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June 9, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted via regulations.gov

RE: Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider (CMS-2023-0057)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 member hospitals and health systems the Florida Hospital Association ("FHA") appreciates the opportunity to express our support and concerns related to the Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates ("Proposed Rule").

The FHA is supportive of a number of Centers for Medicare and Medicaid Services' ("CMS" or "the Agency") proposals. For example, the Agency will help provide care to rural areas by allowing rural emergency hospitals (REHs) to be designated as non-provider sites for Medicare graduate medical education (GME). CMS's proposal to treat urban hospitals that have reclassified as rural as geographically rural hospitals will support hospitals in the bottom quartile of the wage index nationally. And many quality reporting provisions throughout the rule are well considered and should improve patient care.

However, we cannot, and do not, support the proposed payment updates. FHA is deeply concerned about the inadequacy of the proposed market basket update given the changing health care system dynamics and its workforce challenges. As such, we strongly urge CMS to utilize its authority to provide a market basket adjustment to account for what the agency missed in the FY 2022 market basket forecast.

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Proposed Market Basket Increase

CMS proposes a market basket update of 3.0% less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. This update, especially when taken together with the FY 2022 payment update of 2.7%, continues to be woefully inadequate.

The Proposed Rule boasts an average update of 2.8%. That average includes two states receiving an increase of more than 5% (California at 8.45% and New York at 5.56%), which skews the projected national increase by half a percent. If you remove just those two states the national average increase is ~2.26% - however, only 8 states, including New York and California are projected to achieve even a 2.26% increase. At the state level, including all proposed payment modifications, Florida is projected to receive a 1.3% payment increase; weighed against current inflation levels, especially regarding staffing costs, the proposed rate update is a significant cut.

For FY 2022, CMS finalized a market basket of 2.7%, based on estimates from historical data through March 2021. because the market basket was a forecast of what was *expected* to occur, it missed the *unexpected* trends that actually did occur in the latter half of 2021 into 2022 with hospitals combatting high inflation and workforce shortages. **Indeed, including data through September 2022 yields a CMS estimate of 5.7% for the actual FY 2022 market basket — a staggering 3.0 percentage points higher than the IPPS payment update that was given to hospitals.** The rationale for using historical data as the basis for a forecast is reasonable in a typical economic environment. However, when hospitals and health systems continue to operate in atypical environments, the market basket updates become inadequate. This is, in large part, because the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs. This is exactly what occurred at the end of the calendar year 2021 into calendar year 2022, which resulted in a large forecast error in the FY 2022 market basket update.

These updates fail to account for the fact that labor composition and costs have not reverted to "normal," pre-COVID-19 public health emergency levels and that as a result, the hospital field has continued to face sustained financial pressures. Workforce shortages continue to create outsized pressures on hospitals and health systems, and workforce financial pressures are particularly challenging because labor on average accounts for about half of a hospital's budget. **Therefore, we urge CMS to use its "special exceptions and adjustments" authority to make a retrospective adjustment to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is for FY 2022. We also urge the agency to use the same authority to eliminate the productivity cut for FY**

2024 and to fully restore the shortfall resulting from the American Taxpayer Relief Act of 2012 (ATRA) documentation and coding adjustments.

Hospitals have been facing unprecedented inflation. The most recent analysis from Kaufman Hall in its *National Hospital Flash Report* indicates that from 2020 to present, overall expenses have risen by 20.8% for hospitals. This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019. It is true that contract labor utilization rose significantly during the pandemic. It is also true that, even as some of the labor effects of the pandemic have receded, hospitals are not near their former, low contract labor utilization, staffing mix, nor do they expect to be soon. Inflationary and labor shortage pressures on hospitals will continue, with the Department of Health and Human Services (HHS) finding that health care workforce shortages will persist well into the future.

These national trends are consistent with the experience of Florida's hospitals. Since 2020 hospital labor costs have risen 45%, an increase of $6.2 billion in spending. Hospital margins are down significantly; operating margins decreased 5.3 points between 2021 and 2022 and cash on hand has decreased by 28% since 2019. Over the last three years hospital expenses have increased by more than 35%! **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 more accurately reflect the cost of providing hospital care.**

Productivity Adjustment

Under the Affordable Care Act (ACA), the IPPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2024, CMS proposes a productivity cut of 0.2 percentage points.

FHA has deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate. We ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2024.

Medicare Disproportionate Share Hospital Payment

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments).

The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. If adopted, the total DSH and UCC Medicare payments to Florida hospitals are estimated to decrease approximately $25 million or .3%.

In determining the calculation of uncompensated care DSH payments, the Agency uses the percent change of individuals who are uninsured, determined by comparing the percent of the individuals who were uninsured in 2013 and the percent of individuals who were uninsured in the most recent period for which data is available. In the FY 2023 final rule, CMS determined that the uninsured rate was 9.2%. In this rule, CMS proposes to maintain this uninsured rate at 9.2% for FY 2024. **We strongly disagree with this estimate. Indeed, it is expected that health coverage for millions of people will end as the Medicaid continuous coverage requirements are now unwinding. As such, we expect to see a large *increase* in the number of uninsured in FY 2024.**

The Kaiser Family Foundation finds that 18 million people could lose Medicaid coverage in the 14 months following the end of the COVID-19 PHE. In Florida, we estimate 900,000 Medicaid beneficiaries will lose program eligibility. Another Kaiser Family Foundation study found that in the year following disenrollment from Medicaid, roughly two-thirds of people had a period of uninsurance. While we recognize that some people who lose Medicaid coverage may be eligible for other subsidized health insurance coverage, many people losing coverage become uninsured - this may be especially true in a non-expansion state like Florida. Simply put, any assertion that Medicaid would have a modest growth following the expiration of maintenance of enrollment requirements does not make sense; logically, as Medicaid coverage goes down, those disenrolled are more likely than not to be uninsured for some period of time. **The Agency must reevaluate its methodology in calculating uncompensated care and FHA urges CMS to use the latest data to do so.**

Graduate Medical Education

Medicare direct GME and indirect medical education (IME) funding is critical to educating the physician workforce and sustaining access to care. Yet, the currently insufficient funding levels and limitations on the number of residents for which each teaching hospital is eligible to receive GME reimbursement are a major barrier to reducing the nation's significant physician shortage. CMS proposes several modifications that would affect Medicare direct GME payments to teaching hospitals.

- *Rural Emergency Hospital*

Hospitals may count residents training in "non-provider" sites for direct GME and IME payment. Beginning on Oct. 1, 2019, CMS stated that this includes critical access hospitals (CAHs). Specifically, hospitals may include FTE residents training in a CAH in their direct GME and IME FTE counts as long as the CAH meets the non-provider setting requirements. CMS acknowledges that the term "non-provider" is not explicitly defined in statute; therefore, the agency is using its same logic that defines a CAH as "non-provider" to allow it to also define an REH as a non-provider, which would allow hospitals to count training time in REHs in their direct GME and IME FTE counts. **We support this proposal that will allow either the hospital or the REH to receive payment from Medicare for incurring the cost of training occurring at an REH.**

- *Nursing Allied health ("NAH") Education Payments*

Medicare pays providers for Medicare's share of the costs that providers incur in connection with approved education activities, including NAH programs. The costs of these programs are not included in the calculation of payment rates for hospitals paid under the IPPS; instead, they are separately paid on a reasonable cost basis. Hospitals that operate approved NAH programs and receive Medicare reasonable cost reimbursement also receive additional payments from Medicare Advantage (MA) organizations. The total spending for these programs is capped at $60 million for any calendar year (CY). However, during CYs 2010 through 2019, CMS inadvertently did not apply the $60 million cap; as such, it began seeking recoupment of the overpayments that resulted from its error.

Section 4143 of the Consolidated Appropriations Act (CAA) 2023 provided relief for hospitals subject to this recoupment by lifting the $60 million cap during these years. This only applies to hospitals that as of enactment of the CAA 2023 continue to operate schools of nursing or allied health. This proposed rule provides the details for implementation of Section 4143. Specifically, the MACs would recalculate a hospital's total NAH MA payment and reconcile them with prior amounts already paid or recouped. Amounts previously recouped would be returned to hospitals and recoupments that would have occurred would no longer occur. **We support this proposal and urge CMS to direct MACs to expeditiously recalculate and reconcile NAH payments before the final rule goes into effect on Oct. 1, 2023.**

Permanent Cap on Wage Index Decreases

In the FY 2020 final rule, CMS adopted a transitional policy that placed a 5% cap on any decrease in a hospital's wage index due to the combined effects of policy changes. In FY 2021,

CMS again adopted a 5% cap on any decrease in a hospital's final wage index due to its adoption of updates from Office of Management and Budget (OMB) bulletin 18-04. In last year's rule, CMS permanently adopt the 5% cap for all wage index decreases, regardless of the reason, in a budget neutral manner; as such, it proposes to continue this policy for FY 2024. **The AHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control. While we support this policy that would increase the predictability of IPPS payments, we continue to urge CMS to apply this policy in a non-budget neutral way.**

Rural Wage Index and the Rural Floor

CMS proposes to revise its methodology for calculating the rural wage index and the rural floor. **FHA supports CMS's proposal.**

Under the agency's existing methodology, CMS calculates the rural wage index and the rural floor for each state using the highest average hourly wage resulting from the following three calculations: (1) all geographically rural hospitals (Calculation 1); (2) geographically rural hospitals that do not have MGCRB or Lugar redesignation (Calculation 2); or (3) all geographically rural hospitals, urban hospitals that have reclassified as rural under section 1886(d)(8)(E) ("reclassified rural hospitals") unless they have MGCRB or Lugar redesignation, and out-of-state hospitals that have reclassified into the rural area of the state (Calculation 3).

CMS proposes to change Calculations 1, 2 and 3 so that the wage data of urban hospitals that have reclassified as rural under section 1886(d)(8)(E) are treated in the same manner as the wage data of geographically rural hospitals. In other words, revised Calculation 1 would consist of the wage data of all geographically and reclassified rural hospitals. Revised Calculation 2 would include the wage data of geographically and reclassified rural hospitals that do not have an MGCRB or Lugar redesignation. And revised Calculation 3 would be the same except it would no longer exclude the wage data of reclassified rural hospitals that have MGCRB or Lugar redesignations.

CMS explains that it is proposing this change to account for its new interpretation of section 1886(d)(8)(E). In light of recent court decisions, CMS now understands section 1886(d)(8)(E) to mean that reclassified rural hospitals should be regarded as rural for all purposes of subsection (d), including the calculation of the wage index. "[T]he best reading of section 1886(d)(8)(E)'s text…is that it instructs CMS to treat [reclassified rural] hospitals the same as geographically rural hospitals for the wage index calculation." **This proposal is the only approach that is consistent with statutory requirements.**

CMS's proposed rule accurately reflects the scope of section 1886(d)(8)(E). As multiple Federal courts have explained, the plain text of section 1886(d)(8)(E) directs CMS to treat reclassified rural hospitals as rural for all purposes of subsection (d), including the wage index. In *Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services*, the United States Court of Appeals for the Third Circuit held that "[f]or purposes of this subsection" necessarily "refers to subsection (d) *in its entirety*." 794 F.3d 383, 395 (3d Cir. 2015) (emphasis added). Likewise, in *Lawrence + Memorial Hospital v. Burwell*, the United States Court of Appeals for the Second Circuit found that "[b]y using the broad language 'for purposes of this subsection,' Congress mandated that specified hospitals be treated as rural for the purposes of the *entire section*." 812 F.3d 257, 266 (2d Cir. 2016) (emphasis added). And finally, in *Bates County Memorial Hospital v. Azar*, the United States District Court for the District of Columbia ruled that "Congress enacted a general command to treat [section 1886(d)(8)(E) hospitals] as rural for purposes of Subsection (d)." 464 F. Supp. 3d 43, 51 (D.D.C 2020).

CMS's current methodology for calculating the rural wage index fails to treat reclassified rural hospitals as rural for all purposes of subsection (d), as required by section 1886(d)(8)(E). Calculation 1, although it is intended to capture the wage data of all hospitals located in the rural area of the state, currently does not include the wage data of reclassified rural hospitals. The current version of Calculation 2 fails to test the effect of excluding from the rural wage index the wage data of reclassified rural hospitals that have obtained MGCRB and Lugar redesignations, as required not only by section 1886(d)(8)(E), but also by the hold harmless provision in 1886(d)(8)(C)(ii). And the current version of Calculation 3 excludes the wage data of reclassified rural hospitals that have obtained MGCRB and Lugar redesignations, although it includes such data of geographically rural hospitals.

CMS's proposal would rectify these errors by including the wage data of reclassified rural hospitals "in all calculations in which geographically rural hospitals are included." In other words, the changes that CMS has proposed to make to its methodology for calculating the rural wage index align with the agency's statutory obligation to treat reclassified rural hospitals as rural for all purposes of subsection (d).

In addition to being consistent with the agency's obligations under the statute, **CMS's proposed change to the calculation of the rural wage index and rural floor would also advance the agency's goal of reducing the disparity between high and low wage index hospitals.** This is because the proposed change would have a disproportionately positive impact on hospitals with wage index values at or below the 25th percentile nationally, thereby helping to close the gap between the low and high wage index hospitals. We believe this ancillary benefit is especially important since serious legal questions have been raised regarding the validity of CMS's alternative approach for assisting hospitals in the bottom wage index quartile.

In an analysis prepared using the wage index tables published with the proposed rule and the wage index public use file published April 30, 2023, 836 hospitals would be at or below the 25th percentile if CMS does not finalize its proposed change to the rural wage index and rural floor. If CMS does finalize its proposed change to the rural wage index, 98.68 percent of those 836 hospitals would receive a higher wage index, either from a higher rural wage index, a higher rural floor or a quartile adjustment. By comparison, only 15.64 percent of hospitals that would be above the 25th percentile if CMS did not finalize its proposal will receive a higher rural wage index if CMS does finalize its proposal.

The table below illustrates how the wage index percentile groups would shift if CMS finalized its proposed change to the calculation of the rural wage index and rural floor (Tribal hospital data omitted).

Percentile	CMS does not finalize proposal	CMS finalizes proposal
25th	0.8355	0.8646
50th	0.9267	0.9337
75th	1.0353	1.0395
100th	1.9172	1.8971

As shown in the table, CMS's revised methodology for calculating the rural wage index and rural floor would help close the gap between the highest and lowest wage index values nationally. The 25th percentile wage index would increase by 2.9 percent. The 50th and 75th percentiles would increase by 0.7 percent and 0.4 percent, respectively. And the 100th percentile would decrease by 2 percent.

FHA supports this proposal and urges CMS to finalize its proposal to change its methodology for calculating the rural wage index and rural floor.

Low-volume Adjustment and Medicare Dependent Hospital (MDH) Program

The Consolidated Appropriations Act 2023 extended both the low-volume adjustment and Medicare Dependent Hospital programs through FY 2024. Thus, CMS is proposing to make conforming changes, including continuing the past process for hospitals to apply for low-volume hospital status. In addition, in anticipation of the MDH program expiring, CMS previously revised

the SCH program to allow MDHs to apply for SCH status. CMS is unaware of any hospitals that cancelled MDH status to become an SCH and asked any hospitals uncertain of their status to contact their MACs for verification. **We support the agency's proposals and appreciate its support of hospitals that serve rural communities. Additionally, we urge CMS to expeditiously process claims and provide instructions to MACs during program extensions, especially in instances when extensions are made retroactively. Seamless transition of programmatic support are crucial life lines for rural providers. We look forward to working with CMS and Congress to make these programs permanent.**

Addition of Severe Sepsis and Septic Shock Management Bundle (SEP-1)

Beginning FY 2026, CMS proposes to add the SEP-1 measure to the Hospital Value-based Purchasing's (HVBP) safety domain. In the proposed rule, CMS suggests that adopting SEP-1 would be consistent with its renewed focus on patient safety and would accelerate hospital progress on delivering better care for sepsis patients. **FHA hospitals support including sepsis in a federal hospital quality program, however, believe there are too many concerns around SEP-1 and recommends the agency not finalize this proposal.**

While the measure has been publicly reported in the Inpatient Quality Reporting (IQR) program for a few years, systemic reviews of interventions have only been supported with low-quality and conflicting evidence regarding the benefit on patient outcomes. FHA members disagree with CMS when the agency states the measure would allow hospitals to target better care as the bundled nature of the measure does not help hospitals target specific areas for improvement and survival rates where SEP-1 was employed were not significantly improved with the bundle. Including this measure would put receiving hospitals at a disadvantage since patients received in transfer are excluded from SEP-1, which lowers the denominator for measure calculation. Furthermore, this measure unfairly disadvantages facilities that have large subsets of patients when elements of the SEP-1 bundle may be contraindicated, but are not excluded, for example, with burn victims or patients with sickle cell.

Additionally, including SEP-1 in the VBP safety domain goes against CMS's efforts to move away from chart abstracted measures. **FHA strongly urges CMS to not finalize the inclusion of this measure and recommends that the agency consider redesign or replacement of SEP-1, moving away from the pass-fail bundle model and limiting the measure to individual elements with strong, consistent evidence-based criteria such as time to antibiotic, or to use an outcome measure such as sepsis mortality observed to expected ratios.** Measures other than SEP-1 will allow hospitals the flexibility to adjust as best practice evidence evolves.

Addition of Three New eCQMs

Beginning with the CY 2025 reporting/FY 2027 payment year, CMS proposes to add three new measures to the menu of electronic clinical quality measures (eCQMs) to the list hospitals can choose to fulfill the IQR's eCQM reporting requirements. These include Hospital Harm - Pressure Injury, Hospital Harm – Acute Kidney Injury and Excessive Radiation Dose or Inadequate Image Quality for CT in Adults.

- *Hospital Harm – Pressure Injury*

FHA supports adding this proposed measure to the menu of available eCQMs in the IQR and Promoting Interoperability Program. This measure assesses the proportion of inpatient hospitalizations for patients 18 years and older that develop a new stage 2, stage 3, stage 4, deep tissue or unstageable pressure injury, and is not risk-adjusted. CMS uses a nearly identical version of this measure in several post-acute care quality reporting programs, where pressure injuries are under constant surveillance due to the nature of patients receiving long-term care.

We appreciate that CMS has taken steps to improve this measure from its initial development by more effectively excluding pressure injuries that are unlikely to be attributable to the hospital. For example, the measure now excludes pressure injuries that are present on admission or that develop in a time window where the cause is unlikely to be tied to quality of care at the admitting hospital. In addition, we believe using EHRs as the basis to capture pressure injury data likely is appropriate as more clinical documentation of pressure injuries becomes electronic.

- *Hospital Harm – Acute Kidney Injury*

FHA does not support the adoption of this measure for the IQR or Promoting Interoperability Program currently. While we appreciate the concept of using an EHR-based measure to identify a precursor to a potentially serious safety event, there are significant questions about whether the definitions and focus of this measure are appropriate. At a minimum, we urge CMS not to adopt the measure unless and until it has been endorsed by a consensus-based entity.

- *Excessive Radiation eCQM*

FHA supports adding Excessive Radiation Dose or Inadequate Image Quality for CT in Adults to the menu of available eCQMs for the IQR program; However, we urge CMS not

to mandate reporting for this measure until hospitals gain further implementation experience.

Severity Level Designations for Homelessness

CMS requested public comments on how the reporting of diagnosis codes in categories Z55-Z65 might improve the ability to recognize severity of illness, complexity of illness and/or utilization of resources under MS-DRGs.

We support the use of all diagnosis codes to evaluate the resources needed to care for the patient and believe that z-codes provide valuable information about the patient that impacts their care. FHA appreciates CMS's review and analysis of data to measure the impact of homelessness on hospital resource use for those patients with secondary diagnosis of Z59.0 (Homelessness unspecified), Z59.01 (Sheltered homelessness) and Z59.02 (Unsheltered homelessness). Longer hospital stays are associated with homeless patients since these patients typically are accessing care at later stages of an illness and are less likely to have resources to manage chronic conditions or medications. Additionally, while they have been medically cleared for discharge, they do not have a safe place to recover so they remain in the hospital until they are better able to function as they could prior to admission. The data proved what hospitals have shared regarding patients with housing challenges.

FHA strongly supports changing the severity level for diagnosis codes X59.00, Z59.01 and Z59.02 from NonCC to CC for FY 2024 and appreciates CMS acknowledging the additional resource requirements associated with patients who are homeless.

Modified COVID-19 Vaccination Coverage among Health Care Personnel (HCP) Measure

Beginning with the FY 2025 IQR, CMS would adopt a modified version of the COVID-19 Vaccination Coverage among health care personnel ("HCP") currently used in the IQR. While the current measure assesses the number of HCP "who have received a complete vaccination course against COVID-19," CMS would replace this term with "who are up to date" with their vaccination as recommended by the Centers for Disease Control and Prevention ("CDC") at the time of the reporting period.

The FHA supports appropriate vaccination of HCP to guard against transmission of and exposure to infection diseases within the hospitals, and to protect patients and staff. However, the evidence around the optimal cadence for booster doses of COVID-19 vaccines, as well as the seasonality of the virus itself, is evolving rapidly. Even federal guidance on vaccine

utilization is frequently in flux; for example, as CMS notes in the Proposed Rule, the monovalent booster recommended by the CDC is no longer authorized for individuals 12 years or older.

Over the past several months, CDC and FDA have indicated they are seriously considering adoption of a once-yearly regimen for COVID-19 vaccinations, comparable to the well-established approach used for influenza vaccination.

We recommend CMS withdraw the proposed mandatory reporting requirement and continue to collect up-to-date vaccination status on a voluntary basis. Once FDA and CDC have completed their recommendations on an updated vaccination schedule, CMS considers ways to minimize the burden of data collection and reporting by working with provider stakeholder, and can offer a single annual reporting period, then a new proposed rule should be offered.

FHA is concerned that CMS is overlooking the administrative burden associated with collecting and reporting COVID-19 vaccination statute. We encourage CMS to learn from the experience of implementing the previous version of this measure and anticipate logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs.

Health care facilities are collecting and reporting data on up-to-date COVID-19 vaccination status on a voluntary basis. However, facilities have reported that this collection process is quite administratively burdensome under CDC's current up to date definition. This is because the collection protocol uses a reference time-period for determining up to date status that changes every quarter. Practically speaking, this means that HCP who counted as up to date in a given quarter may no longer be up-to-date in the next quarter.

Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCP may need an additional booster. In fact, collecting accurate data on a HCP's underlying risk factors likely would require hospitals to both obtain permission to have such data, and a mechanism to keep the data fully secure. This would be a resource intensive process, that would make reporting incredibly difficult.

Insofar as CMS moves forward with this measure, the adoption of a once-yearly vaccination regime would alleviate some of the administrative complexity of collecting up to date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and

White House, suggests that such a schedule could be adopted as soon as Fall 2023. By delaying the required reporting of "up to date" vaccination status, CMS could align its reporting requirements around this more efficient approach.
As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS's stated goals of encouraging vaccination).

CMS also should consider what may not be reflected in the data and how incomplete data could impact information provided to patients. Many HCPs are not vaccinated because of religious or medical reasons. Understanding whether an HCP is not up to date because of religious or medical reasons will become even more difficult to ascertain as the CMS withdraws the condition of participation that requires health care facility staff to be vaccinated. Similar to the burden associated with hospitals tracking HCP risk factors (described above), hospitals will not have access to HCP reasons for not receiving the COVID-19 vaccine. **As patients consider a facility's up to date vaccination rates the numbers should not be skewed by HCP who are not up to date because of religious or medical reasons.**

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among health care personnel. **The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of health care personnel who are up-to-date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects.**

Updated Hybrid Measures

Starting with the July 1,2024-June 30, 2025 performance data and impacting the FY 2027 payment determination, CMS is proposing to expand the cohort of the Hybrid Hospital Wide Mortality ("HWM") and Hospital Wide Readmission ("HWR") to include a cohort of patients which includes both Fee For Service ("FFS") and Medicare Advantage ("MA") patients 65-94 years. **FHA supports including MA beneficiaries in the data cohort as they represent 55% of all Florida Medicare beneficiaries, with some areas much higher than the state average.** We agree using data on Medicare Advantage beneficiaries along with Medicare FFS

will increase the size of the measure's cohort, enhance the reliability of the scores, increase the number of hospitals receiving results and ensuring that quality is measured across all Medicare beneficiaries.

However, given some of the discharge challenges are our hospitals are experiencing with patients in MA plans, we encourage CMS to review differences in outcomes for these two patient populations to ensure MA patients receive the same standard of care and necessary resources. For example, our hospitals frequently share challenges with placing MA patients in skilled nursing facilities and significant delays in MA patients getting the necessary home care, which could lead to higher readmission rates or mortality. These issues could impact the hybrid hospital-wide readmission and mortality rates in ways that are beyond the hospital's control. CMS should consider having these measures reviewed by a multi-stakeholder consensus building entity prior to implementation.

Proposed Measure Removal

CMS proposes to remove three measures – Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty, beginning with the April 1, 2025 through March 31, 2028 reporting period/FY 2030 payment determination; Medicare Spending Per Beneficiary beginning with the CY 2026 reporting period/FY 2029 payment determination and the Elective Delivery Prior to 39 Completed Weeks Gestation beginning with the CY 2024 reporting period/FY 2026 payment determination. Additionally CMS is proposing to codify the Measures Removal Factors previously adopted for the Hospital IQR program. **FHA supports the removal of these three measures and the codification of the Measures Removal Factors.**

HCAHPS Changes

CMS proposes several significant changes to the data collection and survey administration processes for the HCAHPS. These changes would affect HCAHPS data collection starting with discharges on or after Jan. 1, 2025, and affecting FY 2027 payment. **FHA supports CMS adding three new permissible survey models, specifically the web-based option.**

Potential Future Structural Measures on Care for Geriatric Patients

For future IQR programs, CMS is considering the adoption of two structural measures reflecting the extent to which hospitals adopt certain practices related to geriatric care. One of the measures, "Geriatric Hospital Care," includes eight domains and 14 individual practices that CMS believes would comprise a "comprehensive framework for the optimal care of older

patients." The second measure, "Geriatric Surgical Care," includes seven domains and 11 individual practices reflecting practices thought optimize pre-and-post surgical care and outcomes. CMS also is considering a future designation for geriatric care that would be reflected on its Care Compare website that could include these measures or other measures focused on the care of older adults.

As CMS notes, as the population ages, care can become more complex with patients developing multiple chronic conditions and having complex behavioral and psychosocial needs beyond their medical condition. CMS notes this requires a more holistic approach that reimagines how care is delivered. In the proposed rule, CMS discusses the work that has been championed by several organizations, including the American Hospital Association, regarding Age-Friendly Health Systems. **FHA supports this work and believes in the value of adopting practices that provide patient centered care specifically addressing the unique needs of the aging population.**

We appreciate the work that has gone into the development of these measures and support a separate category for surgical care. While we feel the domains addressed are the right ones, we do not feel the attestation based structural measures are useful for public reporting because they do not directly reflect actual performance as either process or outcome measures. For example, several of the questions ask hospitals to confirm whether they "have protocols" for establishing certain processes. These attestations are not clear and specific enough to glean meaningful information about quality of care or patient experience. **CMS should continue its work to develop measures that are more likely than these attestation measures to lead to improvement in care for the geriatric population.**

Thank you again for the opportunity to provide feedback on this proposed rule. If you have any questions please do not hesitate to reach out to Michael Williams, FHA's Senior Vice President of Federal Affairs at michaelw@fha.org.

Sincerely,

Mary C. Mayhew, President and CEO