June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Submitted electronically

RE: CMS-1771-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation: Proposed Rule (Vol. 87, No. 90), May 10, 2022.

Dear Administrator Brooks-LaSure:

On behalf of our 31 member hospitals, the New Hampshire Hospital Association (NHHA) appreciates this opportunity to address the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2023. Our comments presented in this letter are similar to those presented by the American Hospital Association (AHA). In general, NHHA supports the American Hospital Association's (AHA) detailed comments.

We support a number of the inpatient PPS (IPPS) proposed rule's provisions, such as those related to the full-time equivalent cap calculation in the graduate medical education (GME) program and the cap on area wage index decreases. We also support several aspects of CMS's quality-related proposals, including additional steps to recognize the ongoing impact of the COVID-19 pandemic on its programs, and important steps to advance health equity.

At the same time, we have strong concerns about the proposed payment updates, which, together with the rule's policy changes, would result in a net decrease in payments to IPPS hospitals in FY 2023 compared to FY 2022.

In particular, we are deeply concerned about the inadequacy of the proposed market basket update given the extreme inflationary environment in which we continue to operate. As such, we strongly urge CMS to utilize its authority to

provide a market basket adjustment to account for the unexpected and persistent increase in inflation. We also are concerned about the agency's proposed cuts to disproportionate share hospital (DSH) payments and the lack of transparency in the underlying calculations. Additionally, we are concerned about the dramatic increase in the proposed high-cost outlier threshold. Finally, we have concerns about several of the agency's quality-related proposals. A summary of our key recommendations follows.

IPPS Payment Update

CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, combined with the FY 2022 payment update hospitals received last year for IPPS, are woefully inadequate and do not capture the unprecedented inflationary environment hospitals and health systems are experiencing.

The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems. Health care providers remain on the front lines fighting this powerful virus, while at the same time struggling with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic. We urge CMS to consider the changing health care system dynamics, including those described below, and their effects on hospitals. Taken together, these shifts in the health care environment are putting enormous strain on hospitals and health systems, which will continue in FY 2023 and beyond.

Fannie Mae forecasts that inflation will remain elevated through at least the end of 2022, averaging 5.5% in the fourth quarter of the calendar year.[1] Because this high rate of inflation is not projected to abate in the near term, it is critical to account for it when considering hospital and health system financial stability in FY 2023 and beyond. More recent inflationary pressures are also likely to work their way into wage expectations, particularly in industry sectors such as health care where labor is in short supply, thus driving up labor costs even further.

Indeed, the financial pressures hospitals are experiencing are massive. Expenses continue to rise across the board, with hospitals facing increasing costs for labor, drugs, purchased services, personal protective equipment (PPE), and other medical and safety supplies needed to care for patients.

Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update is essential to ensure that Medicare payments for acute care services accurately reflect the cost of providing hospital care. Therefore, **we urge CMS to use its "special exceptions and adjustments" authority to make a**

[1] Fannie Mae. April 19, 2022. Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'. https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and- threatens-soft-landing

retrospective adjustment to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022.

The NHHA has deep concerns about the proposed productivity cut, given the extreme and uncontrollable circumstances in which hospitals and health systems are currently operating. As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2023. It is clear that significant uncertainty will continue to persist regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions and the war in Ukraine) continue to affect productivity. This uncertainty, as well as the continued divergence in hospital productivity from overall private nonfarm business sector productivity, should be accounted for in the FY 2023 payment update.

Disproportionate Share Hospital (DSH) Payments

The NHHA continues to be concerned about the agency's lack of transparency with regard to how it is calculating DSH payments. **Specifically, we disagree with the agency's estimates of both the inpatient discharge volume for FY 2023 and the number of uninsured.** For instance, signs of volume recovery are emerging and it is clear that a large increase in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions being to unwind. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate.**

High-cost Outlier Threshold

We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven an increase in the high-cost outlier threshold. However, we remain concerned about the dramatic scale of the proposed change — a 39% increase from the FY 2022 threshold. **We ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.**

Permanent Cap on Wage Index Decreases

For FY 2023, CMS now is proposing to permanently adopt a 5% cap on all wage index decreases each year, regardless of the reason, in a budget neutral manner. The NHHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control. This proposed policy would increase the predictability of IPPS payments for hospitals and we are pleased the agency would make it permanent, as was urged last year. That said, we maintain that budget neutrality is not a requirement of the statute that provides CMS the authority to implement this policy. We continue to urge CMS to apply this policy in a non-budget neutral way.

Medicare Dependent Hospital (MDH) Program

Under current law, the MDH program is set to expire Sept. 30, 2022. Providers under the MDH program serve rural Americans and are more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment. The NHHA supports making the MDH program permanent through H.R.1887/S.4009. Additionally, we also support the additional base year that hospitals may choose for calculating MDH payments to provide more flexibility for these hospitals to provide care for their patients.

In the proposed rule, CMS reiterated its policy that allows MDHs to apply for Sole Community Hospital (SCH) status and be paid as such under certain conditions, following the expiration of the MDH program. Hospitals wishing to apply for SCH status must apply at least 30 days before the end of the MDH program, or by September 1, 2022, in order for SCH status to be effective upon expiration of the MDH program. The NHHA supports this policy.

However, the possibility remains that Congress may extend the MDH program retroactively, after it expires on October 1, 2022. To account for this distinct possibility, we ask that CMS provide hospitals with the ability to, in turn, rescind their new SCH status retroactively and reinstate their MDH status in a seamless manner, if a retroactive extension to the MDH program is made. Such an allowance would be extremely helpful for these hospitals, which are facing an unreasonably uncertain future of Medicare inpatient payments.

Health Equity

Consistent with hospitals and health systems' steadfast commitment to advancing health equity, the NHHA is pleased to support the addition of health equity-related measures to the inpatient quality reporting (IQR) program. At the same time, we offer several recommendations to ensure the measures are meaningful, feasible, and accurate and achieve their critically important objectives. This includes providing more specific implementation guidance on and revising the scoring methodology of the Hospital Commitment to Equity Measure. We also ask that CMS adopt its proposed health related social needs screening measures for voluntary reporting for now, and revisit a date for mandatory reporting after it has assessed the first year of voluntary reporting.

The NHHA also thanks CMS for recognizing the continued disruption posed by the COVID-19 public health emergency (PHE) on its quality measurement and value programs, and support CMS's proposals not to penalize hospitals under the Hospital Value-Based Purchasing and the Hospital-Acquired Condition Reduction Program for FY 2023. However, the NHHA has significant concerns about several of CMS's proposed new quality measures, and urges CMS to reconsider their implementation. In addition, we object to the heavy-handed proposed use of Conditions of Participation (CoP) to compel

data reporting for COVID-19 and future PHEs, and instead urge CMS to work with hospitals to obtain needed data in a more collaborative and sustainable fashion.

The NHHA's opposition to the use of CoPs to compel reporting should not be construed as an unwillingness to share important data on the COVID-19 pandemic with the federal government. In fact, the evidence is clear that hospitals were more than willing to voluntarily report important COVID-19 data to the government. The NHHA understands the potential need for the federal government to continue to have some key data elements on the status of COVID-19 even after the PHE ends. We believe the optimal approach to obtaining these data would be to:

- Let the COVID-19 data reporting CoP expire at the end of the PHE, and re-establish HHS's voluntary mechanism to collect COVID-19-related data;
- Retain the reporting guidance, portals and process that HHS has already established so that hospitals still have a usable mechanism to share data with the government; and
- Streamline the number of requested data elements and reduce the frequency of reporting.

If CMS is intent on retaining its COVID-19 data reporting CoP, our recommendations around reporting process and streamlining data elements would still apply. We encourage CMS and HHS to engage hospitals and health systems in a dialog about how frequently data would be needed to monitor COVID-19 status, and what data elements would be necessary. At a minimum, we believe reporting frequency could be reduced to weekly, and perhaps even to every other week or monthly. Furthermore, we believe that most of the data fields around supplies could be sunset.

We appreciate your consideration of these issues. Our detailed comments are attached. For more information or questions about this document, please contact Brooke Belanger, Vice President, Financial Policy & Compliance at bbelanger@nhha.org or (603) 415-4253.

Sincerely,

Steve Ahnen

Steve Ahnen
President