



A Passionate Voice for Compassionate Care

June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1808-P

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Brooks-LaSure:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule published in the *Federal Register* on May 2, 2024 (89 FR 35934). We appreciate the ongoing efforts of CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **Proposed Changes to Payment Rates under the Inpatient Prospective Payment System (IPPS)**

CMS is proposing to update hospital IPPS rates by 2.6 percent in fiscal year (FY) 2025. This rate update equals the hospital market basket of 3.0 percent less 0.4 percentage points for total factor productivity.

CHA believes that CMS should adjust the FY 2025 hospital update for forecast error in the FY 2021 through FY 2023 hospital market baskets. In each of these years, the difference between the hospital market basket used for the update and actual increase exceeded 0.5 percentage points. **For FY 2022 alone, the understatement was 3.0 percentage points.** The combined understatement of the update in these three years was 4.3 percentage points as shown in the below table:

IPPS Market Basket	FY 2021	FY 2022	FY 2023	Total
Forecast Used in the Update	2.4	2.7	4.1	
Actual Based on Later Utilization	3.0	5.7	4.8	
Difference	-0.6	-3.0	-0.7	-4.3

For the Skilled Nursing Facility (SNF) prospective payment system (PPS) update, CMS makes an adjustment for forecast error where the difference between update applied and the actual increase in the market basket exceeds 0.5 percentage points.¹ **Consistent with CMS’ policy for the SNF PPS, CHA requests that CMS adjust for forecast error in the FY 2021 through FY 2023 IPPS market baskets as forecast error exceeded 0.5 percentage points in each of these years.**

The combined 4.3 percentage point understatement of the FY 2021 through FY 2023 market basket results in a permanent reduction in IPPS payments below the rate of inflation. To avoid this permanent reduction in IPPS payments below the rate of inflation, CMS must make an adjustment for forecast error consistent with the policy it has adopted under the SNF PPS.

CHA believes the extraordinary circumstances of the pandemic and the large difference between the FY 2021 through FY 2023 updates and the market basket justify CMS making a 3.0 percentage point adjustment to the FY 2025 hospital market basket update.

- **Documentation and Coding**

For the first time in many years, CMS makes no mention of the documentation and coding adjustment that has been applied to the IPPS standardized amounts annually since FY 2008 to recoup additional spending due to documentation and coding that resulted from implementation of the MS-DRGs. Once the recoupment was complete, CMS was required to restore IPPS rates to what they would have otherwise been had CMS not made the recoupment adjustments from FY 2018 through FY 2023 under the provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) and the 21st Century Cures Act. Since FY 2014, CMS had made recoupment adjustments to IPPS rates totaling 3.9 percent. However, CMS only restored 2.9588 percentage points of these reductions, falling short by — 0.9412 percentage points.

CMS is required by law to restore this 0.9412 percentage point difference between the recoupment adjustments it has made and the amounts restored to the IPPS standardized amounts since FY 2018. Section 7(b)(2) and 7(b)(4) of the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (TMA)—as subsequently amended by the Taxpayer Relief Act of 2012, MACRA and the 21st Century Cures Act—are explicit that CMS may not carry forward any documentation and coding adjustments

¹ 89 Federal Register (FR), 23428, April 3, 2024

applied in fiscal years 2010 through 2017 (excepting FY 2013, where the issue is not applicable) into IPPS rates after FY 2023.

Section 7(b)(2) of the TMA states “an adjustment made under paragraph (1)(B) [documentation and coding] for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges in a subsequent year.” Section (7)(b)(4) of the TMA is explicit as to the particular years in question where documentation and coding adjustments have been applied and for which years they may not be carried forward:

Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) [documentation and coding] other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.”

CHA respectfully requests that CMS restore the full amount of the documentation and coding recoupment adjustments in the FY 2024 IPPS final rule as is required under section (7)(B)(2) and (4) of the TMA.

In the FY 2025 IPPS final rule CMS rejected this comment, stating, “we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023.” This statement, although true, is irrelevant to the point CHA and many other commenters have made.

It is the TMA that is relevant to whether any documentation and coding adjustments made in the past may be carried forward into future years after FY 2023. MACRA and the 21st Century Cures Act provisions specify the adjustments for FYs 2018 through 2023 but it is the TMA that says any adjustments made from FYs 2010 through FY 2017 may not be carried forward into years beginning with FY 2024. **CHA requests that CMS analyze this comment again and incorporate a +0.9412 adjustment to the IPPS rates to avoid a permanent understatement of IPPS rates and the potential for future litigation on this point from others in the hospital community.**

- **Proposed Change to the Severity Level for Homelessness**

Under the MS-DRGs, designation of a secondary diagnosis code as a complication or comorbidity (CC) or a major complication and comorbidity (MCC) signifies increased resource use for the patient. Accordingly, if a CC or MCC is coded on the inpatient claim, CMS will classify the patient into a higher paying MS-DRG.

CMS requested public comments in the FY2023 proposed rule on Social Determinants of Health (SDOH) diagnosis codes that are most likely to increase hospital resource utilization for inpatient care. CMS noted that homelessness is one of the more frequently reported codes that describe a SDOH and the presence of these diagnosis codes signify higher patient care costs. In the FY

2024 IPPS rule, CMS’ changed the Z codes for homelessness, unspecified (Z59.00), sheltered homelessness (Z59.01) and unsheltered homelessness (Z59.02) from a non-CC to a CC.

For the current proposed rule, CMS reviewed data on the impact on resource use for seven Z codes related to inadequate housing/housing instability:

ICD-10-CM SDOH for Inadequate Housing/Housing Instability		
ICD-10-CM Code	Description	Total Count of Discharge Claims with the Secondary Diagnosis
Z59.10	Inadequate housing, unspecified	227
Z59.11	Inadequate housing environmental temperature	74
Z59.12	Inadequate housing utilities	162
Z59.19	Other inadequate housing	987
Z59.811	Housing instability, housed, with risk of homelessness	165
Z59.812	Housing instability, housed, homelessness in past 12 months	141
Z59.819	Housing instability, housing unspecified	1,237

CHA is a strong proponent of, and our members actively engage in, screening for and addressing social determinants of health. Our members track and analyze the use of Z codes and report that homelessness is one of the most commonly used. Many are actively engaged in a variety of efforts to identify and serve patients experiencing homelessness and housing instability. More accurate coding, incentivized through appropriate reimbursement policy, can lead to better understanding of the needs of the patients and communities we serve.

These seven codes are currently designated as NonCCs, when reported as a secondary diagnosis. CMS proposes to change the severity level designation for the seven inadequate housing/housing instability to CC. **CHA supports CMS’ proposal to change these seven Z codes from non-CC to CC.**

- **Changes to the Wage Index**

Low Wage Index Policy

Beginning in FY 2020, CMS began increasing the wage index values for hospitals with a wage index in the lowest quartile by one-half the difference between a low wage index hospital’s wage index and the 25th percentile. This policy was intended to allow low-wage hospitals to use the higher wage index to increase hospital wages that will then become part of the low-wage hospital’s succeeding fiscal year’s wage index. As there are four years between the data year and the payment year used for the wage index, CMS was intending to keep this policy in place for four years.

In last year’s final rule, CMS extended the low wage index policy for one additional year on the basis that it only had one year of data upon which to make a determination of the policy’s

success. CMS is now proposing to extend the low-wage index policy for an additional four years because the effects of COVID-19 PHE funding received by hospitals complicate its ability to determine whether low wage hospitals have been provided a sufficient opportunity to increase employee compensation.

CHA supports CMS extending its low-wage index policy for an additional three years. CHA believes it is appropriate for CMS to analyze revisions to the wage index as concerns about the equity and accuracy of the index have long been documented. **We urge CMS to implement the low-wage hospital policy in a non-budget neutral manner.**

Revisions to Labor Market Areas

CMS is proposing to make significant changes to labor market areas in light of Office of Management and Budget (OMB) changes to core-based statistical area (CBSA) delineations based on the 2020 Census. Changes to the labor market delineations may have significant impacts on hospital wage indexes, geographic reclassifications being requested by hospitals and other policies. CMS states it is generally following the same practices for handling these issues as it has for earlier revisions to the labor market areas based on revised OMB CBSA delineations.

CMS proposes to continue for FY 2025 the policy it adopted last year to cap all wage index decreases at 5 percent, regardless of the reason for the decrease. CHA supports extending the 5 percent cap policy but urges CMS to apply it in a non-budget neutral manner. CMS notes it is not proposing a transition period for implementing the new CBSA delineations because the 5 percent cap will apply to any resulting wage index decrease. CHA appreciates the extension of the 5 percent cap policy and its application to mitigate potential negative effects of the CBSA delineations.

Rural Hospitals Becoming Urban. Critical Access Hospitals (CAHs) in rural counties becoming urban will be given a two-year period to apply for an urban to rural reclassification in order to maintain CAH status. However, CMS urges Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) in rural counties becoming urban to apply for urban to rural reclassification prior to the October 1, 2024 effective date of the IPPS rule in order to maintain their special status. **CHA agrees with CMS proposal to provide CAHs with two years to apply for urban to rural reclassification to maintain CAH status and urges CMS to adopt the same policy for MDHs and SCHs.**

Urban Hospitals Becoming Rural. When an urban hospital becomes rural, its DSH payments are affected. Existing regulations will result in a phase-down of any reductions in DSH payments to a hospital in this situation over three years where payment is based on 2/3 of the urban DSH adjustment and 1/3 of the rural adjustment in the first year; 1/3 of the urban DSH adjustment and 2/3 of the rural adjustment in the second year and 100 percent of the rural DSH adjustment in the third year. **CHA agrees with this policy.**

- **Disproportionate Share Hospitals (DSH) and Uncompensated Care Payments**

Uncompensated Care Payments

Hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The hospital's uncompensated care payment will equal its share of total uncompensated care costs using Worksheet S-10 of the Medicare cost report.

CMS estimates that the amount available to distribute as uncompensated care will increase from \$5.9 billion in FY 2024 to \$6.4 billion in FY 2025, an increase of 9.4 percent or \$560.1 million.

While CHA supports increasing the uncompensated care payment by at least \$560.1 million, we believe the proposed rule does not fully account for the effect of Medicaid disenrollment in the wake of the end of the COVID-19 public health emergency and has underestimated the uninsured rate for FY 2025. CMS uses projections from the latest National Health Expenditure Accounts (NHEA) historical data, which accounts for expected changes in enrollment across several categories of insurance coverage, including Medicaid. NHEA projected that in 2024 the uninsured population would increase by a growth rate of 11 percent and by an additional 4.2 percent in 2025. Additionally, NHEA projects that there would be a significant 8.9 percent drop in Medicaid enrollment in 2024 and continued declines in Medicaid enrollment of 0.7 percent in 2025.² CMS itself projects even steeper decreases of 13.9 percent in FY 2024 and 4.3 percent in FY 2025.³ According to the Kaiser Family Foundation, over a quarter of people disenrolled from Medicaid are uninsured.⁴ The calculation of aggregate uncompensated care, once determined, is not changed to reflect subsequent updates to the data sources once the rule is finalized. For this reason, it is critical that CMS' estimates accurately reflect the latest information available.

CMS indicates that it intends to use more recent data that may become available for purposes of revising Factor 1 and Factor 2 estimates for the FY 2025 IPPS/LTCH PPS final rule. In the past, we have observed large changes in the estimates of uncompensated care between the proposed and final rules. **CHA urges CMS to use the latest possible data for the proposed rule in order to minimize changes in the potential estimates of uncompensated care between the proposed and final rules.**

² CMS. National Health Expenditure Projections 2022-2031. <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>.

³ 89 Fed. Reg. 36192 (May 2, 2024).

⁴ <https://kffhealthnews.org/news/article/quarter-medicare-disenrolled-uninsured-kff-survey/>.

We appreciate and support CMS’ proposal to use audited Worksheet S-10 data and a three-year average in calculating the uncompensated care distribution. We believe this approach will allow for less year over year variation in distributions at the hospital level and encourage CMS to finalize this as proposed.

Section 1115 Demonstration Waiver Days

On August 1st, 2023, CMS finalized the FY 2024 Inpatient Prospective Payment System (IPPS) rule (CMS-1785-F) which prohibits hospitals from counting 1115 demonstration “waiver days” or patient days towards the Medicaid fraction of the Medicare DSH percentage in states that utilize a CMS-approved uncompensated or undercompensated care (UCC) pool. This data is crucial for determining both Medicare DSH and 340B eligibility. The effect of this policy is that several safety-net hospitals are being unfairly penalized and may lose access to the 340B program, thereby limiting vulnerable patients’ access to affordable prescription medications. **We urge CMS reconsider its stance and retract this provision in the FY 2025 IPPS final rule due to the marked negative impact it will have on hospitals and patients, especially those in underserved areas.**

Section 1115 waivers are approved by CMS because they can increase access to care for Medicaid patients. Adopting a policy that excludes those patients is in direct conflict with CMS’ determination and the Administration’s broader efforts to improve access to health services. The policy embedded in the final IPPS rule will affect numerous hospitals in Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas, all states that utilize UCC pools. If hospitals in these states are unable to achieve an 11.75 percent Medicare DSH adjustment percentage, they may lose their 340B eligibility, crucially impacting resources available and patients’ access to care.

- **Payments for Indirect Medical Education (IME) Direct Graduate Medical Education (DGME) Costs**

Proposed Distribution of Additional Resident Positions:

Hospitals receive Medicare payment for direct graduate medical education (DGME) and indirect medical education (IME) based on the full time equivalent (FTE) number of residents in training. The number of FTEs for determining DGME and IME payment has been capped since 1997 although section 126 of the Consolidated Appropriations Act (CAA) of 2021 required CMS to distribute an additional 1,000 resident positions beginning July 1, 2023.

Section 4122(a) of the 2023 CAA requires CMS to distribute 200 additional residency positions effective July 1, 2026, at least 100 of which are to be distributed for psychiatry or psychiatry subspecialty residency training programs. Hospitals must be notified of the additional residents they are awarded by January 31, 2026. The specifications for awarding additional residents under

section 4122(a) are similar to section 126 of the CAA, 2021 that required CMS to distribute an additional 1,000 resident positions. CMS' proposals follow the model it established for implementing section 126 of the CAA, 2021. The statute prohibits administrative and judicial review of CMS' implementation. **CHA continues to support CMS implementation of section 4122(a) of the CAA, 2023.**

Proposed Changes to the Definition of New Medical Residency Training Programs:

When the Balanced Budget Act (BBA) of 1997 capped the number of residents a hospital may count for DGME and IME, it also provided authority for CMS to establish rules that allowed the caps to be adjusted for hospitals that had not previously trained residents and established "new medical residency training programs." In order to address a concern that hospitals could move an existing program to a new teaching hospital in order to train more residents at its own hospital inconsistent with the BBA 1997, CMS defined the term "new medical residency training program."

The three primary criteria for a residency program to be considered new are that: 1) the residents are new, 2) the program director is new and 3) the teaching staff are new. Over the years, CMS has received questions as to whether a program may still be considered new if the three criteria were partially but not fully met. CMS has responded that a residency program's newness would not be compromised as long as the "overwhelming majority" of the residents or staff are not coming from previously existing programs in that same specialty. CMS is using the FY 2025 IPPS proposed rule to further clarify its policy on what it means for a medical residency training program to be "new."

CMS proposes that a program may still be considered new if 90 percent of the residents did not have previous training in the same specialty as the new program. For the teaching staff, CMS proposes that 50 percent of the staff may have prior experience in a teaching program but they should each be coming from a different previously existing program. For the residency program director, CMS is proposing that the director may have prior residency program director experience unless a period of time (five to ten years) has passed since the individual last served as a residency program director.

CHA finds these criteria to be overly prescriptive in defining what constitutes a new program and remains concerned about how these more specific requirements will interact with the rules of the Accreditation Council on Graduation Medical Education rules for accrediting residency programs. **Our preference would be for a "reasonable person" standard as to whether a program is new or is a transfer of an existing program to a new hospital.** That said, CHA understands that CMS has a need to specify criteria that makes a program new versus and existing one transferred from another hospital and is responding to questions it has received to determine more precise criteria for when a program is "new."

Of the proposals CMS has made, the one that is most concerning to us is that a residency program director may not have had residency program director experience in the past five or ten years. In our view, recruitment of an experienced director may be very important to the success of a new medical residency program. This requirement appears superfluous and unnecessary if 90 percent of the residents are first year residents and 50 percent or more of the teaching staff have come from different specialty programs. Programs meeting these criteria would be new and should be considered such even if directed by an individual with recent experience as a residency program director.

We are also concerned that CMS' is proposing that 50 percent of the faculty have no prior experience teaching residents. Again, it seems the success of a new medical residency program will be dependent on being able to recruit highly experienced faculty. It should be sufficient to determine that the program is not a transfer of an existing program if the teaching staff are coming from multiple existing programs and not a single residency program.

CHA recommends that CMS not finalize its proposals that 50 percent of the faculty or the residency program director have no recent experience in these roles in order for the medical residency program to be considered new.

- **Maintaining Access to Essential Medicines**

In the 2024 OPSS proposed rule, CMS requested comment on separate payment under the IPPS and OPSS for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines. The majority of commenters did not support making a reasonable cost payment to maintain a buffer stock of essential medicines because of concerns about exacerbating existing drug shortages or causing demand-driven shortages.

Considering these comments, CMS proposes to establish a separate payment under the IPPS but limit it to small (100 beds or fewer) independent hospitals for the estimated additional resource costs of voluntarily establishing and maintaining access to six-month buffer stocks of essential medicines. CMS is focusing this proposal on small, independent hospitals, many of which are rural, because these hospitals may lack the resources available to larger hospitals and hospital chains to establish and maintain buffer stocks of essential medicines for use in the event of drug shortages. By limiting separate payment to smaller, independent hospitals, CMS believes it will mitigate concerns raised by commenters regarding large demand driven shocks to the supply chain.

CMS makes a detailed proposal for how it would implement this policy. As part of this policy, hospitals would have to report detailed costs on a forthcoming supplemental cost reporting worksheet. In the impact section of the rule, CMS' analysis makes clear that it estimates the average payment to approximately 493 eligible hospitals would be just above \$600.

Given the administrative burden, reporting costs for a subsidy of approximately \$600 does not make it appear worthwhile for CMS to continue pursuing this proposal. **CHA requests that CMS carefully consider the public comments on this issue before deciding whether to finalize the proposal.**

- **Maternity Care Request for Information (RFI)**

CHA very much appreciates CMS' attention to maternity care. Reducing maternal morbidity, ending disparities in maternal health outcomes and improving the health of mothers and infants is a top priority for CHA. We fully agree with CMS that more must be done to protect the health and lives of mothers and infants.

Providing compassionate care for mothers and babies has long been an integral part of Catholic health care, beginning with the work of our founding women religious who were pioneers in the communities they served. CHA's members continue to be leaders in providing maternal health services. While great strides have been made in the delivery of health care for women and infants, there is much more that needs to be done. Recent data from the Centers for Disease Control and Prevention (CDC) show that maternal deaths in the U.S. during the past few years have increased by a dramatic 89 percent. The CDC also reports that up to 80 percent of these maternal deaths are considered preventable. This maternal health crisis has also exposed glaring racial and ethnic disparities, particularly for black women who are dying at two to three times the rate of their white counterparts.

CMS is seeking information on differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients relative to non-Medicare patients. Medicare, of course, is predominantly a program for people 65 and older and its female population is largely beyond childbearing years. Medicare rates for childbirth services would be based on the 13 percent of beneficiaries that are under 65 and eligible for Medicare based on disability, having ESRD or amyotrophic lateral sclerosis (ALS). These beneficiaries, to the extent they are in need of childbirth and maternity services, are likely to be in a high-risk population and to require more costly pregnancy and childbirth services than women who are not eligible for Medicare. As Medicare rates are based on average patient costs it seems highly likely that Medicare rates will not be representative of childbirth and maternity costs for a non-Medicare population.

CMS appears to be concerned that non-Medicare payers, or other commercial insurers, may be using the IPPS as a basis for determining their payment rates for inpatient pregnancy and childbirth services. As non-Medicare payers often look to Medicare as a reference point for setting their rates, it is possible that Medicare rates are being used as the basis for private payer rates for inpatient pregnancy and childbirth services although it is unclear why this issue would

be of concern to CMS and what action CMS could take if it had more detailed information on this issue.

CMS also invites input on policy steps that would improve maternal care and outcomes. Adequate reimbursement and increasing staffing are key policy areas for improving hospitals' ability to provide needed maternal care in their communities. This is one reason why it's so important to make sure Medicare DSH and uncompensated care payments accurately reflect the care that hospitals provide to patients who rely on Medicaid or have no insurance. A federal add-on payment for labor and delivery, similar to what some states do in their state Medicaid program, would help support maternal care. To ensure we have well-trained medical staff to provide labor and delivery services, we need more capacity for graduate medical education programs. CMS could work with state Medicaid agencies to create new Medicaid GME programs focused on maternity care. CMS should also take what steps it can to provide incentives for the training of maternity nurses, especially in rural areas. The use of telehealth services can also alleviate staffing shortages, and CMS should encourage state Medicaid programs to reimburse for these services.

- **Request for Information on Obstetrical Services Standards**

CMS establishes health and safety requirements known as Conditions of Participation (CoP) that hospitals must comply with to participate in Medicare. There are no baseline care CoPs that are specific to labor and delivery, prenatal and post-partum care, or care for newborn infants. Given the ongoing concerns about the delivery of maternity care in Medicare and Medicaid certified hospitals, CMS plans to propose baseline health and safety standards for obstetrical services in the 2025 Outpatient Prospective Payment System (OPPS) proposed rule.

Given that the comment period end date on the IPPS rule ends on June 10, 2024, or about one month before the OPPS rule is typically available to the public, it seems unlikely that CMS will be able to incorporate any comments it receives in response to the IPPS rule on its OPPS rule proposal. Nevertheless, CHA does not agree that the CoPs are the appropriate way to address the need to improve maternal care services, given the many and complex factors that contribute to poor maternal health outcomes. CHA urges CMS to proceed with caution in proposing new CoPs for maternity care. Failure to comply with a particular CoP requirement could result in the loss of Medicare certification. While CMS' intention may be to improve obstetrical care services, the establishment of a specific CoP could result in hospitals eliminating this service to avoid the risk of being found out of compliance. Such a result could further limit access to obstetrical care and potentially exacerbate rates of maternal morbidity/mortality.

As an alternative, CHA recommends that CMS not finalize this proposal and instead work with stakeholders to establish best practices for ensuring high quality obstetrical care.

- **CoP Requirements for Hospitals and CAHs to Report Acute Respiratory Illnesses**

During the COVID-19 PHE, CMS required that hospitals and CAHs report specified information about COVID-19 in a format and frequency specified by the Secretary. CMS later required that, beginning at the conclusion of the COVID-19 PHE declaration and continuing until April 30, 2024, hospitals and CAHs electronically report information about COVID-19 and seasonal influenza virus, influenza-like illness, and severe acute respiratory infection in a standardized format.

CMS now proposes to revise the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend a modified form of the current COVID-19 and influenza reporting requirements that will include data for RSV and reduce the frequency of reporting for hospitals and CAHs.

CMS proposes requiring reporting of confirmed infections of respiratory illnesses among hospitalized patients, hospital bed census and capacity, and limited patient demographic information, including age. Hospitals and CAHs would report these data weekly (either in the form of weekly totals or snapshots of key indicators) through a CDC-owned or supported system.

CHA appreciates and understands CMS' needs and interests to be prepared for future PHEs like the world has experienced with COVID-19. Nevertheless, **CHA requests that CMS balance the needs of these additional reporting requirements with the burden that this reporting requirement will place on hospitals and consider instead a voluntary reporting process to accept acute respiratory illness data from hospitals.**

- **Transforming Episode Accountability Model (TEAM)**

CMS is proposing a new five-year mandatory episode payment model, the Transforming Episode Accountability Model (TEAM) using its Centers for Medicare and Medicaid Innovation Center (CMMI) authority (section 1115A of the Act). The model would test five surgical episode types: lower extremity joint replacement, surgical hip/femur fracture treatment (SHFFT), coronary artery bypass graft (CABG), spinal fusion, and major bowel procedure. All acute-care hospitals in the 25 percent of core-based statistical areas (CBSAs) identified for participation in the model (out of roughly 800 eligible CBSAs) would be required to participate in TEAM.

Mandatory Model

CHA has deep concerns with the mandatory nature of the proposed model, its potential impact on safety-net hospitals serving vulnerable populations and its overall scope.

In discussing the background for TEAM, CMS reviews the agency's experience with previous bundled/episode-based payment models, such as the Bundled Payment for Care Initiative

(BPCI), BPCI Advanced, and the Comprehensive Care for Joint Replacement (CJR) model. While there are subtleties in the models' performance with respect to quality and cost measures across models and over time, at a high level of abstraction, BPCI, BPCI-Advanced, and CJR have either produced no statistically significant savings or have produced losses for the Medicare program, once reconciliation payments are accounted for.

We understand that at least part of the agency's rationale for proposing TEAM as a mandatory model is to offset selection bias that can affect voluntary models. That is, under voluntary models the most likely participants are those who have estimated that they will perform well, and thus gain financial rewards. This would at least in part explain why these prior models have resulted in losses for the Medicare program. But by implication, a mandatory model will also force participation by hospitals that are likely to "lose" under the model, an implication reinforced by CMS' own impact analysis estimating program savings (or, from a different perspective, hospital losses) of 2.7 to 3.2 percent in performance years two through five of the model.

Given CMS' stated intention to oversample core-based statistical areas (CBSA) with a large proportion of safety-net hospitals, **CHA is extremely concerned that the anticipated program savings will disproportionately come from penalizing safety net hospitals who do not perform well under TEAM.** Given that hospitals experienced a record decline in their Medicare margins in 2022 (the most recent year available), reaching -11.6 percent overall, and Medicare safety-net payments having steadily decreased since 2019,⁵ we do not see any compelling rationale to test another version of bundled/episode payments, especially given their past performance and the likely adverse financial impact on safety-net hospitals.

We are also concerned about the scope of TEAM as proposed. After specifying proposed exclusions, CMS has identified slightly over 800 CBSAs that would be candidates for TEAM, and the agency estimates that approximately 25 percent of those CBSAs would be selected for participation, in order to ensure statistical reliability of evaluation results.⁶ Depending on the specific CBSAs selected for participation, however, the share of hospitals required to participate could well exceed 25 percent of hospitals in the 800 candidate CBSAs. If so, we would be concerned that as proposed, TEAM may exceed the scope of traditional models, and could be construed as a programmatic change affecting a large number of Medicare-participating hospitals.

For these reasons, CHA urges CMS not to finalize the proposed TEAM model. We urge HHS and CMS general counsels to closely evaluate whether TEAM as proposed is indeed consistent with the definition of a "model." **Should CMS proceed with the model, it should only do so if participation is voluntary and if it narrows the scope of TEAM to the**

⁵ Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2024. Washington, DC.

⁶ Any given hospital's likelihood of being selected as a TEAM participant would range from 20 to 50 percent, depending on the sampling strata of the geographic area in which it is located.

maximum extent possible while maintaining statistical reliability of its results. Or, if not, to add additional protections for safety-net hospitals that may be required to participate (such as modifying the risk tracks as discussed below).

Refinements to TEAM

If CMS proceeds with TEAM as a voluntary model, CHA offers the following recommendations for improvements to the model and issues for CMS's consideration.

Lower discount rate

CHA is concerned that the proposed discount rate of 3 percent is too large, given the proposed 30-day episode length, and given the potential impacts of failing to meet financial targets that include a 3 percent discount on safety net hospitals and the patients they serve. **We urge that CMS consider a lower discount rate of no more than 1 percent if the agency proceeds to implement TEAM.**

CMS notes that it has extensive experience fielding bundled payment models, such as BPCI, BPCI-Advanced, and CJR. In TEAM, CMS proposes that episodes would begin with an anchor (inpatient) hospital admission or an anchor (outpatient) hospital procedure, end 30 days after discharge from the anchor admission or the date of the anchor procedure and include most Part A and Part B covered services related to the anchor admission/procedure provided during that period.⁷ CMS also proposes to calculate the prices for each TEAM episode incorporating a 3 percent discount rate. In comparison, both CJR and BPCI-Advanced included a similar 3 percent discount [off the episode target prices], but episodes under each of those models were 90 days in duration.^{8,9}

We are concerned that hospitals participating in TEAM, and especially safety net hospitals, who already have poor financial performance under Medicare, will have undue difficulty keeping their episode costs under the discounted target price under a 30-day episode. The services provided earlier in the episode are more essential to the anchor procedure/admission and hospitals would have less discretion to reduce these services relative to potentially more discretionary services provided longer after the anchor procedure/admission. For example, a post-operative evaluation and management visit may be essential three days after the procedure/discharge, but more discretionary 60 days after the procedure/discharge. In essence, the 30-day episode costs are “front-loaded” with services that are harder for hospitals to reduce in order to remain under the discounted target price. **If CMS proceeds with a 30-day episode**

⁷ Excluded services are defined at §512.525(f), and include admissions / procedures for certain diagnoses, new technology add-on payments, payments for certain drugs covered under Part B, *et cetera*.

⁸ https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cjr-percent20faqs-percent2003-percent2008-percent2018_2.pdf

⁹ <https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>;
<https://www.cms.gov/priorities/innovation/files/x/bpci-advanced-faqs.pdf>

in TEAM as proposed, a lower discount rate will be essential to reflect these front-loaded costs.

Track 1 should be available for a minimum of two years, at least for a subset of participant hospitals

CMS proposes three risk tracks under TEAM. All TEAM participants would be permitted to start TEAM in Track 1 in the first Performance Year (PY) of the model during which participants can earn bonuses for good performance but are not at risk for losses should they fail to meet TEAM cost and quality objectives. Track 2 (asymmetrical upside (up to 10 percent) and downside (up to 15 percent) risk is available to certain hospital participants¹⁰ in PYs 2-5, while other TEAM participants would be required to move into Track 3 (up to 20 percent upside and downside risk) beginning in PY 2.

CHA is concerned that the one-year duration of Track 1 of upside only risk is too short before participating hospitals would be exposed to downside risk (*i.e.*, the risk of losses). We are particularly concerned given CMS' stated intention of over-sampling CBSAs with high numbers of safety-net hospitals and with limited exposure to prior bundled payment models to select hospitals for participation in TEAM. We are also concerned that even safety net hospitals would be required to take on downside risk beginning in PY 2. As noted above, we understand that CMS has proposed TEAM as a mandatory model to explicitly avoid selection issues that can influence the performance voluntary models, and to ensure that safety net (and similar) hospitals will be included in TEAM. However, hospitals in general, and safety net hospitals in particular, exhibit precarious financial performance under Medicare's IPPS even at unreduced payment rates, and safety net hospitals may struggle under a track that puts them at downside risk under episode payment rates that include a 3 percent discount.

CHA recommends that CMS lengthen the duration of Track 1 to a minimum of two years. Ideally all hospitals would be eligible to stay in Track 1 for two years given that, as proposed, TEAM is distinct enough from prior bundled payment models that prior participation in those models may not be enough to guarantee successful performance under TEAM. However, if CMS determines that broad eligibility for a second year in Track 1 would substantially undermine the objectives of TEAM, at a minimum, CHA strongly recommends that the more vulnerable hospitals proposed to be eligible to elect Track 2) be allowed to continue in Track 1 for at least an additional year beyond PY 1.

Health Equity.

CHA strongly supports the inclusion of policies to advance and improve health equity in all CMS programs, whether through permanent payment system policies and value-based purchasing arrangements, or through testing of alternative payment models such as TEAM fielded through CMMI. We agree that properly designed alternative payment models can help safety net providers "focus on care redesign and improving quality of care for beneficiaries in

¹⁰ Medicare-Dependent Hospitals, Sole Community Hospitals, rural hospitals, safety net hospitals, and Essential Access Community Hospitals.

underserved communities.” However, CHA strongly asserts that such models must be designed with a clear recognition of the precarious financial position under which many safety-net providers operate, and the unique challenges they face in delivering high-quality care to vulnerable and under-served populations. Hence, should the agency proceed to move forward with its TEAM proposal, we have suggested changes to the risk tracks and the discount rate (above) to better protect safety-net hospitals from undue financial harm as a result of participation in TEAM.

We also support CMS’ proposed beneficiary social risk adjustment under TEAM, under which TEAM episode target prices would be adjusted to reflect the social risk factors of the beneficiary incurring a TEAM episode.¹¹ Our support is based on the understanding that this approach to social risk would result in adjusting episode target prices higher for beneficiaries with indicators of increased social risk, thus making it easier for TEAM participants to meet the financial performance targets while treating a potentially costlier population.

CMS proposes that TEAM participants in PY1 voluntarily collect and submit to CMS demographic data on their beneficiaries incurring TEAM episodes. TEAM participants would also voluntarily submit to CMS a health equity plan that would identify health disparities among the TEAM participant’s beneficiary population; identify health equity goals; describe the health equity plan intervention strategy; and identify health equity plan performance measures. Both of these requirements would become mandatory in PY2 and subsequent model years. CMS also proposes that starting in PY1 and for each subsequent PY, TEAM participants would be required to screen TEAM beneficiaries for four health-related social needs (HRSN),¹² and report aggregated screening and screen-positive information to CMS on an annual basis, in a form, manner and date(s) to be determined by the agency.

As we note above, CHA strongly supports policies to advance health equity throughout the Medicare program. However, such policies should be designed to be as effective as possible, and at the same time remain cognizant of the unique situations facing safety-net providers serving vulnerable populations.

With respect to the proposed requirement that TEAM participants collect and report to CMS certain demographic information on their patients incurring TEAM episodes (race, ethnicity, language, disability, *et cetera*), our concerns are two-fold. First, we are concerned that such collection and reporting may impose a non-negligible burden on TEAM participants. Second, in the absence of guidance on standardized protocols for collecting and reporting such information,

¹¹ As part of MS’ proposed risk adjustment methodology under TEAM, CMS proposes to use a single binary social risk measure consisting of three components: the beneficiary’s eligibility for full benefits under both Medicare and Medicaid, the position of the beneficiary’s residence on the distribution of geographic Area Deprivation Indices, beyond a threshold to be determined, and the beneficiary’s eligibility for the Part D Low-Income Subsidy. The beneficiary would receive a score of “1” on the binary social risk measure if he or she met any of the three component criteria.

¹² Food insecurity, housing instability, transportation needs, and utilities difficulty.

we would be concerned that different hospitals may collect and report such data in ways that vary across geography, health systems, ownership status, *et cetera*. Data would need to conform to United States Core Data for Interoperability (USCDI) version 2 data standards developed by the Office of the National Coordinator for Health IT (ONC). The proposed rule indicates that hospitals would be required to report the data in a “form and manner and by a date specified by CMS” but does not provide details on the level of completeness that CMS would require for such data, or what mechanisms CMS would use to collect and protect the confidentiality of the data. **CHA recommends that CMS not make the reporting of demographic data mandatory until it can provide more details in rulemaking and has gained experience with accepting the data from hospitals.** While we appreciate the importance of demographic data in identifying inequities and providing a basis to track improvements it is not clear the USCDI demographic standard is as ready to support reporting as CMS appears to assume. Furthermore, CMS’ proposal lacks important details that would help hospitals plan for these requirements and ensure they could meet CMS’ expectations and report data consistently.

CHA agrees that there is merit in requiring TEAM participants to develop and report to CMS health equity plans. Such plans would have value in helping TEAM participants to identify specific health disparities, develop interventions for addressing those disparities, and measuring their progress in achieving stated goals.

CHA supports screening in screening TEAM beneficiaries for HRSNs and referring them for services related to HRSNs as screening warrants. However, screening for food insecurity, housing instability, transportation needs and utility needs is already required in other CMS reporting programs. In December 2023, CMS also included two measures assessing whether hospitals screen outpatients for HRSNs on its pre-rulemaking Measures Under Consideration list for the OQR program. As a result, CMS could propose the HRSN screening measures for the OQR as soon as the CY 2025 outpatient PPS rule this summer. The adoption of the measures in the OQR would ensure that all inpatient and outpatient episodes of care include an assessment for HRSN screenings. Thus, a separate reporting requirement for the TEAM model could lead to unhelpful administrative burden and inconsistency between CMS’ measurement programs and the TEAM model. **CMS should coordinate HRSN reporting requirements across its programs to ensure consistency and to reduce administrative burden.**

CMS discusses and seeks comment on the potential for upfront infrastructure investment payments to facilitate the development of health equity plans and the associated proposed reporting requirements.¹³ **To the extent CMS proceeds to implement TEAM, CHA believes it is essential to provide safety-net providers the resources necessary to comply with these requirements, in order to maximize their chances of being successful under TEAM and improving the health outcomes they achieve for the populations they serve.**

¹³ Such payments would be analogous to the earlier ACO Investment Model (AIM) payments.

Proposed Waivers of Medicare Program Requirements

CMS discusses, but does not propose, waiving the “homebound” requirement as a condition for beneficiaries to receive Medicare-covered home health care,¹⁴ and similarly discusses, but does not propose, waiving the “incident to” billing rules to allow physicians or non-physician practitioners to provide services in a beneficiary’s home who is not otherwise eligible for the Medicare home health benefit. **CHA recommends CMS waive both these requirements.**

CHA supports the proposed telehealth waivers. CMS proposes to waive the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas. CMS would also waive the originating site requirements, but only when telehealth services are being furnished in the TEAM beneficiary’s home or place of residence during the episode.

CMS also proposes to waive the three-day rule for discharges to SNFs but only for SNFs with at least a three-star rating on the Nursing Home Compare website. **While CHA supports waiver of the three-day rule we are concerned the structure of CMS’ proposed waiver could lead to two separate and unequal tiers of care:** a more flexible, patient-centered level for patients in markets with an adequate supply of three-star SNFs and a more restrictive, regulation-driven level of care for patients in markets with an inadequate supply of three-star SNFs. As CMS notes, there may be instances where a TEAM participant would like to use the three-day SNF rule waiver, but the TEAM beneficiary receives inpatient post-acute care through swing bed arrangements in a hospital or critical access hospital (CAH), which is not subject to the Five-Star Quality Rating System. CMS believes that allowing TEAM participants to use the three-day SNF rule waiver for hospitals and CAHs operating under swing bed agreements may support beneficiary freedom of choice and provide greater flexibility to TEAM participants for their care coordination efforts. **We agree and urge CMS to allow TEAM participants to use hospitals and CAHs operating under swing bed agreements for the three-day SNF rule waiver.**

Decarbonization and Resilience Initiative

CMS proposes to include in the TEAM model a voluntary Decarbonization and Resilience Initiative to assist hospitals in addressing the threats to the nation’s health and its health care system presented by climate change and the effects of hospital carbon emissions on health outcomes, health care costs and quality of care. The initiative has two parts.

First, all interested TEAM participants could receive technical assistance in three areas: developing approaches to enhance organizational sustainability and resilience; transitioning to care delivery methods that result in lower GHG emissions and are clinically equivalent to or

¹⁴ As required by sections 1835(a) and 1814(a) of the Social Security Act.

better than previous care delivery methods (for example, switching from Desflurane to alternative inhaled anesthetics); and identifying and using tools to measure emissions and associated measurement activities.

The second aspect of the initiative is a voluntary reporting program. CMS proposes hospitals that volunteer to report information on direct emissions related to health care operations and emissions related to purchased electricity consumption, Scope 1 and Scope 2 in the Greenhouse Gas Protocol (GHGP) framework. Scope 3, which considers other indirect GHG emissions, could be added in the future.

Catholic health care is committed to protecting the environment, to minimizing environmental hazards and to reducing our contribution to the problem of climate change. We care for those who are harmed by the environment, we strive for internal practices to ensure environmental safety and we advocate public policies and private actions that bring solutions. With our members, CHA is working to raise the issue of environmental stewardship as a mission-based clinical and public policy imperative. We act as responsible stewards of God's creation as we respond as a ministry to building healthier communities.

CHA shares concerns voiced by CMS about the threats that climate change poses to health care organizations, their patients and their communities as well as the way operations can contribute to climate change. Our members are particularly attentive to these concerns, as our mission as Catholic health care providers leads us to serve a large population of historically disadvantaged and vulnerable patients. We believe that developing and implementing responses to climate change impacts is an essential part of our preparedness to protect the patients we serve by keeping them safe and maintaining our operations during emergencies.

Several CHA members have been voluntarily working on reducing their greenhouse gas emissions for the past several years, driven by their commitment to care for creation and vulnerable populations the least prepared to deal with climate change. They have joined initiatives such as the U.N.'s Race to Zero, the America Is All In coalition of leaders in support of climate action in the US, Health Care Without Harm's Health Care Climate Council and Health Care Climate Challenge, the National Academy of Medicine's Action Collaborative on Decarbonizing the US Health Sector, the new HHS Office of Climate Change and Health Equity pledge to reduce carbon emissions and strengthen resilience and the Vatican's Laudato Si' Action Platform which calls the global Catholic Church, including Catholic health care, to take action on the causes of climate change and its impacts.

CHA appreciates CMS's commitment to addressing the health impacts of climate change. Should CMS finalize its TEAM proposal, CHA supports including the voluntary Decarbonization and Resilience Initiative in the model, so long as it remains voluntary. We are especially supportive of providing technical assistance to hospitals on reducing greenhouse gas emissions. With respect to the voluntary reporting, we urge CMS to be very intentional in not creating undue burdens for hospitals, especially given that many of the hospitals required to

participate in the TEAM will be safety-net hospitals already facing challenges. If the metrics and reporting are too onerous, few hospitals will participate in what could be an important contribution to reducing emissions in the health care sector.

CMS asks for input on whether, in the future, to consider proposing any bonus payments or payment adjustments for participating in the initiative. CHA believes at this time that tying participation to any form of reimbursement will continue to be inadvisable into the future. Adapting operations to achieve meaningful reduction in emissions can be challenging from an operational reliability and financial standpoint. Federal and state funding will be important to drive adoption and offset the expense of initiatives that are the right thing, yet do not yield a positive return on investment. We urge CMS to bear this in mind when making reimbursement policy decisions that affect hospital financing.

- **Hospital Inpatient Quality Reporting (HIQR) Program**

Electronic Clinical Quality Measures (eCQMs)

CMS is proposing to adopt two new Hospital Harm eCQMs into the HIQR measure set (the Hospital Harm– Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM). The measures would be added to the list of eCQMs from which hospitals can self-select beginning with the 2026 reporting period/FY 2028 payment determination. These measures are also proposed for inclusion in the Medicare Promoting Interoperability (PIP) programs beginning with the 2026 reporting period/FY 2028 payment determination.

CHA supports measures such as these, which are intended to improve patient safety. We continue to appreciate efforts made by CMS to align eCQM reporting requirements for the HIQR Program and the PIP. Our members continue to experience challenges with reporting on new eCQMs and eCQM implementation and maintenance remains very time consuming and costly for hospitals. Alignment partially mitigates these time and cost burdens incurred by our members. In addition, we support the addition of these proposed eCQM measures within both programs as optional self-selected measures.

Increase in Mandatory eCQMs:

CMS is also proposing, for both the HIQR and the Medicare Promoting Interoperability programs, a progressive increase in the number of mandatory eCQMs that a hospital would be required to report beginning with the 2026 reporting period/FY 2028 payment determination by phasing in the addition to the list of mandatory eCQMs the five Hospital Harm eCQMs currently on the list of optional self-selected measures. For the CY 2026 reporting/FY 2028 payment year, hospitals would report nine eCQMs, three of which would be self-selected from the menu of available eCQMs. For the CY 2027 reporting/FY 2029 payment year, hospitals would be required to report 11 eCQMs, three of which would be self-selected.

CHA appreciates CMS' acknowledgement of the need to phase-in the proposed increase in the number of mandatory eCQMs. **However, even with the phase-in, we do not support and have strong concerns about the substantial increase in number of mandatory measures over a short period.** In the span of two years, the reporting requirements would significantly increase from the current six measures to eleven measures, almost doubling. Given the continued challenges experienced by our members with reporting on eCQMs, we are extremely concerned about the extent of burden and cost that will be placed on hospitals in order to implement and maintain the substantial increase in eCQMs. If CMS proceeds with finalizing a policy to transition optional eCQMs to mandatory eCQMs, CHA recommends phasing in such a policy over a greater number of years and strongly encourages CMS to consider transitioning fewer eCQMs to mandatory measures. For example, CHA continues to recommend that the Hospital-Harm Opioid-Related Adverse Events eCQM remain for the foreseeable future in the optional, self-selected for reporting category. CHA continues to support efforts led by CMS to address our nation's opioid epidemic. But as we expressed in a previous comment letter, we are uncertain that this measure is impactful given that the overall number of inpatient naloxone rescue events is small and therefore believe that any benefit from requiring the measure as a mandatory eCQM would be very small and overshadowed by the cost and burden faced by hospitals.

We are also concerned about the substantial cost and time burden faced by hospitals when adopting eCQMs since CMS has indicated actively working to move from eCQMs to digital quality measures (dQMs). CHA continues to recommend that CMS coordinate its strategies to expand eCQMs in its quality and PIP programs with its plan for revising those same measures to dQMs to avoid unnecessary and costly overlap and conflicts.

The Age Friendly Hospital Measure:

CMS proposes adoption of the attestation-based structural measure, the Age Friendly Hospital measure, for the HIQR Program, beginning with the 2026 reporting period/fiscal year 2028 payment determination. The measure assesses hospital commitment to improving care for patients age 65 years or older receiving services in the hospital, operating room, or emergency room; and consists of five attestation domains and corresponding attestation statements, including (i) Eliciting Patient Healthcare Goals, (ii) Responsible Medication Management, (iii) Frailty Screening and Intervention, (iv) Social Vulnerability; and (v) Age-Friendly Care Leadership.

CHA is a partner, along with the American Hospital Association, the Institute for Health Care Improvement (IHI) and the John A Hartford Foundation, in the Age-Friendly Health Systems Initiative. The IHI has recognized over 3,922 hospitals, practices and long-term care organizations as Age-Friendly Health Systems Participants. Three of the original five pioneering Age-Friendly Health Systems were from Catholic health care. The goal of the initiative has been to develop and spread a model for caring for older adults based on four high-level interventions (referred to as the "4 Ms"):

- What Matters: Understanding and actively supporting what matters to older adults
- Mobility: Reviewing mobility plans for each patient
- Medications: Discussing whether medications are unnecessary or potentially harmful
- Mentation: Improve mentation by addressing problems like dementia, delirium, and depression

CHA commends CMS for its consideration of measures that acknowledge the importance of a more holistic approach to the health care needs of older adults and appreciates the alignment of the proposed measure with the Age-Friendly Health Systems Initiative. However, CHA continues to believe that only measures endorsed by the consensus-based entity (CBE) should be considered for inclusion in the HIQR measure set, and therefore we believe that adoption of any measure should be delayed until such measure receives endorsement by the CBE. We are particularly concerned that the PRMR Hospital Committee did not reach consensus and did not recommend including this measure in the HIQR Program because of concerns that the domains were not structured tightly enough in scope to drive action. We strongly believe that measures adopted into the measure set should produce actionable information to further the quality of care.

The Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations (Onc) Measure and the Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations (Onc) Measure

CMS proposes to adopt the CAUTI-Onc and CLABSI-Onc measures into the HIQR Program measure set beginning with the 2026 reporting period/fiscal year 2028 payment determination. The CAUTI measure and CLABSI measure are both currently used in the HAC Reduction and Hospital VBP Programs and measure the respective risk-adjusted standardized infection ratio among adult inpatients. Though the current measures include most major inpatient care wards at inpatient hospitals reporting under the HIQR Program, oncology wards at these hospitals have not been included. The proposed measures would use the same specifications as the existing measures but would look only at patients in oncology wards and be stratified for oncology specific locations. An oncology ward is defined by the Centers for Disease Control and Prevention as an area for the evaluation and treatment of patients with cancer. Hospitals would need to verify that all locations, including those with oncology patients, are mapped in NHSN in order to report the measure.

CHA supports CMS' proposal for a measure to address a gap that the agency has identified in its quality measurement. Patients with cancer make up a population that is vulnerable to developing health care-associated infections. We appreciate the need to address this gap through an actionable measure. However, we are concerned with the ability of hospitals to identify locations that satisfy the definition of an oncology ward and to verify that all locations, including those with oncology patients, are mapped in NHSN. If CMS finalizes its proposal to adopt this

measure, CHA recommends that the agency provide further guidance and assistance to hospitals for making such identifications and verification in a manner that is efficient and minimalizes burden.

- **Cross-Cutting Quality Program Proposals**

Modified Hospital Consumer Assessment of Healthcare Providers and Systems:

In addition to the quality proposals discussed above, CMS proposes to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure in the HIQR Program, PCHQR Program, and Hospital Value Based Purchasing (HVBP) Program. **CHA supports the agency's proposed approach that would align the updated HCAHPS measure across the HIQR, PCHQR, and HVBP Programs.** We particularly appreciate the proposal for modifying the scoring under the HVBP Program prior to the proposed implementation of the updated measure under the program so that hospitals could consistently administer a single survey under the HIQR and HVBP Programs and not be required to administer two different surveys, which causes unnecessary complications, confusion, and burden. We strongly believe in the importance of, and advocate for, the patient's voice and therefore support measures incorporating feedback from patients and their caregivers. We also believe it is important to not overburden patients and caregivers with too many survey questions, especially if questions could be consolidated in a manner to arrive at the same information. Therefore, we encourage CMS to ensure its proposed updates reflect such a streamlined approach to the survey.

Request for Comment: Advancing Patient Safety and Outcomes Across the Hospital Quality Programs

CMS is seeking feedback on ways to build upon current measures in the CMS quality reporting programs that account for unplanned patient hospital visits to incentivize hospitals to improve discharge processes, such as by introducing existing quality reporting measures into the VBP Programs or by adopting new measures that better represent the range of patient outcomes post discharge.

CHA applauds CMS' efforts to align hospital quality program initiatives. We believe in the importance of a holistic approach to care and in the value of care coordination through strong discharge planning and processes to further improve patient outcomes. We therefore appreciate the agency's desire to explore advancing patient safety and outcomes through quality measures that better represent the range of patient outcomes post discharge. Generally, CHA continues to support the following as essential characteristics of measures focused on issues of health:

- **Data-driven:** Measures should be developed based upon well-documented outcome disparities, including with clear associations to well-defined social risk factors.

- Actionable: Measures should be designed to yield performance results for which change is possible.
- Have utility: In the near-term, process measures may be more feasible and could point the way to meaningful outcome measures.
- Give feedback: Measures should be constructed for timely performance scoring and prompt provider feedback.
- Feasible: Measures should be based on considerations of provider burden and CMS operational capabilities.
- Aligned: Measures should be standardized and aligned within CMS programs, across agencies, and among stakeholders.

While we appreciate and agree with the importance of incentivizing hospitals to have quality discharge procedures, we believe time is needed to identify where the gaps in measurement exist and where improvement is needed. Also, we see the value in ensuring there has been sufficient time in observing the effectiveness, impact and consequences of applying a measure under the HIQR Program (or any pay-for-reporting program) before adopting the measure as a required measure with payment consequences under a value-based program. In addition, in considering the application of eCQMS, we encourage CMS to ensure such time is provided for any eCQM that is currently under the optional, self-reported category under the HIQR Program before consideration of adoption of the measure as a required measure under the HVBP Program, for example. We believe that CMS should generally engage in extensive testing on specific measures and scoring methodologies before using those measures or methodologies in the programs. We further recommend that the agency take into account the effects a measure would have on reporting burdens created for providers and the optimal allocation of finite provider and CMS resources.

- **Medicare Promoting Interoperability Program**

Proposal to Separate the Antimicrobial Use and Resistance (AUR) Surveillance Measure Into Two Measures:

CMS proposes to separate the AUR Surveillance Measure into two measures, an Antimicrobial Use (AU) Surveillance Measure and an Antimicrobial Resistance (AR) Surveillance Measure, beginning with the EHR reporting period in 2025. Hospitals would need to report a “yes” response or claim an exclusion separately for each measure to receive credit. An additional exclusion would be added for hospitals that do not have a data source containing the minimal discrete data elements required for reporting.

CHA appreciates the proposal’s goal to have separate measures in order to provide for more appropriately targeted potential exceptions since the AU and AR data rely on different data sources. We also support the additional exclusion to ensure the appropriate data source is available to report on the applicable measure.

The Honorable Chiquita Brooks-LaSure
June 10, 2024
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In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2024 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa A. Smith". The signature is fluid and cursive, with the first name "Lisa" being the most prominent.

Lisa A. Smith
Vice President
Advocacy and Public Policy