this and includes outpatient volume in their calculation of the LIS share.

Area-Based Indicators

GNYHA believes that appropriately constructed area-based indicators of deprivation or vulnerability could be a valuable tool in identifying SNHs. Specifically, such an indicator can help to capture relative differences in clinical risk that exist at the neighborhood level, regardless of individual characteristics. For example, an individual that is commercially insured, but who resides in a "vulnerable" neighborhood may experience barriers to accessing care that would not generally be associated with the commercially insured population. That is, neighborhood-level factors may have an impact on the vulnerability of a given patient that is greater than the sum of the effects of many individual-level characteristics. Furthermore, the impact of social risk on health is multidimensional and complex. Individual indicators, like dual eligibility, are likely insufficient to paint an accurate picture of social risk. In addition, individual-level characteristics are often correlated with each other and therefore difficult to interpret.

The Area Deprivation Index

While GNYHA appreciates the important role that area-based indicators can play, we have major methodological concerns with the ADI as currently constructed and caution CMS against further use of the indicator. The ADI comprises four primary domains: Income, Employment, Education, and Housing. The ADI is calculated by first assigning patients to Census Block Groups, which are assessed based on 17 indicators calculated from US census data. Each of the 17 indicators is weighted based on the results of factor analysis. The value of each indicator for each census tract group is multiplied by its applicable weight to produce the ADI for that census tract group.[9] While the ADI has been found to be predictive of clinical outcomes, its ability to accurately identify the relative disadvantage of Census Block Groups has been called into question.[10]

GNYHA's methodological concerns with the ADI are documented by Hannan et al. and stem from an over-reliance of ADI on median home value, which stems from a lack of standardization of the units of each of the 17 included variables. Indicators included in the ADI range from proportions between 0 and 1, such as the percent of the population with income below the Federal poverty level, and measures of costs expressed in dollars, such as median home value. While the former is restricted to a value between 0 and 1, the latter can be in the millions. Therefore, while median home value is weighted less than many other indicators, the weighted median home value will always be large in comparison to a weighted indicator between 0 and 1.

An assessment of the census tract groups in the Bronx provides clear evidence of this issue. Profound deprivation is well established in many areas of the Bronx. In fact, the South Bronx includes some of the nation's poorest neighborhoods. Yet, an analysis of ADI national percentiles paints a far different picture of the county. Only 24 out of 1,090 ranked Census Block Groups in the Bronx score at or above the 90th percentile in ADI. Weighted by population, the mean ADI for Bronx County is 28. This suggests that on average, the Bronx is a less deprived region than 72% of the United States.

An informed assessment of the Bronx community suggests a profile of extreme need in at least three of the four ADI domains, as demonstrated by the 2019 American Community Survey 5-Year Estimates. Out of 62 counties in New York State, the Bronx ranks last (worst) in percent of population below 150% of poverty, with an estimated 41% of its population falling below this level, nearly 10 percentage points more than the next lowest ranked county. Furthermore, the Bronx is last by a considerable margin in unemployment rate, at 10%, with Sullivan County second at 7.5%. In the Education domain, the Bronx is again last in the State, with 72.8% of the population holding a high school diploma. Despite these ratings, the methodology used to calculate base scores for the ADI yields a county profile that places the Bronx as the 10th *least* deprived county in New York State. Housing is the clear outlier, with the Bronx ranked 8th in median home value among New York counties. This comports closely with Housing domain data but contradicts status in the three remaining domains. This is clearly a failure of the ADI's ability to assess neighborhood deprivation, particularly in areas with high costs of living and high real estate prices relative

[9] Kolak M, Bhatt J, Park YH, Padrón NA, Molefe A. Quantification of Neighborhood-Level Social Determinants of Health in the Continental United States. *JAMA Netw Open.* 2020;3(1):e1919928. doi:10.1001/jamanetworkopen.2019.19928.

[10] Hannan E, Wu Y, Cozzens K, Anderson B. The Neighborhood Atlas Area Deprivation Index For Measuring Socioeconomic Status: An Overemphasis On Home Value | Health Affairs. Health Affairs. 2023;42(5):702-709. doi:10.1377/hlthaff.2022.01406.

to the rest of the country. Of further note is whether real estate prices bear any importance in describing neighborhood deprivation in areas in which rental properties are the norm and homeowners are the minority. The example above demonstrates the inability of the ADI to accurately portray relative disadvantage. **We therefore strongly oppose using the ADI to identify SNHs.**

Supporting Safety Net Hospitals

First and foremost, CMS should improve overall payment adequacy through the Medicare program. GNYHA estimates that Medicare reimbursement covers only 84% of costs at New York State hospitals. Furthermore, as safety net providers tend to have higher costs of care, this payment shortfall is likely more pronounced at these organizations. Ensuring that payment rates cover cost is an important first step in supporting the safety net and will help address some of the barriers to investing in organizational improvements. Furthermore, CMS must recognize and help to fill drastic payment shortfalls through Medicaid programs. While improving Medicare payment adequacy will provide some relief to SNHs, it likely will not be enough to counter inadequate Medicaid payments. For this reason, it is essential that CMS not adopt the myopic view that the Medicare program should only be interested in SNHs that treat high Medicare shares. Supporting all SNHs will benefit Medicare beneficiaries. As the financial position of SNHs, regardless of Medicare share, improves, access to high-quality care options will increase.

Next, CMS should at a minimum protect current funding levels and ideally work with Congress to increase the amount of funding available for Medicare supplemental funding for SNHs. MedPAC concurs that increased supplemental funding is necessary. In its March report, MedPAC recommended increasing the total funds available for supplemental safety net payments by $2 billion to improve the financial sustainability of SNHs. GNYHA also recommends that CMS carve out and make Medicare DSH/uncompensated care pool payments directly for care provided to Medicare Advantage (MA) beneficiaries as it does for indirect medical education payments. This will avoid issues related to distortions in MA premiums associated with hospital-specific adjustments. **In addition, CMS should work with Congress to continue to delay the Medicaid DSH cuts, allow hospitals to include in their DSH cap calculation Medicaid shortfalls from Medicare dual-eligible patients and individuals dually covered by an "applicable plan," and set Medicaid DSH caps at 110% of losses from Medicaid and uninsured for high SNHs.**

Lastly, CMS should also continue its efforts to design and implement alternative payment models that promote safety net participation. These models should provide upfront investments so providers can invest in the infrastructure necessary to engage in delivery system reform efforts and improve efficiency and quality of care. In addition, CMS should ensure that current benchmarking methodologies do not disadvantage SNHs. As mentioned, average cost of care at SNHs is often higher than at non-safety net facilities. Therefore, SNHs may have more difficulty reaching regional or average spending targets than their non-safety net counterparts. Furthermore, SNHs may be less willing or able to take on downside risk. Therefore, CMS should provide options with less risk at the onset of the model and allow for the phasing in of risk over time.

Reversal of MA Nursing and Allied Health Recoupments

CMS is proposing a method for Medicare Administrative Contractors (MACs) to implement Section 4143 of the Consolidated Appropriations Act (CAA), 2023, which requires CMS to recalculate MA nursing and allied health (NAH) payments for calendar years (CY) 2010-2019, effectively reversing certain

recoupments made per a 2020 transmittal. **GNYHA supports this proposal and believes it is consistent with Congressional intent.**

Background

CMS introduced MA payments for NAH in 2001. Total spending for MA NAH payments (the "pool") is limited to no more than $60 million in any CY and CMS is required to reduce aggregate direct graduate medical education (DGME) payments by this amount through an across-the-board adjustment. This reduction applies to all hospitals that receive MA DGME payments, including those that do not receive additional MA NAH payments. CMS provided instructions to the MACs in 2003 on how to calculate the MA NAH payments and the corresponding offset to DGME payments for CY 2001 but did not update the instructions for CYs 2002-2018 based on more recently available data, which resulted in MA NAH overpayments. In 2020, CMS released Change Request (CR) 11642 providing detailed instructions for calculating MA NAH payment amounts for CYs 2002-2018 and the proportional reduction to MA DGME payments. To correct MA NAH overpayments, CMS updated the pool amount and other formula inputs (i.e., total NAH payments, total and MA inpatient days, and related ratios) for each CY. Affected providers (those with open cost reports or cost reports settled within three years of the implementation date) had a portion of their MA NAH payments recouped. To offset the decrease in MA NAH payments (i.e., the recouped amount), CMS reduced MA DGME payments by a lower percentage, resulting in higher MA DGME payments.

Stakeholders expressed concerns over the MA NAH payment recoupments for two reasons: 1) it was unfair to penalize hospitals for a mistake that CMS made almost two decades prior that resulted in MA NAH overpayments, and 2) the recoupments occurred during the COVID-19 PHE, which placed considerable financial stress on hospitals and precipitated a workforce shortage, and therefore could lead to NAH program cutbacks and closures.

Section 4143 of the CAA instructed CMS to reverse the MA NAH recoupments by eliminating the annual cap ($60 million) on MA NAH payments for CYs 2010-2019 for hospitals that, as of the date of enactment of the CAA, are operating a school of nursing, a school of allied health, or a school of nursing and allied health. The statute also explicitly states that corresponding changes will not be made to the MA DGME payments resulting from the elimination of the MA NAH cap. On March 16, CMS released CR 13122 implementing a portion of Section 4143 by directing MACs to recalculate MA NAH payments for CYs 2010-2019 without imposing the $60 million cap on the pool, but did not consider other changes in calculations made under CR 11642, such as total NAH payments, total and MA inpatient days, and related ratios. Therefore, newly calculated MA NAH payments under CR 13122 do not reverse the entire amount of the recoupment from the 2020 CR.

Proposed Recalculation and Reversal of Recoupments

In the FY 2024 proposed rule, CMS proposes to repay hospitals for the full amount of the MA NAH recoupments made in 2020 by recalculating MA NAH payments for CYs 2010-2019 without imposing the cap on the pool (consistent with CR 13122) and by returning any additional amounts from the recoupments to the affected hospitals, making them whole.

We are pleased that CMS made the initial first step through CR 13122 to quickly return a portion of recoupments to affected MA NAH programs while it engaged in rulemaking to fully satisfy the intent of

Section 4143 to return the amounts in full. **GNYHA supports CMS's proposal to return the full amount of the recoupment to affected hospitals.**

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)

GNYHA supports CMS's proposed clarification to the instructions for how to report information on the cost report for teaching hospitals that have entered into a Medicare GME affiliated group agreement to share resident cap slots. CMS's proposed new instruction language to clarify from which lines to pull relevant information in completing Worksheet E, Part A, will assist hospitals in ensuring that they complete the worksheet and report resident full-time equivalent (FTE) training in the proper manner. GNYHA continues to believe that it is unfortunate that Congress's continued unwillingness to significantly lift the resident caps imposed on teaching hospitals, particularly as the nation faces a critical physician workforce shortage, necessitates that academic medical centers and other teaching hospitals are burdened with these administrative and reporting complexities while trying to train the physicians of the future and serve their communities.

GNYHA also supports CMS's proposal that, effective for portions of cost reporting periods beginning on or after October 1, 2023, a rural emergency hospital (REH) may decide to be a non-provider site such that a hospital can include resident training at the REH in its resident FTE count, or the REH may decide to be paid on a reasonable cost basis for that training. As evidenced by our strong advocacy for rural training programs (formerly rural training tracks) and the inclusion of hospitals located in rural areas among the beneficiaries of resident cap relief legislation, GNYHA supports innovative strategies that will incentivize bringing physician services to those living in rural areas.

Changes to Severity Levels for Z-Codes Describing Homelessness

GNYHA supports CMS's proposal to change the severity designation of the three ICD-10-CM diagnosis codes describing homelessness from non-complication or comorbidity to complication or comorbidity for FY 2024. GNYHA member hospitals have said that patients experiencing homelessness often suffer from multiple complicated diagnoses (including mental health and substance use) and can be difficult to discharge if they do not have stable housing. Patients living in a homeless shelter can also be difficult to discharge, as that setting may not be equipped to assist patients with discharge instructions, medication regiments, and post-discharge visits to the ambulatory care setting. These discharge-related challenges can result in a longer length of stay.

GNYHA believes that the increased severity designation will encourage hospitals to identify and document homelessness and ensure that it is included as a diagnosis on the claim. This will further support the implementation of social needs screening and reporting in the inpatient setting.

GNYHA urges CMS to consider increased severity designations for additional Z codes in future rulemaking. Social needs and experiences such as social isolation (Z60.2 or Z60.4), domestic violence (Z91.410), and housing quality concerns such as pests (Z77.128) and mold (Z77.120) can impact patients' abilities to be safely discharged and can result in a longer length of stay.

Quality Proposals

Hospital Inpatient Quality Reporting (IQR) Program Changes (Section IX.C.)

Proposed New Measures

CMS proposes three new electronic clinical quality measures (eCQMs) beginning with the CY 2025 reporting period/FY 2027 payment determination: Hospital Harm-Pressure Injury, Hospital Harm-Acute Kidney Injury, and Excessive Radiation or Inadequate Image Quality for Diagnostic CT.

GNYHA generally supports adoption of these measures into the IQR program as measures from which hospitals can select to meet the eCQM requirements. GNYHA members are committed to reducing hospital harm. They are engaged in activities and measurement across their organizations to improve patient safety. As hospitals gain experience with electronic medical records and the data within, they are increasingly agile with implementing eCQMs. Each new eCQM, though, requires time, resources, and manpower to implement, mostly from information technology, but also from clinicians who inform the data extraction. In addition, hospitals need time to educate clinicians on the template changes and new quality measures. Hospitals, especially safety net hospitals, are limited in the resources available to implement these new measures. Hospitals also need additional time to study the results prior to reporting to CMS and therefore, these measures should remain optional at this time.

Hospital Harm-Pressure Injury eCQM

The Hospital Harm-Pressure Injury measure is an outcome eCQM that has been revised since the FY 2020 IPPS proposed rule. GNYHA appreciates the revisions made in recent years as the intent is to only include those pressure injuries that develop within the hospital. Hospitals need time, resources, and manpower to address operational challenges that will present when implementing this measure. Hospitals will need to build new templates, modify the electronic health record (EHR), and educate staff on changes. Measuring complications based on EHR data may cause hospitals to shift from other quality improvement activities to EHR data abstraction and reporting. Therefore, CMS should not consider making this measure mandatory. The measure received conditional support for rulemaking from the Measure Applications Partnership (MAP) pending endorsement by the consensus-based entity (CBE). **GNYHA believes that the Hospital Harm-Pressure Injury eCQM should not be adopted without CBE endorsement.** The proposal raises important questions that must be addressed in the endorsement process: Can this measure be feasibly reported? Is the measure applicable to and appropriately specified for the program's intended population? The MAP also had concerns about the measure disproportionately penalizing facilities that treat more complex patients and suggested that risk adjustment could be beneficial. **GNYHA supports adoption of this measure into the IQR program as an optional measure once it has CBE endorsement and the potential for risk-adjustment has been evaluated.**

Hospital Harm-Acute Kidney Injury eCQM

The Hospital Harm-Acute Kidney Injury eCQM measure is an outcome measure that is intended to improve patient safety. The measure has not yet been endorsed by the CBE. **GNYHA believes that the Hospital Harm-Acute Kidney Injury eCQM should not be adopted without CBE endorsement, like the Pressure Injury eCQM.** GNYHA supports adoption of this measure into the IQR program as a measure from which hospitals can select to meet the eCQM requirements after it has CBE endorsement. However, GNYHA would not support its inclusion as a mandatory measure.

Excessive Radiation or Inadequate Image Quality for Diagnostic CT eCQM

It is critical to ensure that patients are exposed to the lowest possible level of radiation while preserving image quality. The Excessive Radiation or Inadequate Image Quality for Diagnostic CT eCQM measure appropriately discourages unnecessarily high radiation doses while preserving image quality. The measure requires that hospitals use translation software to report to CMS. The integration of the required translation software could be a burden, especially for safety net institutions. While **GNYHA supports this measure in the IQR program, it is important that it remains optional** given the additional time and resources required to implement an eCQM.

Refinements to Current Measures

CMS proposes to refine three existing IQR measures.

Hybrid Hospital-Wide All Cause Risk Standardized Mortality and Hybrid Hospital All Cause Readmission

MA is rapidly growing and accounts for almost half of all Medicare beneficiaries. CMS proposes to modify the current Hybrid Hospital-Wide All Cause Risk Standardized Mortality measure and the Hybrid Hospital All Cause Readmission measure by adding MA patients. **GNYHA generally supports the expansion, as this is more representative of the Medicare population**. **Before adopting the modified measures into the IQR program though, GNYHA recommends that they undergo CBE endorsement**.

COVID-19 Vaccination Coverage among Healthcare Personnel

CMS is proposing to modify the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure starting with the fourth quarter of the CY 2023 reporting period/FY 2025 payment determination. Specifically, CMS proposes to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition to align with the Centers for Disease Control and Prevention (CDC), and to update the numerator to specify the timeframes within which one is considered "up to date" with recommended COVID-19 vaccines. The CDC's guidelines on what determines whether one is "up to date" on vaccinations have changed and will likely continue to change.

GNYHA is concerned that this measure will place an undue burden on hospitals, especially in the context of the end of the PHE. CMS is undoing the Federal mandate requiring the vaccination of health care personnel, as are many states, including New York. Given these changes, **GNYHA asks CMS to consider the utility of the benefit of this measure for consumers and hospitals and urges CMS to revise the measure to require only annual reporting in alignment with influenza. Additionally, the measure should not be adopted without CBE endorsement.**

Potential Future Inclusion of Two Geriatric Care Measures

As the population is aging rapidly, care becomes more complex with patients often developing multiple chronic conditions. Rather than addressing individual clinical issues in isolation, geriatric care is holistic in its approach. GNYHA agrees that hospitals should prioritize patient-centered care for the aging patient populations with multiple chronic conditions.

CMS proposes two structural geriatric measures, *Hospital Geriatric* and *Geriatric Surgical*. The Hospital Geriatric measure has eight domains, and the Geriatric Surgical measure has seven domains. The lack of detail on the appropriate processes that must be in place to have a "yes" is problematic. Attestation of

compliance is a weak indicator, as it is too easy to check "yes" without evaluation of whether relevant processes are in place and effective. Therefore, these measures are not meaningful and add to the existing measurement burden. There is a questionable impact on care processes that impact outcomes when the bar is set too low for "yes" answers. **GNYHA strongly recommends that CMS focus on developing process and outcome measures rather than using these structural measures in the IQR program.** Secondly, there is a significant overlap between the hospital and surgical geriatric measures. If CMS chooses to move forward with these measures, **GNYHA recommends that there should be one measure not separated into surgery and medicine.** If CMS includes the measures in the IQR program, then the number of domains should be reduced to those that are most meaningful.

Adding a hospital designation that appropriately captures the quality and safety of patient-centered geriatric care that is available on a consumer-facing CMS website would allow patients and families to choose hospitals with a demonstrated commitment through implementation of best practices. However, the Hospital Geriatric and Geriatric Surgical measures are not sufficient for this purpose.

Proposed Removal of Three Measures

CMS proposes to remove three measures from the IQR program.

Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure (RSCR THA/TKA)

This measure has undergone review and modification and was readopted into the IQR program last year with the intent of it being adopted into the Hospital VBP program. The revised measure would be removed from IQR beginning with April 1, 2025, through March 31, 2028, for FY 2030 payment determination. The original version is currently part of the VBP program. **GNYHA supports the modified measure and removal from the IQR program.** However, CMS should remain aware that hospitals will be reporting two slightly different measure specifications: the revised measure to the IQR program and the original measure to the VBP program prior to the transition of the revised measure from IQR to VBP. This will increase the burden on hospitals as they will be required to monitor and validate two different performance rates.

Medicare Spending Per Beneficiary (MSPB) Measure

MSPB has undergone review and several modifications. The original measure is currently in the VBP program. CMS proposes to remove the modified MSPB measure in the IQR program contingent on the adoption of the updated measure into the VBP program, like the RSCR THA/TKA measure proposal. **GNYHA supports the revised measure and removal from the IQR program.** However, CMS should remain aware that hospitals will be subject to two slightly different measure specifications: the revised measure to the IQR program and the original measure to the VBP program prior to the transition of the revised measure from IQR to VBP. This will increase the burden on hospitals as they will be required to monitor and validate two different performance rates.

Elective Delivery Prior to 39 Weeks Gestation (PC-01) Measure THA/TKA Complication Rate

As PC-01 has "topped out," **GNYHA supports the removal of this measure**. Hospitals are committed to improving maternal health and are preparing for mandatory reporting of the Cesarean eCQM and Maternal Morbidity eCQM measures.

Proposed Changes to the HCAHPS Survey

For the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, the publicly reported survey of patients' experience of hospital care, CMS is proposing changes related to the administration and submission of data. **GNYHA appreciates efforts to increase the response rate through several of the proposed changes, as a robust dataset is more useful for interpretation and improvement of patients' experience**. CMS is proposing to:

- Add three new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the existing modes
- Allow for proxy respondents to the HCAHPS Survey
- Extend the response time from 42 to 49 days
- Require the official Spanish translation for Spanish language-preferring patients
- Limit the number of supplemental items to 12
- Remove two options for administration that are not currently used by hospitals

GNYHA generally supports these changes as they are patient-centered and will likely increase the response rates, which will support hospitals efforts to continuously improve patients' experience.

Regarding the request for comment on the potential inclusion of patients with a primary psychiatric diagnosis, GNYHA recommends that CMS take time to engage with hospitals to test which psychiatric patient populations to include before implementing changes.

Hospital Acquired Conditions (HAC) Reduction Program (see Section V.L.)

CMS has requested comments on potentially adopting the following eCQMs that are currently part of the IQR program into the HAC Reduction Program:

- Hospital Harm-Opioid-Related Adverse Events eCQM
- Hospital Harm-Severe Hypoglycemia eCQM
- Hospital Harm-Severe Hyperglycemia eCQM

CMS also requests input on three additional eCQMS (proposed for IQR in the FY 2024 proposed rule) for inclusion in the HAC Reduction Program:

- Hospital Harm-Pressure Injury eCQM
- Hospital Harm-Acute Kidney Injury eCQM
- Excessive Radiation Dose or Inadequate Image quality for Diagnostic CT in Adults eCQM

GNYHA supports changes that CMS is making to digitize measurement and ultimately streamline reporting. Digital measurement presents many challenges to organizations, though, including difficulties extracting data and time constraints to test, validate, educate staff, and monitor performance prior to reporting and inclusion in a pay-for-performance program. Additionally, there is a cost to build templates and make changes to an EHR, which presents issues for most hospitals in the current environment. Organizations need additional time to implement these measures, and it is premature to consider them for pay-for-performance. **GNYHA does not support adoption of these eCQMs into the HAC program at this time. GNYHA urges CMS to work closely with hospitals to better understand what is required operationally to make these changes.**

Value-Based Purchasing (VBP) Program (see Section V.K.)

VBP Health Equity Adjustment

CMS proposes to add a new Health Equity Adjustment (HEA) to the Hospital VBP (HVBP) program, which would award hospitals bonus points based on their overall performance and share of underserved patients. CMS proposes to calculate the HEA based on a hospital's performance across all four Hospital VBP Program domains and the proportion of patients with dual-eligible status treated by that hospital. The HEA is based on a hospital's quality performance compared to other hospitals (through the "performance scaler"), as well as the proportion of patients that are considered underserved ("underserved multiplier"). To determine the performance scaler, CMS would assign hospitals into three groups based on their performance relative to other hospitals for each of the four domains under the Hospital VBP program. Hospitals would be assigned points based on where they fell within the ranking, with the top-third receiving four points per measure, the middle-third receiving two points per measure, and the bottom-third receiving 0 points per measure, for up to 16 total points across the four domains. The underserved multiplier would be calculated as the share of inpatient stays for patients with dual-eligible status out of the total number of inpatient Medicare (fee-for-service and MA) stays during the calendar year two years before the start of the respective program year, transformed via a logistic exchange function. CMS also seeks comment on other potential metrics to use for this adjustment such as the ADI and Part D LIS eligibility.

GNYHA does not support CMS finalizing its proposed HEA in the VBP program. GNYHA is concerned that the HEA may result in unintended consequences. As VBP is a budget-neutral program, methodological changes will result in redistribution. After CMS awards the HEA to some hospitals, it must calculate a new linear exchange function to determine the minimum total performance score at which a hospital begins to earn a bonus rather than incurring a penalty. Therefore, for providers who previously were performing just above the cut-point, which indicates slightly better than average performance and results in a small bonus payment through the program, the HEA can be the difference between earning that small bonus and being penalized. **GNYHA supports rewarding providers that provide high-quality care and appreciates CMS's attempt to support providers that treat a high share of safety net beneficiaries but does not recommend that CMS do so at the expense of other safety net providers.**

In addition, GNYHA is concerned that CMS relies on the share of dual-eligible patients alone in calculating the HEA. Dual eligibility does not paint a complete picture of the vulnerable populations treated by hospitals, nor does it accurately represent the myriad social risk factors of these populations. While we believe dual eligibility is an appropriate variable to include, along with other indicators of social risk, we do not believe that it should be used on its own as a proxy for social risk in risk adjustment methodologies. Instead, we recommend that CMS develop a HEA methodology that better accounts for these complexities.

GNYHA notes that dual eligibility is one of two social factors for which CMS has developed a methodological approach for measuring health disparities, and CMS currently privately reports disparity data to hospitals based on those methods, with race/ethnicity being the second factor. GNYHA believes that private reporting of health disparity data is a valuable resource that CMS should continue to use to assist hospitals in targeting health disparities and improving health equity, but worries that measuring disparities based on individual indicators is often misleading and confounded by other social risk factors. GNYHA asks that CMS not publicly report quality data stratified by social risk factors and not tie the results

to payment in its VBP programs at this time. In addition, we encourage CMS to continue to develop methods that better account for social risk.

Lastly, GNYHA strongly opposes the use of the ADI for purposes of calculating such an adjustment. The ADI has proven incapable of accurately reflecting neighborhood deprivation in high-cost areas such as New York. For a complete discussion of the ADI, please see our response to CMS's request for information on safety net hospitals. While GNYHA believes that eligibility for the Part D LIS may be a more appropriate metric than dual eligibility to capture the Medicare low-income population since eligibility for the Part D LIS is standard across all states, we believe that, like dual eligibility, it alone is not a reasonable proxy for all social risk.

Proposed Substantive Measure Modifications

MSPB measure

CMS proposes to adopt the updated measure (see IQR program) in the VBP program beginning with FY 2028 (performance period starting with January 1, 2026 discharges). CMS proposes to remove it from the IQR program contingent on finalizing adoption of the updated measure to the VBP program. **GNYHA supports the revisions to the measure and replacing the original with this modified measure.** However, CMS should remain aware that hospitals will be subject to two slightly different measure specifications: the revised measure to the IQR program and the original measure to the VBP program prior to the transition of the revised measure from IQR to VBP. This will increase the burden on hospitals as they will be required to monitor and validate two different performance rates. CMS should closely monitor the results for both programs during this time.

RSCR THA/TKA

CMS proposes to adopt the revised RSCR THA/TKA measure (see IQR program) into the VBP program beginning with FY 2030 (performance period April 1, 2025, through March 31, 2028). The measure was previously adopted with the same revisions to the IQR program. **GNYHA supports adoption of this modified measure into the VBP program.** However, CMS should remain aware that hospitals will be subject to two slightly different measure specifications: the revised measure to the IQR program and the original measure to the VBP program prior to the transition of the revised measure from IQR to VBP. This will increase the burden on hospitals as they will be required to monitor and validate two different performance rates. CMS should closely monitor the results for both programs during this time.

Proposed New Measure

CMS proposes to adopt the Severe Sepsis and Septic Shock: Management Bundle (SEP-1) measure beginning with the FY 2026 VBP program.

GNYHA opposes adoption of the SEP-1 into the VBP program at this time. The measure is a chart abstraction measure that requires considerable time and resources. It is more complex than other chart abstracted measures due to the number of data elements and complicated specifications (e.g., for "Time Zero" and organ dysfunction).[11] The sheer complexity of the measure negates potential improvement efforts

[11] Rhee C, Strich JR, Klompas M, Yealy DM, Masur H. SEP-1 Has Brought Much Needed Attention to Improving Sepsis Care…But Now Is the Time to Improve SEP-1. Crit Care Med. 2020 Jun;48(6):779-782. doi: 10.1097/CCM.0000000000004305. PMID: 32433077; PMCID: PMC8300864.

that hospitals may undertake, as the reporting alone requires significant resources and expertise. The measure has undergone frequent updates, which has led to confusion and challenges. Frequent updates require hospitals to make changes to the EHR to reflect the measure specification changes and educate staff, which requires significant resources.

Ideally, electronic process measures for sepsis that clearly impact outcomes will be developed and replace this chart abstraction measure. Organizations are committed to improving sepsis care but much of the quality improvement resources are dedicated to reporting, leaving little-to-no resource capacity for actual improvement.