PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 8, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1785-P

Submitted electronically to: http://www.regulations.gov

Re: Medicare Program; 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 and Supplier Disclosure of Ownership [Docket Number: CMS-1785-P]

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed rule, which was published in the May 1, 2023 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Adopt new or supplemental data sources, such as PINC AI™ data, to ensure labor costs are adequately reflected in the Medicare hospital payment update in the final rule. Premier also strongly urges CMS to apply a one-time adjustment to course correct for its significantly lower estimates of costs for FYs 2021-2023. At a minimum, CMS must address the gross underpayment that occurred in FY 2022 via a one-time adjustment of at least 3 percent.

- Provide greater transparency around the assumptions it uses for calculating uncompensated care payments and better account for the unwinding of certain COVID-19 policies, such as the Medicaid continuous enrollment provision, when estimating the rate of uninsured for FY 2024.

- Solicit input from the hospital community on 1) reforms to the wage index and 2) efforts to improve the sustainability of workforce, especially in rural and underserved communities.

- Finalize its reclassification of the Z-codes representing homelessness and consider ways to address persistent issues that may limit how accurately these and other Z-codes are capturing the significant resource use involved in providing care to underserved populations.

- Continue to evaluate and revisit the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure and its utility for patients and facilities as part of next year's rulemaking. Premier is generally supportive of revising the measure to align with the Centers for Disease Control and Prevention (CDC) recommendations; however, we are concerned this change will impose significant burden on facilities and believe the measure should be re-evaluated in light of where the nation is in its COVID-19 response. At a minimum, Premier urges CMS to revise the measure to only require annual reporting, which would align with reporting requirements for the influenza measure.

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- Not finalize adoption of the Severe Sepsis and Septic Shock: Management Bundle (SEP-1) measure into the Hospital Value-Based Purchasing (VBP) Program. As discussed in greater detail below, this measure poses significant burden on providers and is generally not aligned with national guidelines for care. Premier instead strongly urges CMS to work with relevant stakeholders to develop an outcome-based digital quality measurement that is a true metric of sepsis care.

- Work with stakeholders to fine-tune its methodology for calculating a health equity adjustment in the Hospital VBP Program prior to adoption. While Premier is conceptually supportive of a health equity adjustment, there are several challenges associated with the proxies that CMS is considering for measuring a hospital's underserved population that must be addressed, especially in light of the redistributive impacts the addition of the bonus may have on Hospital VBP Program incentive payments.

- Work with the hospital community to understand the burden associated with implementing certain electronic clinical quality measures (eCQMs) and the system changes that will be required prior to requiring them to be reported in either the pay-for-reporting or pay-for-performance quality reporting programs.

BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters, and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

IPPS RATE UPDATES AND IMPACTS OF RISING LABOR COSTS

Background

The hospital market basket is an input price index that measures the average percentage change in the price of goods and services hospitals purchase to provide inpatient care. As a fixed-weight index, the hospital market basket measures changes in prices over time of the same mix of goods and services purchased during a base period. As a result, any changes in the mix of goods and services are not measured annually. CMS rebases the hospital market basket every four years. The current market basket, which was rebased for FY 2022, reflects hospital costs from Medicare cost reports that began on or after October 1, 2017 and before October 1, 2018.

CMS updates the market basket annually by forecasting costs using available historical data. To update the market basket for the FY 2024 proposed rule, CMS utilized the IHS Global Inc.'s (IGI's) fourth quarter 2022 forecast, which includes historical data through third quarter of calendar year (CY) 2022. Following past practice, we anticipate the final rule will be based on more recent data and include historical data through second quarter of CY 2023.

Proposals and Recommendations

Based on its standard methodology for updating the hospital market basket, CMS proposes to update IPPS operating payments for FY 2023 based on a forecasted 3.0 percent increase to the hospital market basket. After accounting for the -0.2 percent adjustment for productivity, CMS estimates that operating payments will increase by 2.8 percent in FY 2024. **Premier has significant concerns that the proposed payment update does not adequately reflect the rising costs that hospitals have faced over the last few years, especially as it relates to labor costs.**

A recent PINC AI™ analysis found that labor costs have increased by more than 15 percent since the start of FY 2020 through the first half of FY 2023 and do not show signs of returning to a lower level. From FY 2021 to FY 2022 alone, labor costs increased by nearly 10 percent. To determine changes in hospital labor costs, PINC AI™ analyzed the data within its workforce optimization solutions, one of the nation's largest and most robust sources for standardized geographically diverse payroll data and benchmarks. The data comes directly from a hospital's general ledger and is collected and validated by health system users daily.

Our analysis found that increased labor costs are significantly higher than what CMS has finalized over the last couple years and is currently estimating as part of its market basket update for FY 2024. The proposed update to the hospital market basket of 3.0 percent for FY 2024 is based in part on its projection of a 3.9 percent increase in compensation and benefits for FY 2024.[1] CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI). Specifically, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers. As noted above, there is a lag in the data that CMS uses to update the market basket annually, and the proposed update is based on historical data through third quarter of CY 2022. This compares to the Premier data that comes directly from hospital payroll in real time. Another critical difference between Premier's analysis and the ECI data is that the ECI survey of hospital employment costs only includes employed hospital staff, not contracted workers.[2]

The significant increases in labor expenses over the last couple years are largely driven by two factors:

- *Increased utilization of contract staff:* Over the past few years, many hospitals have relied on contract staff – especially contract nurses – to help alleviate workforce shortages. Based on PINC AI™ data, the use of contract labor (as a percentage of total staff hours) nearly doubled from the start of 2021 through 2022. With increased demand, we also saw a significant increase in compensation for contract labor. According to PINC AI™ data, the average salary for contracted nurses doubled between the start of FY 2020 and the first half of FY 2022, when salaries for contract labor peaked. Our data indicates that while salaries for contract nurses has decreased some from this peak in certain geographical areas, salaries remain 72 percent higher as of the first half of FY 2023 as compared to the start of FY 2020. While this increase in the use of contracted staff may be temporary, it does suggest a reason why the hospital

[1] Approximately 67.6 percent of the market basket is related to labor costs, often referred to as the labor-related share. Wages and salaries and fringe benefits for civilian workers in hospitals – which is updated based on the BLS ECI data – account for 53 percent of the market basket. The remaining 14.6 percent of labor costs is accounted for by professional fees, administrative and facilities support, installation, maintenance and repair and all other labor costs.
[2] Per discussions with CMS Office of the Actuaries (OACT)

market basket for FY 2021 and FY 2022 understated hospital increases in costs, as discussed in more detail below.

- *Growth in employee salaries:* Our data also indicates significant growth in salaries for employed workers over the last couple years; this growth does not show signs of slowing as employers leverage increased salary and benefits as a retention strategy to address workforce shortages. According to PINC AI™ data, salaries for employed staff have increased by 13.6 percent overall since the start of FY 2020, with employed nurses seeing a more than 17.5 percent increase in salaries on average overall.

The use of contract labor and overall increased labor costs have been driven by significant workforce shortages. Before the pandemic, many clinical staff were in short supply and growing closer to retirement age. According to pre-pandemic research published in 2018, healthcare was projected to be short more than 1 million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant talent pipeline.[3] Since that time, the pandemic has only exacerbated matters, prompting a significant increase in clinician resignations and retirements; for example, more than 500,0000 nurse retirements were expected in 2022.[4] A recent analysis finds that by 2025, it is expected that the United States may have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap.

This significant and growing deficit in the workforce supply indicates that it is unlikely these increased labor costs are transitory, but rather a new normal that reflects shifting market dynamics. As talent shortages become more severe, providers are paying more to attract and retain scarce staff, and our analysis indicates it is likely that these wage increases have set a new floor. However, the BLS' ECI does not accurately reflect the increased and persistent labor costs resulting from these projected ongoing shortages.

Given the significant delta between the increased cost of labor calculated by PINC AI™ versus what CMS is estimating, Premier has significant concerns that CMS' data source for estimating the cost of labor does not capture current market dynamics and woefully underestimates the true cost of healthcare labor across the country. This gross underestimate by CMS will result in a fourth consecutive year where the IPPS payment update is not reflective of the actual cost increases hospitals are experiencing. This comes at a time when many acute care providers are struggling to stay afloat after years of COVID-related financial losses, high inflation, and increased labor expenditures. **Premier continues to strongly recommend that CMS use its exceptions and adjustments authority to adopt new or supplemental data sources, such as PINC AI™ data, to ensure labor costs are adequately reflected in the payment update in the final rule.** It is imperative that CMS diversify its data sources to ensure a more accurate, blended labor impact rate for FY 2024 and beyond.

In addition to updating the data sources for calculating the annual market basket update in FY 2024, Premier recommends that CMS reevaluate the data sources it uses for rebasing its market basket and calculating the annual market basket update, including labor costs. We strongly encourage CMS to adopt new or supplemental data sources in future rulemaking that more accurately reflect the costs to hospital, such as through use of more real time data from the hospital community. For example, in future years we would encourage CMS to utilize supplemental data sources to evaluate the accuracy of the ECI proxy and to modify methodologies, including adopting new or supplemental data, to calculate the payment update if its analysis determines that the ECI is not adequately capturing labor costs. Premier believes that the current market basket does not account for the higher costs of contract labor which have become more common in hospitals in an era of clinical labor shortages.

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[3] Zhang, Ziaoming, et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit,"*Americna Journal of Medical Quality,* 2018, Vol. 33(3) 229–236, https://edsource.org/wp-content/uploads/2019/02/Zhang-Daniel-Pforsich-Lin-2017-United-States-Registered-Nurse-Workforce-Report-Card-and-Shortage-Forecast_-A-Revisit.pdf

[4] American Nurses Association, "Nurses in the Workforce," https://www.nursingworld.org/practice-policy/workforce/

In addition to ensuring the market basket update is accurately calculated moving forward, we are concerned that CMS has underestimated the hospital market basket update for the last few years, resulting in a permanent depression of payments for hospitals moving forward. CMS finalized market basket updates of 2.4 percent, 2.7 percent and 4.1 percent for FYs 2021, 2022 and 2023 respectively. According to CMS' latest forecasts, these updates are notably lower than what CMS is now estimating based on actual data. Of particular note, CMS now estimates that total hospital costs increased by 5.7 percent in FY 2022, which is *3 percentage points higher* than the market basket update that CMS finalized for that year (2.7 percent).[5] CMS also now estimates that costs for FY 2021 (3.0 percent) were 0.6 percentage points higher than its FY 2021 market basket and projects that FY 2023 costs will be 0.5 percentage points (4.6 percent) higher than its market basket update for that year.

As a result, Premier strongly urges CMS to use its exceptions and adjustments authority to apply a one-time adjustment to course correct for its significantly lower estimates of costs for FYs 2021-2023. Because the annual payment update builds on the prior year's payment rate, failing to correct CMS' gross underestimation of the payment updates during the pandemic will further perpetuate inaccuracies in the payment rate moving forward, resulting in a permanent cut to hospital payments. Given the unprecedented circumstances and the significant effect of the pandemic on hospital inflation, Premier believes that a one-time update to the market basket recognizes the extraordinary price increases that hospitals experienced during the pandemic compared to the inflation update they actually received for FY 2021-2023. **At a minimum, CMS must address the gross underpayment that occurred in FY 2022 via a one-time adjustment of at least 3 percent.**

In last year's IPPS rule, CMS responded to a number of public comments requesting a methodological change to the market basket update, stating "we further note that we did not propose to use other methods or data sources to calculate the final market basket update for FY 2023." The implication of this response is that CMS would not be in compliance with the rulemaking procedures under section 1871 of the Act if it finalized a policy that was not explicitly proposed. However, CMS has made the inpatient update and the hospital market basket subject to public comment. Premier believes CMS could consider adopting policies in response to our comments about utilizing additional data sources and making a one-time adjustment to the FY 2024 hospital market basket on the basis that these policies are a "logical outgrowth" of the proposed policy under consideration consistent with section 1871(a)(4) of the Act.

UNCOMPENSATED CARE PAYMENTS (UCP)

Background

CMS estimates that approximately $6.874 billion will be available in uncompensated care payments for qualifying IPPS hospitals in FY 2024, which is an approximately 2.3 percent decrease from FY 2023. This decrease is driven by updated assumptions regarding hospital discharges, which are discussed in greater detail below.

Since FY 2014, CMS has calculated uncompensated care payments as the product of three factors:

- Factor 1*:* 75 percent of the aggregate DSH payments that would be made in the absence of the Affordable Care Act (ACA)
- Factor 2: Percentage change in uninsured since implementation of ACA
- Factor 3: A hospital's uncompensated care costs for a given time period relative to uncompensated care costs for that same time period for all hospitals that receive Medicare DSH payments

[5] CMS Market Basket history and forecasts, https://www.cms.gov/files/zip/market-basket-history-and-forecasts.zip

Below we detail concerns about CMS' estimates of Factors 1 and 2 that determine the aggregate pool of uncompensated care funding that will be distributed to hospitals. As the statute precludes administrative or judicial review of the uncompensated care calculation, it is imperative that CMS accurately determine both Factor 1 and Factor 2 as these estimates are not subject to any further revision.

Proposals and Recommendations

Factor 1

CMS' Office of the Actuary estimates Factor 1 based on the most recently available data and adjusts this estimate to account for inflation, changes in utilization, case-mix and other factors. CMS proposes a Factor 1 amount of $10.216 billion, which is a $245 million decrease (-2.3 percent) in FY 2024 as compared to FY 2023.

The primary driver of this decrease is changes in assumptions related to discharges. Specifically, CMS decreased its estimate of discharges in both FY 2022 and FY 2023 by 4.6 percent and 7.7 percent, respectively. CMS also estimates similar discharges in FY 2024 as in FY 2023, noting that its FY 2024 estimate is based on "recent trends recovering back to the long-term trend and assumptions related to how many beneficiaries will be enrolled in Medicare Advantage (MA) plans."

Premier urges CMS to provide greater transparency around the assumptions it uses for calculating Factor 1. For example, greater clarity is needed regarding the changes in its assumptions regarding hospital discharges. It is unclear how CMS accounted for the impacts of the COVID-19 pandemic in its assumptions and the effects this has on CMS' projections moving forward. Premier also continues to urge CMS to provide additional information on its assumptions around the "Other Factor" component of Factor 1, which includes various adjustments to payment rates not accounted for by the update, case-mix, or discharge factors. To-date, CMS has provided minimal transparency of how the Other Factor is calculated. Additionally, Premier urges CMS to clarify its assumptions regarding MA enrollment and the impact it anticipates this will continue to have on estimated uncompensated care payments. While continued MA enrollment growth is anticipated, hospitals will continue to provide a significant share of uncompensated care despite MA enrollment trends.

Finally, **Premier is concerned that CMS' estimates of case-mix for FY 2022 and FY 2023 underreport the acuity of patients.** During the pandemic, many patients, particularly patients with chronic conditions, delayed or did not seek needed care out of concern of contracting COVID-19 or because they were sheltering at home. Studies have found that delayed care may contribute to higher mortality rates and comorbidities.[6] We continue to urge CMS to evaluate its case-mix predictions to account for effects from the pandemic.

Factor 2

Factor 2 is used to adjust Factor 1 based on the change in uninsured since implementation of the ACA. Since FY 2018, CMS has used uninsured estimates from the National Health Expenditures Accounts (NHEA). For FY 2024, CMS estimates that the uninsured rate will be 9.2 percent, which is the same as the estimate for FY 2023. Premier is concerned that the proposed uninsured estimate does not fully account for the end of PHE and the expiration of the Medicaid continuous enrollment provision.

Under the Families First Coronavirus Response Act, state Medicaid programs were prohibited from disenrolling individuals during the PHE. As a result, Medicaid enrollment grew significantly during the PHE. However, with the end of the PHE and the continuous enrollment provision, HHS' Assistant Secretary for Planning and

[6] Smith, M, Vaughan Sarrazin, M, Wang, X, et al. Risk from delayed or missed care and non-COVID-19 outcomes for older patients with chronic conditions during the pandemic. J Am Geriatr Soc. 2022; 70(5): 1314- 1324. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17722

Evaluation (ASPE) projects that 17.4 percent of Medicaid and Children's Health Insurance Program (CHIP) enrollees (or approximately 15 million individuals) will leave the program.[7] Some of those individuals will lose coverage despite being eligible, which is something many states are working to mitigate. However, ASPE estimates that 9.5 percent of Medicaid enrollees will leave the program due to loss of coverage and will need to transition to another source of insurance. While the ASPE analysis found that most individuals who become ineligible for Medicaid or CHIP will be eligible for other forms of coverage, this will greatly depend on those individuals taking action to enroll in other insurance options. A Kaiser Family Foundation analysis found that among individuals disenrolling form Medicaid, 65 percent had a period of uninsurance in the year following disenrollment and only 26 percent enrolled in another source of coverage following the year of disenrollment.[8]

Because of the end of the continuous enrollment provision, Premier is skeptical that the uninsured rate will remain level from FY 2023 to FY 2024. **Therefore, Premier urges CMS to take the expiration of the continuous enrollment provision into account when updating its estimate of uninsured in the final rule.** At a minimum, CMS should provide additional detail on how it accounted for the expiration of this policy in its analysis.

Factor 3

Factor 3 is used to determine the amount of uncompensated care payments that each hospital will receive. Beginning in FY 2018, CMS began transitioning to data from Worksheet S-10 of the Medicare hospital cost reports when calculating allocations of uncompensated care. In FY 2023, CMS finalized a policy of using a multi-year average of audited Worksheet S-10 data to determine Factor 3 for subsequent fiscal years. For FY 2024, CMS will be using the most recent 3 years of audited cost reports from FY 2018, FY 2019, and FY 2020.

Premier continues to support moving to a three-year average of audited Worksheet S-10 data. As we have noted in prior comments, using three years of data will help to smooth out variations in uncompensated care from year-to-year.

Finally, we appreciate recent CMS efforts to clarify the Worksheet S-10 instructions over the last several years. **Premier urges CMS to work with its Medicare Administrative Contractors (MACs) to establish consistent auditing practices and provide greater transparency on auditing protocols, such as making audit instructions publicly available.** Some stakeholders have expressed concern with the lack of consistency that the MACs apply to audits – both across MAC jurisdictions and across auditors within the same MAC. This has resulted in auditors requesting hospitals to resubmit information in completely different formats than what was originally required or hospitals having to submit different information depending on the individual auditing them. Additionally, CMS should consider implementing a system edit to ensure the S-10 is complete and internally consistent and instruct the MACs to audit negative, missing or suspicious values.

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[7] Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches (Issue Brief HP-2022-20) Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

[8] Tolbert, Jennifer and Ammula, Meghana, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," Kaiser Family Foundation, April 5, 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/#:~:text=As%20part%20of%20the%20Consolidated,matching%20funds%20through%20December%202023.

CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS

Background

CMS adjusts a portion of hospital payments to account for area differences in the cost of hospital labor, known as the wage index. Statute requires CMS to update hospitals' wage indexes annually based on a survey of wages and wage-related costs (fringe benefits) of short-term, acute care hospitals, which is collected through the Medicare cost reports. As a result, there is generally a four-year lag in data. FY 2024 wage indexes will be updated based on data from the FY 2020 submitted cost reports. Statute requires any changes made to wage indexes to be done in a budget neutral manner.

As part of FY 2020 rulemaking, CMS adopted a low-wage index policy focused on increasing wage indexes for hospitals in the lowest quartile of wage indexes nationwide. The policy was originally intended to support hospitals in the lowest quartile in increasing wages and was adopted for four years to ensure sufficient time for this data to be reflected in hospitals' cost reports, and subsequently the updated annual wage index. Under this policy, CMS increases the wage indexes below the 25th percentile by one-half the difference between the hospital's wage index and the 25th percentile wage index. CMS applies a budget neutrality adjustment across all hospitals to account for the increase in wage indexes for hospitals in the lowest quartile.

The low-wage index policy has been subject to on ongoing litigation *(Bridgeport Hospital vs. Becerra*), with the D.C. District Court ruling last spring that the Secretary did not have the authority under statute to adopt the low-wage index policy and ordering additional briefing on the appropriate remedy. CMS subsequently appealed the court decision, and that appeal is still pending.

Proposals and Recommendations

The low-wage index policy was intended to only be in place for four years to allow enough time for increased wages to be reflected in cost report data, and thus was set to expire after FY 2023. However, CMS notes that it only has one year of data under the policy because of the lag in applying cost report data to the wage index. As a result, CMS proposes to continue the policy and related budget neutrality adjustments to allow more time to collect data and to evaluate the policy. CMS does note it may modify or discontinue the policy in the final rule pending developments in the court proceedings or public comment.

Premier appreciates CMS' recognition of a shortcoming in the wage index methodology, which has been detrimental to hospitals located in certain states and regions where wages tend to be depressed and especially affects rural hospitals. **Premier is supportive of efforts to improve how the wage index system works to ensure all hospitals receive accurate and adequate payments to support their workforce. Premier strongly encourages CMS to actively solicit input from the hospital community on reforms to the wage index and efforts to improve the sustainability of workforce, especially in rural and underserved communities.**

SAFETY NET HOSPITALS – REQUEST FOR INFORMATION (RFI)

CMS is requesting public feedback on how to identify and define safety net hospitals for policy purposes, noting that "safety net" is commonly used to refer to healthcare providers that furnish a substantial share of services to uninsured and low-income patients.

While Premier supports the concept of developing a mechanism to identify safety net hospitals, we note that context is key, and that it is difficult to fully vet potential approaches to a safety net hospital

definition without better understanding how CMS intends to apply it. That said, Premier offers some considerations for CMS as it identifies next steps:

- Some of CMS' questions relate to potential payment approaches to address the challenges faced by safety net hospitals. **As it is highly likely that a new payment approach would redistribute funds currently available for hospitals, it is imperative that a safety net designation be data-driven, validated and reflect engagement by a wide range of stakeholders.** This process should go beyond soliciting comments in a RFI or other rulemaking process and include stakeholder discussions that provide real-world context to data analysis and feedback received by CMS. Further, any payment approach should not impact current programs, such as Disproportionate Share Hospital (DSH) and uncompensated care payments.

- **Premier recommends that any safety net definition be applicable across CMS programs** – in other words, the same definition should be used to identify safety net hospitals under Medicare and Medicaid, as well as for purposes of the Center for Medicare & Medicaid Innovation (CMMI). In recent publications and speaking engagements, CMMI has noted that it is developing policy levers and outreach to better engage safety net providers in its value-based care models. In this RFI, CMS indicates it is also considering how to assist safety net hospitals. As multiple groups within CMS seek to better integrate safety net providers, it is critical that the work be harmonized and complimentary. Hospitals should be able to apply clear criteria to identify their safety net status and what policies are applicable to them as a result, without having to crosswalk multiple definitions across programs.

- As more care shifts to the ambulatory space, **CMS should consider how to account for outpatient care provided by hospitals to underserved patients** in a safety net hospital definition. Currently, an approach to quantify uncompensated care in an outpatient setting does not exist and would be useful to create as care shifts away from the inpatient setting.

CMS also requests feedback on the potential use of the Area Deprivation Index (ADI) in identifying safety net hospitals. While CMS does not specify how the ADI would be applied, Premier has some general reservations about this use of an area-related index as well as the ADI itself. Specifically, Premier is concerned that an area-related index does not capture patient-specific situations, and thus its use as a proxy may not fully identify undeserved beneficiaries to whom hospitals are providing care. For example, if a patient had their own socioeconomic crisis in a more well-to-do area, it would not be identified through application of an area-related index. In fact, a similar limitation was recently identified in a Health Affairs article focused on the ADI,[9] which essentially noted that high home values can mask high deprivation in other social risk factors.

If CMS does move forward with incorporation of an area-related index into the definition of a safety net hospital, Premier encourages utilization of a dataset that is publicly available and that can be used without restrictions. While users can download full datasets of the ADI data, data use is limited for non-profit education, research and public health purposes. As a result, hospitals would be unable to partner with other organizations to digest and format this data in a way that would allow them to easily identify which of their patients would "count" for purposes of safety net designation.

[9] "ACO Benchmarks Based On Area Deprivation Index Mask Inequities", Health Affairs Forefront, February 17, 2023, https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities

CHANGES TO SEVERITY LEVELS FOR Z-CODES DESCRIBING HOMELESSNESS

Background

IPPS payment is made based on the use of hospital resources in the treatment of a patient's severity of illness, complexity of service, and/or consumption of resources. Generally, a higher severity level designation of a diagnosis code results in a higher payment to reflect the increased hospital resource use associated with the diagnosis.

In prior rulemaking, CMS requested comments on how the reporting of diagnosis codes in categories Z55-Z65 (known as "Z-codes") that describe social determinants of health (SDOH) might improve its ability to recognize severity of illness, complexity of illness, and/or utilization of resources for these SDOHs. CMS also sought comment on which specific SDOH Z-codes were most likely to influence hospital resource utilization related to inpatient care. At the time, the agency noted that it believed a potential starting point was consideration of the SDOH Z-codes describing homelessness, as homelessness can be reasonably expected to have an impact on hospital utilization.

Proposals and Recommendations

CMS proposes to change the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness)) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC) for FY 2024. CMS bases this proposal on its analysis of claims for which these codes are listed as a secondary diagnosis, which resulted in a finding that the resources involved in caring for a patient experiencing homelessness are more aligned with a CC severity level than NonCC. Among the factors that may cause increased financial impact to hospitals, CMS notes that patients experiencing homelessness can require longer inpatient stays due to needing a higher level of care and/or difficulty finding discharge destinations to meet these patients' needs.

Premier supports reclassification of the Z-codes representing homelessness as a positive step in the right direction and urges CMS to finalize this policy. At the same time, Premier encourages the agency to consider ways to address persistent issues that may limit how accurately these codes are capturing the significant resource use involved in providing care to this population:

- For homelessness to be considered and associated resources to be adequately captured, hospitals must report corresponding Z-codes. Only a small fraction of claims incorporate these Z-codes, mainly because these codes introduce complexity for coders, necessitating additional time and lacking incentivization. Based on a Premier analysis using the CMS Medicare Standard Analytical Files for 2021, out of 8.1 million Medicare claims from inpatient acute care and critical access hospitals nationally, only 200,904 total SDOH codes were reported, with another 242,812 codes reported for homeless.
- Coders will need additional guidance as they often see a listing of SDOH information in the patient's history, but nothing documented on how the SDOH is related to an associated problem or risk factor directly. Many times, this impact is inferred from the information in the record but not fully documented specifically by the provider, which complicates an already arduous process.
- Similarly, providers may not be accustomed to routinely capturing this information as part of their provision of care for a patient and may thus require training and education.
- Expressing certain social risk factors, such as homelessness, can be uncomfortable for patients, which could result in underreporting. As a result, the Z-code may not accurately represent the entire population.

Finally, Premier notes that the presence of a home does not guarantee well-being, as individuals may still face problems that may impact their health such as pest infestations, lack of proper air conditioning or heating, and more. **Premier urges CMS to evaluate the severity designation for additional Z59 codes to in the future.**

QUALITY REPORTING PROGRAMS

Hospital Inpatient Quality Reporting (IQR) Program

Background

The Hospital Inpatient Quality Reporting (IQR) Program is a pay-for-reporting quality program. Hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update.

Proposals and Recommendations

Measures proposed for adoption

CMS proposes to adopt three electronic clinical quality measures (eCQMs) into the Hospital IQR Program. These measures would be added to the eCQM measure set that hospitals can select from to meet the eCQM reporting requirements for the Hospital IQR Program. Premier urges CMS to prioritize adoption of outcome-based quality measures that are minimally burdensome to hospitals.

1. ***Hospital Harm – Pressure Injury eCQM***

   The Hospital Harm – Pressure Injury measure is an outcomes-based eCQM that assesses the proportion of inpatient hospitalizations for patients 18 years and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The measure is intended to provide hospitals with a reliable and timely measurement of harm reduction efforts. CMS proposes to adopt the measure beginning with the CY 2025 reporting period / FY 2027 payment determination.

   Premier generally supports adoption of this measure into the IQR program as an eCQM that hospitals can select from to meet the eCQM reporting requirements. However, Premier encourages CMS to work with a technical expert panel to explore potential risk adjustment methodologies to ensure that facilities that treat more complex patients are not penalized. CMS should also consider exclusion criteria for end-of-life patients and those patients experiencing skin failure/perfusion injuries secondary to medical conditions and/or treatments (e.g., medication).

   Additionally, the measure currently excludes inpatient hospitalizations for patients with a COVID-19 diagnosis during the encounter. However, CMS notes that it anticipates removing this exclusion once there is a better understanding of COVID-19-related tissue breakdowns versus pressure injuries. Removal of this exclusion criteria would be considered a substantial measure refinement. As a result, Premier urges CMS to adopt any changes to remove this exclusion criteria through the rulemaking process, which will provide opportunities for CMS to engage with technical experts and receive public input on the change.

   CMS should also work with the hospital community to provide further education on this quality measure to help reduce inconsistencies in how facilities identify pressure injuries or stages of injuries. For example, Incontinence Associate Dermatitis (IAD) or Moisture Associated Skin Damage (MASD) are sometimes mistaken for a stage 2 pressure injury.

   The measure is proposed as an option that hospitals could select in meeting the eCQM reporting requirements. **Premier strongly discourages CMS from considering this measure as a mandatory measure at this time.** While this is an important patient safety measure, there are several operational

challenges that hospitals will need to work through in implementing this measure, including processes for validating assessments made by nursing staff. For example, hospitals will need to consider establishing processes to validate nursing documentation by wound care teams and/or designated individuals on each unit who have received additional pressure injury staging education. Adoption of the measure will also require facilities to build new templates and implement modifications to their electronic medical records (EMRs) to operationalize the measure, which takes both time and resources. As a result, CMS should maintain the measure as an option for those facilities that wish to report the measure to meet eCQM reporting requirements.

Finally, Premier recommends that the measure receive consensus-based endorsement prior to adoption into the IQR Program.

2. **Hospital Harm – Acute Kidney Injury (AKI) eCQM**

The Hospital Harm – Acute Kidney Injury measure is an outcomes-based eCQM that assesses the proportion of inpatient hospitalizations for patients 18 years and older who have a stage 2 or greater AKI that occurred during the encounter. The measure is intended to improve patient safety and prevent patients from developing stage 2 or greater AKI during hospitalizations. CMS proposes to adopt the measure beginning with the CY 2025 reporting period / FY 2027 payment determination.

Premier generally supports adoption of this measure into the IQR program as an eCQM that hospitals can select from to meet the eCQM reporting requirements. However, Premier encourages CMS to work with technical experts to refine the definition of a substantial increase in serum creatinine to ensure the measure accurately captures incidences of AKI. For example, a patient may have an initial decrease in creatinine, especially with a prolonged hospitalization (e.g., muscle mass loss), but then may see a rise in creatinine that is not actually reflective of AKI. Whether this rise is considered substantial may depend on whether it is compared against a chronic baseline or the lowest level of creatinine during a hospital stay.

Additionally, the measure is proposed as an option that hospitals could select in meeting the eCQM reporting requirements. **Premier strongly discourages CMS from considering this measure as a mandatory measure at this time.** Finally, Premier recommends that the measure receive consensus-based endorsement prior to adoption into the IQR Program.

3. **Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM (Excessive Radiation eCQM)**

The Excessive Radiation eCQM provides a standardized method for monitoring the performance of diagnostic computed tomography (CT) scans to discourage unnecessarily high radiation doses while preserving image quality. The measure captures the percentage of eligible CT scans that are out-of-range on either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam.

Premier generally supports adoption of this measure into the IQR program as an eCQM that hospitals can select from to meet the eCQM reporting requirements. There are currently no measures in the Hospital IQR Program that assess risk of radiation exposure from CT scans. If the measure is also proposed for adoption in the Hospital Outpatient Quality Reporting (OQR) Program, Premier encourages CMS to streamline reporting and allow hospitals to report one set of data for both the Hospital IQR and OQR programs, similar to how it approaches reporting for the influenza vaccine measures.

Finally, similar to the other two patient harm eCQMs under consideration, **Premier strongly discourages CMS from considering this measure as a mandatory measure at this time.**

Measures proposed for refinement

CMS proposes to refine three Hospital IQR Measures

1. ***COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)***

As part of FY 2022 rulemaking, CMS adopted the COVID-19 Vaccination Coverage among HCP measure across multiple quality reporting programs, including the Hospital IQR Program. This process measure requires hospitals to submit on a quarterly basis data on the percentage of HCP who have received a complete vaccination course against COVID-19. The measure is reported via the CDC's National Healthcare Safety Network (NHSN). Since adoption of the measure, CDC's guidelines regarding whether an individual is considered up to date on their COVID-19 vaccinations have evolved with the development of booster vaccines. As a result, CMS proposes to modify the measure to match current CDC guidance, beginning with the quarter 4 2023 reporting period/FY 2025 payment determination for the IQR Program.

Under this proposal, CMS would modify the measure to replace the term "complete vaccination course" with the term "up to date." Hospitals would be required to refer to the CDC definition of "up to date" as of the first day of the reporting quarter.

Premier is generally supportive of aligning with the CDC's definition of "up to date," however we are concerned this change will impose significant burden on facilities and that publicly reporting this data may have limited value to the public given the one-year lag in reporting and the end of the PHE.

In the rule, CMS notes that it does not believe updating the measure specifications will impose any additional burden on facilities and compares it to the annual influenza vaccination measure included in the Hospital IQR Program. **Premier disagrees with CMS' assertion that the measure changes will not impose new burden on facilities.** The updates to the measure will require facilities to track CDC guidance on a quarterly basis and will also require facilities to change their processes to track whether HCP have received multiple doses. If CDC were to update their guidance and require additional boosters, facilities would then need to validate whether all HCP met the new requirements. Facilities would also need to revise their exceptions process to ensure it is still consistent with any updated guidelines and that exceptions are still applicable for HCP who may have previously received exceptions. Additionally, the measure is not similar to the annual influenza vaccination measure, which is a simple "yes" or "no" as to whether HCP have received their annual flu shot.

Further**, Premier continues to urge CMS to expand the criteria of HCP that are exempted beyond those with contraindications as defined by the CDC.** There are numerous reasons beyond health contraindications that HCP may decide whether to be up to date with CDC recommendations. Over the course of the PHE, there have been many changes in COVID-19 vaccine availability and evolving CDC recommendations, contributing to wide variation in rates of vaccination among HCP. Further, rates of vaccination among HCP are largely dependent on factors outside a hospital's control, such as where the facility is located and personal preference of the hospital's staff. Additionally, state, local, and even individual health system policies governing COVID-19 vaccinations also vary. Some hospitals are requiring that all staff receive the vaccine, while some hospitals are located in states or localities where political pressure prevents them from setting a mandatory vaccine policy.

With the end of the PHE on May 11, 2023, CMS has rolled back numerous requirements that were in place to tackle the COVID-19 pandemic, including a federal mandate requiring the vaccination of healthcare personnel.[10] In the IPPS proposed rule, CMS notes the efficacy of vaccines in preventing the worst consequences of COVID-19 and that it believes the measure will continue to provide valuable information to patients and their caregivers, even with the end of the PHE. Premier is comfortable with continuing reporting on this measure for 2024 as the Administration and the broader healthcare ecosystem continue to assess what COVID-19 looks like moving forward and the need for ongoing vaccinations and boosters. However, Premier encourages CMS to continue to evaluate and revisit the measure requirements and the utility of this measure for patients and facilities as part of next year's rulemaking. **At a minimum, Premier urges CMS to revise the measure to only require annual reporting, which would align with reporting requirements for the influenza measure.**

Finally, Premier recommends that the revised measure receive consensus-based endorsement prior to adoption into the IQR Program.

2. Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure

The Hybrid HWM measure is an outcomes-based measure that captures the hospital level, risk-standardized mortality within 30 days of hospital admission for most conditions or procedures. The measure is reported as a single summary score, derived from the results of risk-adjustment models for 15 categories of admissions grouped based on similar discharge diagnoses or procedures. The measure was first adopted into the IQR program as part of FY 2022 rulemaking beginning with performance data from July 1, 2022, through June 30, 2023, followed by mandatory data submission and public reporting in subsequent years. Currently, the measure only includes Medicare fee-for-service (FFS) beneficiaries 65 to 94 years of age. CMS proposes to expand the cohort to include Medicare Advantage (MA) patients, beginning with the FY 2027 payment determinations.

Premier conceptually supports expanding the measure cohort to include the MA population. However, Premier strongly urges CMS to continue to evaluate and monitor the quality of MA encounter data prior to incorporating the data into the Hybrid HWM measure. In its March 2022 Report to Congress,[11] the Medicare Payment Advisory Commission (MedPAC) highlighted several concerns with the quality of MA encounter data and reiterated its recommended statutory changes aimed at improving encounter data quality. As part of its analysis, MedPAC highlighted that CMS' current metrics for evaluating encounter data accuracy and completeness are insufficient for addressing the shortcomings in the quality of submitted data. **Premier strongly urges CMS to conduct additional analyses and publicly report on the quality of encounter data that would be used for the Hybrid HWM measure prior to implementing these changes.** Premier also urges CMS to work with Congress to ensure that sufficient incentives are available to drive improvement in MA plans' encounter data quality. Finally, Premier recommends that the measure receive consensus-based endorsement prior to adoption into the IQR Program.

3. Hybrid Hospital-Wide All-Cause Readmission (HWR) measure

The Hybrid HWR measure is an outcomes-based measure that captures the hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmissions within 30 days of hospital discharge for any eligible condition. The measure was first adopted into the Hospital IQR program as part of FY 2020 rulemaking with two voluntary reporting periods using performance data from July 1, 2021 through June 30, 2022, and July 1, 2022, through June 30, 2023, followed by mandatory data

[10] https://public-inspection.federalregister.gov/2023-11449.pdf
[11] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

submission and public reporting in subsequent years. Currently, the measure only includes Medicare FFS beneficiaries at least 65 years of age. CMS proposes to expand the cohort to include MA patients, beginning with the FY 2027 payment determinations.

Premier conceptually supports expanding the measure cohort to include the MA population. However, similar to the Hybrid HWM measure, Premier urges CMS to continue to evaluate and monitor the quality of MA encounter data prior to incorporating the data into the Hybrid HWR measure. As noted above, stakeholders, such as MedPAC, have continued to highlight concerns with the quality of MA encounter data, including data accuracy and completeness. **Premier strongly urges CMS to conduct additional analyses and publicly report on the quality of encounter data that would be used for the Hybrid HWR measure prior to implementing these changes.** Finally, Premier recommends that the measure receive consensus-based endorsement prior to adoption into the IQR Program.

Measures proposed for removal

CMS proposes to remove three Hospital IQR Measures:

1. ***Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure (THA/TKA Complication Measure)***

   As part of last year's rulemaking, CMS readopted the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA measure to the Hospital IQR Program beginning with the FY 2024 payment determination. The original measure version was removed from the Hospital IQR Program as part of burden reduction efforts during FY 2018 IPPS rulemaking but is currently still in place under the Hospital Value-Based Purchasing (VBP) Program. Since its removal from the Hospital IQR Program, the measure underwent comprehensive review and was modified to add 26 ICD-10 diagnostic codes. Statute requires CMS to adopt a measure into the IQR Program and publicly display its results for at least one year prior to adopting it into the Hospital VBP Program. As a result, CMS readopted the modified measure into the IQR Program last year with the intention of adopting the revisions into the Hospital VBP Program once it met this statutory requirement.

   CMS is now proposing to remove the modified measure from the Hospital IQR Program, contingent on the modified measure being adopted into the Hospital VBP Program, as noted below. If finalized, the measure would be removed from the Hospital IQR Program beginning with the April 1, 2025 through March 31, 2028 reporting period associated with the FY 2030 payment determination.

   As noted last year, Premier is conceptually supportive of the revised measures and understands that CMS is statutorily required to include the measure in the Hospital IQR Program prior to adoption in the Hospital VBP Program. However, Premier is concerned that this results in two slightly different measure specifications, which could yield differing results - one set for the Hospital IQR Program measure (revised measure) and a second set for the Hospital VBP Program measure (original measure). This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to monitor and validate two different performance rates.

   Premier continues to recommend that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. Specifically, CMS should only publicly report the existing measure; allowing at least one year of reporting for the new measure before it is publicly reported. This will help improve the usability of data by consumers and reduce the potential for

any confusion caused by two different publicly reported rates. CMS should also closely monitor the measure results for both programs and versions for unintended consequences, particularly during any period in which the measure specifications are not aligned. Finally, even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospitals will still face when it comes to monitoring and validating performance using different measure specifications.

2. Medicare Spending Per Beneficiary (MSPB)—Hospital Measure

As part of last year's rulemaking, CMS readopted the Medicare Spending Per Beneficiary—Hospital measure to the Hospital IQR Program beginning with the FY 2024 payment determination. The original measure version was removed from the IQR Program beginning with the FY 2020 payment determination, because the administrative costs of the measure were judged to outweigh its benefits. Since that time, the measure has undergone comprehensive review and has undergone several revisions, including (1) adding new service inclusion and exclusion rules that reduce the capture of services outside of the control of providers; (2) allowing readmissions to trigger new episodes; and (3) modifying the measure calculation from sum of observed costs divided by sum of expected costs to mean of observed costs divided by expected costs. The originally specified measure is currently in the Hospital VBP Program. As noted above, statue requires measures to be included in the IQR Program and publicly displayed for at least one year prior to adoption into the Hospital VBP Program.

CMS proposes to remove the MSPB – Hospital measure from the Hospital IQR Program contingent on finalizing the adoption of the updated measure under the Hospital VBP Program. If finalized, this policy would be effective beginning with the FY 2028 payment determination.

Similar to the THA/TKA Complication Measure, Premier is conceptually supportive of the revised measure and understands that CMS is statutorily required to include the measure in the Hospital IQR Program prior to adoption in the Hospital VBP Program. However, Premier is concerned that this results in two different versions of this claims-based measure being applied to hospital performance, which could yield differing results between the Hospital IQR and Hospital VBP programs. This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to validate two different performance rates.

As a result, Premier continues to recommend that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. CMS should also closely monitor the measure results for both programs and versions for unintended consequences, particularly during any period in which the measure specifications are not aligned. Finally, even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospitals will still face when it comes to monitoring and validating performance using different measure specifications.

3. Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC–01) Measure (Elective Delivery Measure)

CMS adopted the Elective Delivery Measure into the Hospital IQR Program as part of FY 2013 rulemaking. Since that time, CMS has determined that measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made – also referred to as a measure being "topped out." As a result, CMS is proposing to remove the measure from the IQR Program.

Premier generally supports removal of this measure as it is considered "topped out." However, Premier encourages CMS to continue to monitor elective deliveries as part of its efforts around advancing maternal and infant health and to take additional action if it deems necessary.

Proposed updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

CMS proposes several updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, beginning with January 2025 discharges, including:

- Adding 3 new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the current Mail Only, Telephone Only, and Mail-Phone modes;
- Removing the requirement that only the patient may respond to the survey, allowing a proxy to respond;
- Extending the data collection period for the HCAHPS Survey from 42 to 49 days;
- Limiting the number of supplemental items that a hospital can add to the survey to 12;
- Requiring hospitals to collect information about the language that the patient speaks while in the hospital and requiring the official CMS Spanish translation of the survey to be administered to all patients who prefer Spanish; and
- Removing two options for administration of the HCAHPS Survey (Active Interactive Voice Response survey mode and the Hospitals Administering HCAHPS for Multiple Sites option), both of which are not currently used by participating hospitals.

CMS also seeks comment on the potential inclusion in the HCAHPS Survey of patients with a primary psychiatric diagnosis who are admitted to short-term, acute care hospitals. Currently, only patients with a secondary psychiatric diagnosis are eligible for inclusion in the survey.

Premier is generally supportive of the proposed changes to the HCAHPS survey. However, Premier recommends that CMS work with the hospital community to address challenges with expanding the eligibility of the HCAHPS Survey to include patients with a primary psychiatric diagnosis prior to proposing any changes. Specifically, we encourage CMS to work with stakeholders to explore whether there are certain segments of the population to focus on for inclusion (rather than all patients with a primary psychiatric diagnosis) and the types of questions that would best capture the experience of patients with a psychiatric diagnosis. For example, CMS may only want to consider including patients with certain psychiatric diagnoses or who have been voluntarily admitted to the hospital. Additionally, not all existing questions on the HCAHPS survey are a fair assessment of the healthcare experience of mental health patients. Instead, CMS should evaluate the current list of patient-reported experience measures and consider which metrics would be most appropriate, which could include interpersonal relationships, respect and dignity, access and care coordination, drug therapy, communication/information, psychological care, and the care environment. Finally, if CMS chooses to move forward with expanding the eligibility of this survey to include patients with a primary psychiatric diagnosis, **Premier strongly encourages CMS to first pilot those changes to assess the impact and integrity of responses prior to broader adoption in the hospital quality reporting programs.**

Potential Future Inclusion of Two Geriatric Care Measures

CMS seeks comment on two attestation-based structural measures it is considering for future inclusion in the Hospital IQR Program:

1. The Geriatric Hospital Structural Measure, which assesses a hospital's commitment to improving outcomes for patients 65 years or older through patient-centered competencies and includes 14

attestation-based questions across eight domains. Hospitals would receive one point for each domain for which the hospital attests to each of the corresponding statements included in the domain.

2. The Geriatric Surgical Structural Measure, which assesses hospital commitment to improving surgical outcomes for patients 65 years or older through patient-centered competencies and includes 11 attestation-based questions across 7 domains. A hospital would receive one point for each domain for which the hospital attests to each of the statements included within the domain.

Additionally, CMS seeks public input on establishing a new hospital designation focused on hospitals that participate in patient-centered geriatric care health system improvement initiatives.

Premier supports the need to consider the aging population and improve geriatric care, however, Premier does not support adoption of these two attestation-based geriatric care measures, **which neither measure patient outcomes nor evaluate patient care.** It is unclear what additional value these measures would bring to patients, caregivers, hospitals or other stakeholders. Premier strongly urges CMS to assess what (if any) gaps in quality measurement exist around geriatric care in the current quality reporting programs and to work with the hospital stakeholder community to develop meaningful outcome measures around geriatric care if it is determined that gaps do exist.

Hospital Value-Based Purchasing Program

Background

The Hospital Value-Based Purchasing (VBP) program is a pay-for-performance program that rewards hospitals for the quality of care furnished in the inpatient hospital setting. Under the program, CMS reduces all inpatient hospitals' base operating diagnosis-related group (DRG) payments by 2 percent. Hospitals can earn back a share of payments based on their performance on selected quality measures across four domains, which may be less than, equal to or more than the amount of the hospital's reduction for a given year.

Proposals and Recommendations

Measures proposed for adoption – Severe Sepsis and Septic Shock: Management Bundle

The Severe Sepsis and Septic Shock: Management Bundle (SEP-1) measure is a process-oriented measure that provides a standard operating procedure for the early management of patients with severe infection. The measure evaluates the number of patients with a diagnosis of severe sepsis/septic shock who received certain interventions in line with national standards of care for severe sepsis and septic shock management. The measure was first adopted into the Hospital IQR Program beginning with the FY 2017 payment determination. CMS proposes to adopt the measure in the Hospital VBP Program with technical updates to address hospital abstractor and clinician feedback about the documentation required for fluid resuscitation within three hours of tissue hypoperfusion presentation, beginning with the FY 2026 Program Year.

Premier strongly opposes adoption of the SEP-1 measure into the Hospital VBP Program at this time. While management of severe sepsis and septic shock is a critical area for patient safety, hospitals have faced numerous challenges with reporting this measure as part of the Hospital IQR Program that must be addressed prior to it being considered for adoption into a performance-based quality program. These challenges include:

- ***Measure specifications have undergone frequent updates – which can be challenging for hospitals to implement and educate staff on.*** The SEP-1 measure specifications have continued to undergo regular updates, both to address changes in national guidelines, as well as to address technical issues. This has caused significant confusion amongst the hospital community, as hospitals have had

to familiarize themselves with ever-evolving specifications and work to educate staff on documentation changes. Premier has a team of subject matter experts that support hospitals in reporting and validating quality measures. More than 80 percent of the questions that this team receives from our hospital members are related to the interpretation of the specification manual and chart abstraction for the SEP-1 measure.

Frequent updates to measure specifications also require hospitals to adapt their internal processes, including educating staff on changes in documentation and updating electronic health records (EHRs) to reflect changes to measure specifications. This can require significant time, resources, and manpower. Occasionally, what is required or suggested for changes within the EHR are not possible (e.g., cost, manpower or leadership approval, limitations of willingness of EHR vendor to implement changes), which leaves hospitals to rely on paper documentation during an emergent situation. Further, there can be delays in scanning paper documents into the EHR; this adds additional burden to chart abstractors, as they must now return to the patient's EHR at a later date to complete abstraction.

- ***Given frequent updates to the measure, it is unclear how CMS will establish an accurate and appropriate baseline.*** Beyond the challenges with interpreting frequent updates to the measure specifications, Premier is concerned that these frequent updates also present challenges for how CMS will establish an appropriate baseline for evaluating hospitals' performance on the measure over time. With the proposed shift to use the measure in a pay-for-performance program, it will be critical to ensure an accurate baseline so that hospitals are not unfairly penalized for actions outside of their control. If CMS chooses to move forward with this measure in the Hospital VBP Program, it must provide additional clarity on how it will establish an appropriate baseline and account for changes in measurement between the baseline and performance periods.

- ***Chart abstraction is extremely time- and resource-intensive.*** The sheer volume and complexity of the measure specifications require hospitals to spend significant resources and time on chart abstraction. The SEP-1 measure differs from other chart-abstracted measures because of the number of data elements required, complex measure specifications that require specific values to be used and the calculation of various time elements to be assessed. The measure requires reviewers to evaluate several metrics in a patient's chart, including physician notes, consults, orders, nursing assessments, care management notes, labs, medications, vitals and pharmacy notes. Some patients may have extensive lengths of stay, which can result in lengthy EHRs that must be reviewed in their entirety to see if the patient meets the measure specifications.

  For example, to determine if a patient who has an ICD-10 diagnosis of sepsis meets the specifications for severe sepsis, abstractors must decipher twelve pages of specification notes for a single data element. Determining eligibility for the measure can take upwards of 45 minutes alone if the patient has a long stay. If the patient does not meet the criteria, the case is ultimately excluded, which happens fairly frequently. Although the abstractor will not need to add additional cases to meet the minimum sample, it is not in-line with the CMS' Burden Reduction efforts.

  Many of our member hospitals report spending between 45 minutes to 2 hours on a singular chart abstraction case for this measure. Hospitals must sample at least 10 cases per month – meaning they must spend upwards of at least 7-20 hours per month just extracting cases for this measure. Additionally, because many cases are ultimately excluded for not meeting the criteria for severe sepsis, most hospitals end up oversampling to ensure they present a more accurate representation of their compliance with the measure. As a result, 7-20 hours per month is likely an extreme lower bound for the average amount of time it takes hospitals to successfully report this measure. This comes at a time when hospitals are experiencing significant budget shortfalls and staffing shortages.

Coupled with the constant updates to the measure specifications described above, there are also many nuances to the specifications which can make it challenging for health systems to develop a standard approach to abstraction. For example, abstracted cases may seem nearly identical but have multiple different abstraction outcomes based on small decisions or differences in documentation. As a result, there are instances where a patient received appropriate care and had a good outcome but would still not meet the measure requirements.

- ***The measure does not align with the Surviving Sepsis Campaign and ultimately interferes with physician judgement.*** In addition to the operational challenges noted above, it is critical to acknowledge that the measure itself does not align with the Surviving Sepsis Campaign nor the Third International Consensus Definition (SEP-3), which is what most insurance companies base financial reimbursement on. For example, under national guidelines, antibiotics should be deferred in low-risk patients until an infectious diagnosis is more "clear." However, the measure specifications require a date/time stamp as soon as an infection is noted or even in differential diagnosis that often sets the clock for meeting the three-hour limit of antibiotic administration. The process for determining if an infection is "clear" enough to warrant antibiotics, ordering the antibiotics and starting administration can easily extend beyond the time limits required under the measure – causing hospitals to "fail" the measure specifications even if they are compliant with national standards and are acting in the best interest of the patient.

  Hospitals have also raised concerns that this measure ultimately interferes with clinical judgement. With the shift from use of the measure under a pay-for-reporting to pay-for-performance program, hospitals will feel increased pressure to meet the measure specifications, which ultimately may place pressure on physicians to align their decisions with the specifications and not what is in the best interest of the patient. As a result, it is critical that CMS ensures the measure aligns with national standards for sepsis care in order to preserve physicians' clinical judgement.

Overall, the SEP-1 measure is very time consuming, difficult to educate on, and even more difficult to implement process improvement activities for. While management of sepsis care remains a top priority, hospitals and their patients would be better served if hospitals were able to instead invest this time and resources into quality improvement efforts, rather than on the measurement of care processes. As a result, Premier opposes adoption of the SEP-1 measure into the Hospital VBP Program at this time. Rather, **Premier strongly urges CMS to work with relevant stakeholders to develop an outcome-based digital quality measurement that is a true metric of sepsis care.**

Measures proposed for refinement

CMS proposes to refine two measures under the Hospital VBP Program:

1. ***Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure (THA/TKA Complication Measure)***

   As noted above, measures are statutorily required to be adopted into the Hospital IQR program and publicly displayed for at least one year prior to adoption in the Hospital VBP Program. CMS readopted the THA/TKA Complication Measure into the Hospital IQR Program last year following substantive changes to the measure specifications.

   CMS proposes to adopt the substantive measure updates to the THA/TKA Complication measure included under the Hospital VBP Program's Clinical Outcomes Domain, beginning with the FY 2030 Program Year (performance period of April 1, 2025, through March 31, 2028). As noted above, CMS

also proposes to remove the modified measure from the Hospital IQR Program, contingent on finalizing adoption of the revised measure under the Hospital VBP Program.

Premier is conceptually supportive of the revised measure but is concerned that this policy will result in two slightly different measure specifications, which could yield differing results. This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to monitor and validate two different performance rates.

Premier continues to recommend that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. This will help improve the usability of data by consumers and reduce the potential for any confusion caused by two different publicly reported rates. Even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospitals will still face when it comes to monitoring and validating performance using different measure specifications.

Finally, over the last few years, CMS has removed several lower extremity joint replacement procedures from the Inpatient Only List, which has resulted in a notable shift of less complex procedures to outpatient settings. Premier continues to urge CMS to monitor what impact this may have on hospitals' performance on the THA/TKA Complications measure and to consider additional changes to specifications to account for the more complex cases remaining inpatient. Additionally, CMS should continue to explore measures that effectively evaluate performance of these procedures across settings.

2. Medicare Spending Per Beneficiary (MSPB)—Hospital Measure

As noted above, CMS readopted the Medicare Spending Per Beneficiary—Hospital measure into the Hospital IQR Program as part of last year's rulemaking following substantive revisions to the measure. CMS proposes to adopt substantive measure updates to the MSPB measure included under the Hospital VBP Program's Efficiency/Cost Domain beginning with the FY 2028 Program Year (performance period for discharges beginning January 1, 2026). As noted above, CMS also proposes to remove the modified measure from the Hospital IQR Program, contingent on finalizing adoption of the revised measure under the Hospital VBP Program

Similar to the THA/TKA Complication Measure, Premier is conceptually supportive of the revised measures but is concerned that this policy will result in two slightly different measure specifications being applied simultaneously in the two different programs, which could yield differing results. This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to monitor and validate two different performance rates.

Premier continues to recommend that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. This will help improve the usability of data by consumers and reduce the potential for any confusion caused by two different publicly reported rates. Finally, even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospital will still face when it comes to monitoring and validating performance using different measure specifications.

Proposed Revisions to Hospital VBP Program Scoring Methodology to Add a New Health Equity Adjustment

As part of the Administration's goals around advancing health equity, CMS proposes to add a new Health Equity Adjustment to the Hospital VBP Program, which would award hospitals bonus points based on their overall performance and share of underserved patients. Under this proposal, CMS would calculate the bonus based on a hospital's performance across all four Hospital VBP Program domains and the proportion of patients with dual eligible status. This is similar to the health equity adjustment that CMS finalized for the Medicare Shared Savings Program (MSSP) last year and the framework that CMS is proposing for the Skilled Nursing Facility Value-Based Purchasing Program, with a couple notable differences. The policy would be effective beginning with the FY 2026 program year.

CMS proposes to calculate the health equity adjustment based on a hospital's quality performance compared to other hospitals (through the "performance scaler"), as well as the proportion of patients that are considered underserved ("underserved multiplier"). To determine the performance scaler, CMS would assign hospitals into three groups based on their performance for each of the four measure domains under the Hospital VBP Program. Hospitals would be assigned points based on where they fell within the ranking, with the top-third receiving 4 points per measure, the middle-third receiving 2 points per measure, and the bottom-third receiving 0 points per measure, for up to a total of 16 points across the four domains. CMS will set the underserved multiplier as the number of inpatient stays for patients with dual eligible status out of the total number of inpatient Medicare (FFS and MA) stays during the calendar year two years before the start of the respective program year. CMS also seeks comment on other potential metrics, such as the Area Deprivation Index (ADI) or the Medicare Part D Low-Income Subsidy (LIS) status, which are the metrics used in the MSSP methodology.

To calculate the health equity adjustment proposed under the Hospital VBP Program, CMS will multiply the performance scalar by the underserved multiplier, capping the adjustment at 10 bonus points. The health equity adjustment would then be applied to a hospital's Total Performance Score (TPS) under the program, bringing the total points that hospitals are eligible for to 110 points.

Premier conceptually supports development of a health equity adjustment; however, Premier strongly urges CMS to work with the hospital community to fine-tune the methodology for identifying underserved populations prior to adoption – especially in light of the redistributive impacts the addition of the bonus may have on Hospital VBP Program incentive payments.

There are several challenges with using dual eligibility and the other proxies that CMS is considering for measuring a hospital's underserved populations. For example, dual eligible beneficiary percentages will vary across states depending on nonuniform criteria for Medicaid eligibility. Additionally, as has been highlighted in recent journal articles, the ADI may not adequately capture the needs of underserved patients living in some higher cost-of-living geographic locations.[12]

Given that the Hospital VBP Program distributes a fixed pool of incentive payments to hospitals, it is critical that CMS ensures the methodology for calculating this bonus accurately captures a hospital's underserved population. As a result, CMS should convene a technical expert panel from the hospital community to develop an appropriate health equity adjustment methodology.

In developing this metric, it will be critical to consider the following challenges associated with calculating social risk indices:

[12] "ACO Benchmarks Based On Area Deprivation Index Mask Inequities", Health Affairs Forefront, February 17, 2023, https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities

- *Account for redundant social risk variables.* Many of the variables used within social risk indices, such as the ADI, are highly correlated even across domains (e.g., housing and transportation, minority status, socio-economic status, etc.). This can lead to overstating certain aspects of social risk within the composite index. There are certain statistical techniques that can help account for these redundancies and ensure the variables are not double counted and ultimately improve the accuracy and fairness of the index, as was recently highlighted in a journal article utilizing Premier data.[13]
- *Ensure variables are weighted appropriately.* The second challenge is that current social risk indices are equally weighted, regardless of the disease group being evaluated. Social risk has varying degrees of association with adverse events (e.g., mortality, readmissions, and complications) in the context of certain disease groups. As a result, it is important to weight the aspects of social risk that are most closely associated with the outcome of interest within a certain disease state. For example, researchers have found that THA/TKA mortality is much less sensitive to social risk indices than pneumonia mortality.[14] Furthermore, within pneumonia mortality, certain aspects of social risk are more important than others. As a result, it is critical when developing social risk indices to consider the disease group being evaluated.

At a minimum, **CMS should provide hospitals with additional information on how they would perform on these adjustments through confidential reports and allow more time for stakeholders to provide input on the methodology prior to adoption.**

Hospital-Acquired Condition (HAC) Reduction Program

Background

The Hospital-Acquired Condition (HAC) Reduction program is a pay-for-performance program that links Medicare payments to healthcare quality in the inpatient hospital setting. Under the program, CMS reduces overall Medicare payments by 1 percent for hospitals that rank in the worst-performing quartile of all hospitals on measures related to hospital-acquired conditions.

Proposals and Recommendations

CMS seeks public input on the adoption of new safety-focused eQCMs into the HAC Reduction Program. In particular, CMS seeks comment on potentially adopting patient safety-related eCQMs that are included in the Hospital IQR Program (e.g., the Hospital Harm—Opioid-Related Adverse Events eCQM, Hospital Harm-Severe Hypoglycemia eCQM, and Hospital Harm-Severe Hyperglycemia eCQM), as well as the three eCQMs that are proposed for adoption into the Hospital IQR Program as part of FY 2024 rulemaking.

Premier appreciates efforts by CMS to advance digital quality measurement, including patient safety measures. We have long been committed to advancing providers' capability to analyze data from multiple sources and to manage the health of their populations. However, at this time, **Premier does not recommend that CMS move forward with adopting additional eCQMs into the HAC Reduction Program for the reasons detailed below.**

Premier strongly discourages CMS from adopting any of the patient-safety eCQMs included or proposed to be included in the Hospital IQR Program into the HAC Reduction Program. As we have commented previously, feedback to hospitals about their performance on eCQMs is infrequent and seldom helpful as a basis for performance improvement. Until regular, more frequent, and actionable eCQM performance feedback is provided, CMS should not require hospitals to report any additional eCQMs.

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[13] Korvink, Michael et al, "A Novel Approach to Developing Disease and Outcome-Specific Social Risk Indices," *American Journal of Preventive Medicine,* May 3, 2023, https://www.ajpmonline.org/article/S0749-3797(23)00203-9/fulltext

[14] Ibid.

Additionally, hospitals face several challenges with reporting eCQMs, including difficulties extracting data from "production-ready" eCQM products delivered by developers and insufficient time to complete testing, validation, staff education, and rollout of eCQMs before their reporting is required. Costs to hospitals also remain a substantial obstacle to eCQM adoption. For example, as highlighted above, the proposed pressure injury eCQM has several operational challenges that hospitals will need to work through in implementing the measure, including processes for validating assessments made by nursing staff. Adoption of the measure will also require facilities to build new templates and implement modifications to their EHRs to operationalize the measure, which takes both time and resources.

Premier strongly urges CMS to work with the hospital community to understand the burden associated with implementing certain eCQMs and the system changes that will be required prior to requiring them to be reported in either the pay-for-reporting or pay-for-performance quality reporting programs.

CMS has continued to articulate its interest in moving to full digital measurement, with the goal of streamlining CMS' approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning. As noted above, Premier is supportive of these efforts, especially as they present an opportunity to analyze data from multiple sources, including beyond EHRs. We encourage CMS to continue to work with stakeholders to better understand how digital quality measurement can best support patient safety quality improvement efforts, including types of data sources and data elements that would be most useful for these efforts.

Finally, over the last couple years CMS has suppressed measures in the HAC Reduction Program and other pay-for-performance program in recognition of the impact that the COVID-19 pandemic had on performance. We urge CMS to hold off adopting any additional measures or changes to the HAC Reduction Program while hospitals continue to adapt internal processes to a post-pandemic environment.

CONCLUSION

In closing, Premier appreciates the opportunity to submit comments on the FY 2024 IPPS proposed rule. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy, at melissa_medeiros@premierinc.com or (202) 879-4107.

Sincerely,

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