MHA Michigan Health & Hospital Association | Leading Healthcare

June 9, 2023

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

Via electronic submission

RE: CMS-1785-P, Centers for Medicare and Medicaid Services Proposed Rule for the Calendar Year (CY) 2024 Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes

Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2024. This proposed rule would revise the Medicare IPPS for operating and capital-related costs of acute care hospitals, make changes to Medicare graduate medical education (GME), and make other policy changes. Please note, the MHA will provide separate comments for inpatient hospital services provided by long-term care hospitals.

The MHA is concerned about the inadequate proposed increase for FY 2024 given the historical inflationary increases hospitals are facing in labor, equipment, supplies and drug costs. Recent years have been the most financially challenging for hospitals experiencing negative operating margins. The proposed rule is estimated to provide an overall increase to Michigan hospitals of $55 million, or 1.7%, when all proposed changes are considered, which is significantly lower than the 4% increase in health care inflation for 2022 based on the United States (U.S.) Inflation Calculator. Without substantial support in the final rule, hospitals will struggle to maintain critical and essential services to their communities. **We urge the CMS to evaluate the negative inflationary impacts on healthcare and appropriately support hospitals in the final rule.**

PAYMENT UPDATES

After the proposed 3% market basket update less a productivity adjustment of 0.2 percentage points, and budget neutrality adjustments, the net rate update is 2.3% for hospitals in compliance with the inpatient quality reporting program (QRP) and electronic health record meaningful use requirements. When other policy proposals are considered, such as the decrease in uncompensated care payments (UCP) and new technology add-on payments (NTAPs), the proposed rule is estimated to result in only a 1.7% increase for Michigan hospitals. **The MHA recommends the CMS eliminate the 0.2 percentage point productively cut for FY 2024. We also recommend that the CMS provide a higher update to recognize the extraordinary inflation faced by providers.** Our recommendations more accurately recognize and address inflationary pressures hospitals face and would lessen the financial challenges hospitals face unwinding from the COVID-19 public health emergency (PHE).

The CMS provided an additional payment for new COVID-19 Treatments Add-on Payment (NCTAP) during the federal PHE, with these payments set to end Sept. 30, 2023. The NCTAPs for drugs and biological products used for the treatment of COVID-19 helped mitigate financial challenges for hospitals for COVID-19 treatment during the PHE. **The MHA recommends the CMS continue the NCTAP payments through Dec. 31, 2023, to provide financial assistance for COVID-19 treatments as hospitals navigate the PHE unwinding.**

WAGE INDEX

A. **Permanent Cap on Wage Index:** To reduce large swings in year-to-year wage index changes and increase the predictability of IPPS payments, the CMS adopted a policy to apply a 5% cap on any decrease of the wage index, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. However, consistent with the MHA comments regarding the FY 2023 proposed rule, **the MHA objects to the CMS implementing this policy in a budget-neutral manner through a reduction to the standardized operating rate which reduces operating payments to all hospitals. We urge the CMS to fund this policy initiative using separate and additional funds.**

A. **Rural Floor Wage Index:** In the FY 2023 IPPS final rule, the CMS reversed the policy to exclude hospitals redesignated as rural from the calculation of the statewide rural floor wage index. As a result, the state's rural floor is now equal to its rural wage index. In the FY 2024 proposed rule, the CMS proposes to treat urban hospitals redesignated as rural the same as geographically rural hospitals for the wage index calculation. This proposal will result in significant fluctuations in wage index in states where there are numerous hospital reclassifications and is estimated to negatively impact payments to Michigan hospitals by $16 million under the proposed methodology. The wage data from urban health systems redesignated to rural would be included in the rural wage index and payments to Michigan hospitals would be less under the proposed rule compared to maintaining the current methodology for calculating the rural floor wage index. **The CMS must provide new funding for this policy to support rural hospitals and those that redesignate as rural in a manner that is not budget neutral and does not negatively impact other hospitals.**

B. **Low Wage Areas – Bottom Quartile:** The CMS made changes in the FY 2020 IPPS rule to address wage index disparities between high and low wage index hospitals. The area wage index (AWI) is used to adjust Medicare operating and capital payments for geographic variations in labor costs. For FY 2020 through 2024, the CMS proposed to reduce disparities in the Medicare AWI among hospitals that have a low AWI value by increasing the AWI for hospitals in the bottom quartile funded by a decrease in the national standardized operating rate for all hospitals. Based on current data for FY 2024, hospitals with a wage index below 0.8615 fall into the bottom quartile and are eligible for an increase of half the difference between the otherwise applicable wage index value. This policy change is subject to pending litigation, (Bridgeport Hospital, et al., v. Becerra), in which the court found that the Secretary did not have the authority to adopt this low wage index policy and ordered additional briefing for an appropriate remedy. There is currently only one year of data available, FY 2020, to analyze the policy impact and develop a potential remedy, and therefore the CMS is proposing to continue the low AWI policy that increases the bottom quartile AWI hospitals by half of the difference between the hospital's pre-adjustment wage index and the bottom quartile wage index value across all hospitals. The MHA appreciates the CMS' recognition of hospitals with low wage rates and fully supported past policy that utilized new funds to support frontier states with an increase in the AWI to 1.0. We believe that the CMS could implement a similar solution for low AWI hospitals. **The MHA supports improving the wage index for hospitals with low wage rates, especially in rural areas, but the MHA opposes the CMS' proposed improvement of AWI values for some**

hospitals funded by a reduction to the standardized operating rate for all hospitals. The MHA urges the CMS to fund this policy using additional new funds.

HIGH-COST OUTLIER THRESHOLD

The CMS proposes increasing the outlier threshold by 4.8%, from $38,859 to $40,732, which will result in fewer cases qualifying for an outlier payment. The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case, which is designed to protect the hospital from large financial losses due to unusually expensive cases. The MHA is concerned about the proposed increase in the high-cost outlier threshold, especially following the 25.4% increase last year. **The MHA requests the CMS explain in greater detail the factors driving the increase and that the CMS examine its methodology and consider making changes to mitigate increases to the outlier threshold when hospitals are treating higher acuity patients stemming from patients delaying care over the last several years.**

DISPROPORTIONATE SHARE HOSPITALS (DSH) AND UNCOMPENSATED CARE (UCC) PAYMENTS

The Affordable Care Act (ACA) changed the formula for Medicare disproportionate share hospital (DSH) payments, with 25% being paid under the traditional, empirical formula and 75% being paid under the new uncompensated care (UCC) pool. The UCC pool amount is adjusted annually based on the number of uninsured individuals. The UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals. The CMS projects that Medicare DSH payments and Medicare UCC payments combined will decrease by approximately $115 million nationally for FY 2024. If adopted, the total DSH and UCC Medicare payments to Michigan hospitals are estimated to decrease approximately $4.4 million or 2%.

The MHA objects to these cuts and is particularly concerned that vulnerable patients will lose healthcare coverage as states begin the Medicaid redetermination process and disenroll Medicaid beneficiaries. The DSH and UCC Medicare payments support hospitals that provide a disproportionate share of vulnerable, low-income patients. **The MHA requests the CMS support these hospitals by maintaining DSH and UCC Medicare payments which will help ensure hospitals maintain access and continue providing services to the most vulnerable patients.**

PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

The Consolidated Appropriations Act of 2023 extended the low-volume hospital adjustment criteria established in the Bipartisan Budget Act of 2018 through FY 2024, by allowing more hospitals to qualify for the adjustment with modified criteria of being located more than 15 miles from another subsection (d) hospital and having fewer than 3,800 Medicare discharges during the fiscal year. Beginning in FY 2025, without additional legislative action to extend the low-volume hospital eligibility criteria and adjustment will revert to more stringent requirements that were in effect prior to FY 2011. These payments provide vital support to small, rural hospitals and **the MHA requests the CMS permanently adopted the low-volume hospital criteria and payments established by the Consolidated Appropriations Act of 2023.**

FULL RESTORATION OF THE AMERICAN TAXPAYER RELIEF ACT DOCUMENTATION AND CODING OFFSET

The CMS implemented a 0.8% cut to the annual market basket update in FYs 2014-2016 to recoup the effect of documentation and coding changes that the agency believed did not reflect real changes in patient acuity. For FY 2017, the CMS increased this cut from 0.8 percentage points to 1.5 percentage

points to achieve the $11 billion targeted by the American Taxpayer Relief Act (ATRA). In total, these cuts reduced hospital inpatient payments by 3.9%. The CMS mandated a positive 0.5% adjustment for each year from FY 2018 through FY 2023 to offset the previous recoupment. The 21st Century Cures Act subsequently reduced the FY 2018 "add-back" from 0.5% to 0.4588%. Cumulatively after all negative and positive adjustments, hospitals will have a permanent payment reduction of approximately 1%. **The MHA urges the CMS to restore the full 3.9% previously withheld from hospitals.**

UPDATES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRGS)

A. **Application of the non-complication or comorbidity (CC) subgroup:** The CMS is proposing to continue delaying the application of a new non-CC subgroup to existing MS-DRGs. In the FY 2021 final rule, the CMS created a new non-CC subgroup to existing MS-DRGs but delayed the application in both FY 2022 and FY 2023. **The MHA supports the CMS proposed delay in expanding the non-CC subgroup criteria to existing MS-DRGs for FY 2024.** Implementing the expanded criteria to include CC or major complication or comorbidity (MCC) within an MS-DRG would result in approximately 45 base MS-DRGs being deleted.

B. **MS-DRG Weight Cap Policy:** To mitigate financial impacts due to significant fluctuations, beginning FY 2023, the CMS adopted a permanent 10% cap on reductions to a MS-DRG's relative weight each year compared to the weight in the prior year, implemented in a budget neutral manner. **The MHA urges the CMS to fund this policy for FY 2024 with additional new funds rather than through a budget-neutrality reduction to the standardized operating rate.**

PAYMENTS FOR INDIRECT AND DIRECT GRADUATE MEDICAL EDUCATION COSTS

The CMS pays hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs based on the number of full-time equivalent (FTE) residents the hospital trains. The Consolidated Appropriations Act of 2021 established rural emergency hospitals (REHs) as a new Medicare provider type, effective Jan. 1, 2023. To support REHs and resident training in rural settings, the CMS is proposing for cost reporting periods on or after Oct. 1, 2023, a hospital may include FTE residents training at a REH in its GME and IME FTE counts. **The MHA supports the CMS counting REH residents for GME and IME payment purposes and requests the CMS pay for the resident training at 101% of the reasonable cost under section 1861(v) of the Social Security Act, which would align with critical access hospitals payments based on reasonable cost principals.** Providing GME and IME payments to REHs will support increasing access to physicians in rural areas.

HOSPITAL QUALITY PROGRAMS

A. **Hospital Value-Based Purchasing (VBP) Program**: The hospital VBP program is designed to reward hospitals that make quality of care and hospital stay experience better for patients. The program is budget-neutral and withholds 2% of base operating payments from eligible hospitals and distributes those funds to eligible hospitals based on program performance. Hospitals are scored on 20 measures across 4 domains and may earn 2 scores for each measure – one for achievement and one for improvement. The CMS proposes to modify the Medicare Spending per Beneficiary (MSPB) measure and the elective total hip arthroplasty (THA) and total knee arthroplasty (TKA) complication measure; add one new measure, severe sepsis and septic shock management bundle beginning FY 2026; and change the scoring policy to include health equity for the Healthcare Providers and Systems (HCAHPS) survey. **The MHA fully supports implementing quality and safety guidelines for screening septic patients but urges the CMS to reevaluate the severe sepsis and septic**

shock management bundle due to the variability in sepsis identification and the administrative burden hospitals undergo in manually processing the measure.

Starting in FY 2026, the CMS is proposing to establish performance standards to reward hospitals for excellent care in underserved populations. Hospitals would be measured by the new health equity adjustment points, which intends to measure hospitals total performance score and the hospitals proportion of dual eligible patients. Depending on the hospital's performance in the top, middle or bottom performance of all hospitals within a domain, the hospital would be awarded a measure performance scaler score of 4, 2, or 0 points, respectively, with a maximum potential of 16 points. The heath equity adjustment bonus points would be calculated by the measure scaler score multiplied by the 'underserved multiplier'. The CMS did not provide adequate details on how the underserved multiplier was calculated. The MHA requests the CMS clarify how the underserved multiplier was calculated by answering the following questions:

- **What is the logistic exchange function that will be used to calculate the underserved multiplier used in the health equity adjustment for VBP proposed to begin FY 2026?**
- **Separately, will the CMS recalculate the linear exchange function slope after the total performance scores are adjusted by health equity adjustment bonus points or will the points be a bonus and therefore the linear exchange function will remain the same (and the program will no longer be budget neutral)? The MHA opposes any change that would reduce aggregate payments to hospitals.**

B. **Hospital Readmissions Reduction Program (HRRP):** Hospitals in the HRRP are subject to penalties of up to 3% of base operating payments for all Medicare FFS discharges if they have excess readmissions for six common conditions and procedures. The six conditions and procedures remain unchanged for FY 2024 and include acute myocardial (AMI), heart failure (HF), pneumonia (PN), THA/TKA complication, chronic obstructive pulmonary disease (COPD), and coronary artery bypass surgery (CABG). There are no proposals or updates in the proposed rule for HRRP, but **the MHA encourages the CMS to evaluate and expand social risk adjustments to decrease annual readmission penalties.** Research has repeatedly indicated that hospital readmission rates are significantly impacted by social needs that hospitals alone cannot control including access to primary care, home health and rehabilitation services in the community, transportation options that enable patients to go to follow up appointments and adequate access to nutritious foods.

C. **Hospital-Acquired Condition (HAC) Reduction Program:** Hospitals in the worst performing quartile are subject to a 1% payment reduction under the HAC Reduction Program. There will be no COVID-19 measure suppression for the FY 2024 and beyond for the HAC reduction program. The CMS does not propose any additions or removals from the current measure set, which includes 6 measures:

- Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (CBE 0138);
- Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (CBE 1717);
- Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (CBE 0139);
- Colon and Abdominal Hysterectomy Surgical Site Infection (SSI) Outcome Measure (CBE 0753);
- Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia Outcome Measure (CBE 1716); and
- The CMS PSI 90 measure (CBE 0531).

The MHA remains concerned about the ongoing use of the PSI 90 measure in federal programs and is not confident it adequately measures quality or provides value to healthcare providers to improve

performance. **The MHA urges the CMS to entirely phase out the use of the PSI 90 measure in federal programs.**

The MHA also continues to have concerns about the use of the same measure in multiple programs. For example, CAUTI, CLABSI and MRSA are used in both the VBP and HAC reduction programs and it is inappropriate for a hospital to be penalized twice.

D. **Hospital Inpatient Quality Reporting (IQR) Program:** The CMS is proposing to add 3 new measures to the IQR program beginning with the calendar year (CY) 2025 reporting period and the FY 2027 payment determination.
   - Hospital Harm – Pressure Injury electronic clinical quality measures (eCQM);
   - Hospital Harm – Acute Kidney eCQM; and
   - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level-Inpatient eCQM).

   The MHA opposes the CMS' proposal to increase the number of eCQMs. The MHA is supportive of the CMS' goal to improve quality of care, however we don't believe the timing post-COVID-19 is appropriate for additional measures. Furthermore, while we understand the CMS' desire to incrementally ramp up eCQM reporting requirements to advance digital quality measurement, competing demands for limited hospital quality and health IT resources make increasing the number of eCQMs required for reporting unrealistic at this time. The MHA is concerned that many hospitals will face an untenable situation in which they could lose their entire annual payment update — one quarter for the IQR, and three quarters for the Promoting Interoperability Program — for failing to meet an eCQM mandate that neither they nor their EHR vendors can meet because of other competing federal quality reporting and EHR-related mandates.

E. **Adopt the Up-to-Date COVID-19 Vaccination Among Healthcare Personnel Measure:** The current measure assesses the number of healthcare personnel who have received a complete vaccination course against COVID-19. The CMS is proposing to modify the COVID-19 Vaccination Coverage among Healthcare Personnel measure to replace the term *complete vaccination course* with *up to date* in the measure definition. The MHA supports vaccination as a means of keeping both staff and patients safe and applaud the CMS' efforts to ensure all healthcare providers are up to date on vaccinations but have concerns regarding this measure. This measure – while well-intentioned – will likely have unintended consequences.

   The CDC maintains different definitions for *up to date* and *fully vaccinated*, and the differences in these definitions and could be misreported and give the public a misleading picture of a facility's vaccination rate. The CDC maintains guidance that receiving a dose of COVID-19 vaccine may or should be delayed if a person has or has recently had COVID-19 infection. This could impact the timing of an employee's vaccine dosage, resulting in an inaccurate reporting of employees up to date on vaccination.

   We agree that the constantly changing definition of up to date is challenging and voluntary reporting of healthcare providers who are up to date has proven logistically challenging. Currently most hospitals and health systems only require the initial vaccination series. Given the current workforce shortage, implementing additional requirements on the healthcare workforce will exacerbate this already challenging situation. Although this measure is not a mandate, it will impact how health care systems and providers approach vaccination requirements. It will particularly impact entry-level workers who can choose between working in healthcare or working in other industries without those

requirements. For example, this requirement would likely have a negative impact on attracting environmental services and food service employees.

The MHA opposes the proposed modification to the COVID-19 vaccination among healthcare personnel measure and urges the CMS to not finalize the modified measure.

F. **Health Equity and Social Determinants of Health (SDOH):** In the FY 2023 proposed rule, the CMS requested information related to SDOH codes found in diagnosis categories Z55 – Z65 and continues to solicit feedback on health equity and SDOH. For FY 2024, the CMS is proposing to change the severity level for the following codes regarding homelessness from non-CC to CC.

- Z59.00 – Homelessness, unspecified
- Z59.01 – Sheltered homelessness
- Z59.02 – Unsheltered homelessness

The MHA supports the CMS in updating homelessness z-codes from non-CC to CC and strongly supports the CMS' continuing efforts to address inequities in healthcare. The MHA and its member hospitals are committed to addressing racism and health inequities and worked with the Michigan Department of Licensing and Regulatory Affairs (LARA) to ensure that any new licensing rules related to implicit bias training are consistent with the MHA membership vision and efforts. As part of these efforts, the MHA worked with LARA on implicit bias training for all healthcare staff and is currently helping healthcare providers meet this new educational requirement. **The MHA and its member hospitals are committed to supporting members in advancing health equity and addressing SDOH.** Launched in 2020, 134 Michigan hospitals and health systems signed the MHA Pledge to Address Racism and Health Inequities indicating a unified commitment to addressing disparities, dismantling racism, and achieving health equity. With that commitment in mind, over 74% of members have completed the Health Equity Organizational Assessment (HEOA) designed to provide strategies that support the organization's ability to identify and address disparities. Furthermore, to drive action, the MHA launched a member-wide Health Equity Task Force which will provide guidance in identifying and addressing priorities and key interventions using quality improvement as a lens for tackling health and healthcare disparities.

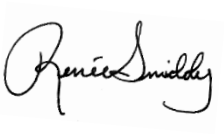
The MHA and Michigan hospitals share the CMS' commitment to advancing health equity within our organizations and the communities served. We believe that there is a role for health equity-related measures in the CMS' quality measurement programs. As the CMS continues to develop health equity policy related to quality measurement and the use of data, we offer the following recommendations to guide the CMS' efforts:

- Focus hospital health equity measures on hospital-level practices and data;
- Employ approaches to accountability that promote collaboration, not competition;
- Ensure any health equity-related measures are appropriately specified and tested before implementation;
- Establish feedback loops to ensure health equity quality measures keep up with evolving practices in the field and measurement science;
- Work to foster alignment and standardization of approaches to collecting analyzing and exchanging demographic and social risk data;
- Prioritize the use of extant data to which the CMS itself may already have access before considering new data reporting requirements.

SUMMARY

The MHA appreciates the opportunity to provide comments to the CMS on the FY 2024 IPPS proposed rule and believe our proposed changes will have a positive impact on both providers and patients. If you have questions regarding this comment letter, please contact me at rsmiddy@mha.org.

Sincerely,



Renée S. Smiddy
Senior Director, Finance Policy