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June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Attention: CMS-1771-P

RE: ***Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation***

Dear Administrator Brooks-LaSure:

On behalf of the New Jersey Hospital Association (NJHA) and its over 400 hospital and health system members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2023.

Core-Based Statistical Areas (CBSAs) For the Proposed FY 2023 Medicare Wage Index

NJHA strongly supports CMS's proposal to implement a permanent 5 percent cap on wage index decreases. We appreciate CMS' proposed mitigation policy and the recognition from CMS of the destabilizing impact that large decreases in payments caused by changes in the area wage index can have.

We also support the agency's proposal to implement a similar cap across all relevant payment systems; however, **we have grave concerns that the proposed payment policy will not have the intended benefit for post-acute providers, and respectfully request that the agency take additional steps to protect those providers that did not benefit from a transition policy in 2022.**

Expanding the proposed policy to all categories of affected health care facilities will ensure that hospitals and others vulnerable health care facilities in affected New Jersey counties will not suffer devastating cuts to their Medicare reimbursement until OMB is able to release updated CBSA delineations based on up-to-date data from the 2020 Census.

Graduate Medical Education; New Residency Slots

NJHA is concerned with CMS's implementation of Section 126 of the Consolidated Appropriations Act ("Act"), 2021. On December 17, 2021, the Centers for Medicare & Medicaid Services (CMS) released their final plan for the distribution of 1,000 new graduate medical education (GME) slots that would be eligible for Medicare GME reimbursement in a manner that is inconsistent with Congressional intent and a plain reading of the statute.

In implementing Section 126 of the Act, CMS created an overall prioritization that will significantly disadvantage many New Jersey teaching hospitals who would otherwise be positioned to receive GME slots based on the eligible hospital criteria language Congress enacted in Section 126.

Section 126 specified four categories of hospitals eligible for additional GME slots: hospitals located in rural areas; hospitals currently training over their caps; hospitals located in states with new medical schools; and hospitals serving Health Professional Shortage Areas (HPSAs). New Jersey is among the 35 states with new medical schools. Some New Jersey hospitals are training over their caps and are therefore eligible for additional residency training slots under Section 126 and are on equal footing with every other hospital deemed eligible for the slots. Section 126 as written does not include any additional specifications or directives to the Secretary about which hospitals should receive residency training slots beyond the four eligibility criteria.

As part of the rulemaking implementing Section 126, CMS proposed to create a new "super prioritization" not found in the statute. Under CMS's proposal, hospitals that provide at least 50% of training in certain federally-designated geographic or population HPSAs would be given prioritization above all other eligible hospitals. This prioritization improperly overlaid an additional "location-specific" criterion not contained in the statute, and it is inconsistent with Congressional intent. In addition, Section 126 as written explicitly addressed how HPSAs should be considered in the context of eligibility for GME slots; Section 126 did not direct CMS to add an additional HPSA consideration that effectively overrides the equal footing the four eligibility categories established. When implementing previous policies on the distribution of additional GME slots, such as under the Medicare Modernization Act and the Affordable Care Act, CMS worked within the eligibility and prioritization criteria contained within the authorizing statute. As such, we are extremely concerned that CMS elected to apply an additional location-specific criterion to the list of eligibility categories included in the text of the law.

According to the Health Resources Services Administration, New Jersey does not have any geographic or population HPSAs. Due to this status, applications to CMS for Section 126 residency slots from all New Jersey hospitals would be placed at the bottom of the list for all applications and would only be considered after applications from hospitals meeting the super prioritization CMS created as part of its rulemaking.

NJHA urges CMS to modify implementation of this policy by establishing an alternative method for prioritization in line with Congressional intent for these new GME positions.

Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies

CAR T-cell therapy is an intensive treatment that requires specialized expertise and resources to support the patients who receive it. As numerous stakeholders have expressed through previous comment letters, current MS-DRG payments for CAR-T is inadequate in addressing the extraordinary level of resources necessary to provide this lift-saving therapy. In fact, as the American Hospital Association noted in its comments in response to the FY 2021 IPPS Proposed Rule, the MS-DRG is almost 30% below the cost of CAR-T cases and does not even cover the cost of the therapy itself. **NJHA continues to be concerned about Medicare's under-reimbursement of CAR T-cell technology**, especially considering the full extent of resources used to treat patients undergoing these complex, novel cell therapies and the adverse impact wholly inadequate reimbursement has on beneficiary access.

In the FY 2023 IPPS proposed rule, CMS notes that there were no requests or proposals for new procedure codes to describe the administration of CAR T-cell or other gene therapy at the 2021 ICD-10 Coordination and Maintenance Committee meeting. While the ICD-10 Committee 2022 meeting agenda includes proposals for new procedure codes to describe the administration of a CAR T-cell or another type of gene or cellular therapy product, because the diagnosis and procedure code proposals are not yet finalized, CMS indicates, in the FY 2023 IPPS proposed rule, that it will use its established process to assign to the most appropriate MS-DRG. **We appreciate CMS' acknowledgement of stakeholders' concerns regarding Medicare reimbursement of CAR T-cell technology, including recommendations to ensure that reimbursement adequately reflects both patient care and product costs**.

Further, CMS' proposal for how it will calculate fixed-loss amounts for FY 2023 will likely have, as you know, important implications for CAR-T reimbursement, especially because these stays are more likely than other outlier inpatient stays to qualify for outlier payments. Total payment for CAR-T under the proposed outlier threshold would be $364,478 vs. $352,281 under the alternate outlier threshold. Both amounts are less than total payment under the FY 2022 final rule for non-clinical trial CAR-T payments. **We are hopeful that, as part of the ICD-10 Coordination and Maintenance Committee meetings, new procedure codes will be finalized that better reflect the cost to administer CAR-T cell or other gene or cellular therapy products, and that CMS will work with stakeholders to improve the predictability and stability of hospital payments for these critical, life-saving therapies.**

<u>Hospital Readmissions Reduction Program (HRRP)</u>

The HRRP imposes penalties of up to 3% of base IPPS payments for having "excess" readmission rates for selected conditions when compared to expected rates. CMS uses six Medicare claims-based readmission measures to assess performance in the program. As required by the 21st Century Cures Act, CMS implemented a sociodemographic adjustment approach beginning with the FY 2019 HRRP in which CMS places hospitals into one of five peer groups based on the proportion of patients dually eligible for Medicare and Medicaid that they treat. In this rule, CMS proposes several changes to account for the impact of the COVID-19 PHE.

NJHA urges CMS not to finalize its proposal to reintroduce the pneumonia readmission measure for FY 2024. Instead, we urge CMS to conduct further analysis to ensure it has minimized the overlap between this measure and COVID-19-related pneumonia. In last year's inpatient PPS final rule, CMS adopted a COVID-19 measure

suppression policy across its quality measure programs that permits the agency to not use quality measure data the agency believes have been affected by the pandemic and would result in distorted hospital performance.

CMS used this policy to suppress the use of the PN readmissions measure from the FY 2023 HRRP because of data showing a substantial proportion of the measure cohort included admissions with a COVID-19 diagnosis. As a result, the measure's "clinical proximity" to COVID-19 was close enough to affect performance. CMS now believes its proposed technical changes to the measure are sufficient to minimize the overlap with COVID-19-related pneumonia. Specifically, CMS would remove patients with COVID-19 as a principle or secondary diagnosis from both index admissions and readmissions. CMS also believes the ICD-10-CM code it adopted in January 2021 that captures pneumonia due to COVID-19 as a secondary diagnosis (J12.82) is now sufficiently well-known and used by hospitals that patients with a COVID-19 diagnosis now make up a small portion of PN admissions.

NJHA agrees that these specification changes are directionally appropriate, and we appreciate that the proposed rule includes data showing the impact of these changes. Indeed, the percentage of pneumonia patients with COVID-19 present on admission dropped from 9.8% in January 2021 to 0.7% in July 2021. However, it is notable that there were upticks in these percentages in August and September 2021, rising to 3.5% of patients.

We recommend CMS run the same data for the entirety of 2021 to ensure these increases are anomalies — rather than trends — before re-introducing the PN readmission measure into the HRRP. This would enable agencies and the hospitals to determine whether additional education on the new codes is necessary, or if further measure specification tweaks may be required.

NJHA supports the concept of CMS's proposal to include patient history of COVID-19 diagnosis in the 12 months prior to the index hospitalization as a co-variate in the HRRP measures' risk adjustment models. However, we urge CMS to conduct further analysis before finalizing this proposal to ensure prior COVID-19 is captured across hospitals in a complete, consistent and equitable way.

Payment Update

For FY 2023, CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the unprecedented inflationary environment. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. When historical data is no longer a good predictor of future changes, the market basket becomes inadequate. Yet, this is essentially what has been done when forecasting the FY 2022 and 2023 market basket and productivity adjustments. Indeed, with more recent data, the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year. Additionally, the latest data also indicate decreases in productivity, not gains. We urge CMS to consider the changing health care system dynamics and their effects on hospitals.

Specifically, we urge CMS to 1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023.

The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on our hospital. We remain on the front lines fighting this powerful virus—our doctors and nurses continue to care for COVID-19 patients even if other industries have moved on from the pandemic. At the same time, we continue to struggle with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic.

Specifically, historic inflation has continued and heightened the severe economic instability that the pandemic has wrought on our hospital. Indeed, the financial pressures we are experiencing are massive. Because this high rate of inflation is not projected to abate in the near term, and inflationary pressures are also likely to continue to work their way into wage expectations, it is critical to account for these challenges when considering hospital and health system financial stability in FY 2023 and beyond. As such, the market basket updates for FY 2022 and FY 2023 are resulting in woefully inadequate reimbursements for our hospital. We ask CMS to implement, for FY 2023, a retrospective adjustment to account for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022.

Additionally, we ask that CMS eliminate the productivity cut for FY 2023. The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes the hospital field can mirror productivity gains across the private nonfarm business sector. This has not been our hospital's experience, particularly during the pandemic. Therefore, we have strong concerns about the proposed productivity cut given the extreme and uncertain circumstances in which our hospital is currently operating. We urge CMS to eliminate the cut for FY 2023.

Disproportionate Share Hospital (DSH) Payments

We are concerned with CMS' proposal to decrease DSH payments—by approximately $800 million—to hospitals for FY 2023. These payments are extremely important to our hospitals since we care for [describe your community's patient population and uncompensated care situation]. We ask for more clarity on the agency's calculations for DSH payments. Specifically, we ask CMS to provide more details on the agency's assumption of small increases in discharge volume for FY 2022 and FY 2023. Although it appears likely that volumes will remain lower than historic, pre-pandemic levels, the trends we are seeing now indicate that FY 2022 and 2023 volumes will continue to increase substantially.

Additionally, we question the agency's estimate that the uninsured rate will decrease from 9.6% to 9.2% from FY 2022 to FY 2023 when determining DSH payments. In our communities, it is clear that a large increase in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions begin to unwind. We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.

Hospital Value-Based Purchasing (HVBP)

The ACA mandated that CMS implement the HVBP program, which ties a portion of hospital payment to selected measures of the quality, safety and cost of hospital care. CMS funds the program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance. Hospitals may earn back some, all or more than the 2% withhold based on their measure performance. By statute, the program must be budget neutral — that is, the entire pool of

dollars must be paid back to hospitals, and CMS may not hold back any portion of it to achieve savings to the Medicare program. CMS proposes several significant changes to the HVBP program for FY 2023 and beyond to account for the continued impact of the COVID-19 PHE. FY 2023 Measure Suppressions and Neutral Payment Adjustments.

NJHA supports CMS's proposals to suppress most of the HVBP program's measures for FY 2023, and to apply neutral payment adjustments to all hospitals for FY 2023. We appreciate the agency engaging with hospitals to gauge the impact of COVID-19 on individual measures and programs, and using a data-driven approach to inform its proposals.

Hospital Infectious Disease Data Reporting Condition Of Participation For Covid-19 And Future Public Health Emergencies

In 2020, CMS adopted a condition of participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 and other acute respiratory illnesses (i.e., influenza) to HHS. While the CoP was written to expire at the conclusion of the COVID-19 PHE, CMS suggests its need to monitor the impact of the pandemic could extend beyond the current PHE. As a result, CMS proposes to revise the COVID-19 hospital data reporting CoP it adopted in 2020 so that hospital COVID-19-related reporting would continue after the conclusion of the current PHE through April 30, 2024, unless the Secretary establishes an earlier end date.

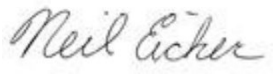
The broad data reporting categories proposed in the rule align with current reporting requirements. In addition, CMS proposes to establish a new CoP for future public health emergencies that would require hospitals and CAHs to report certain data to the CDC in the event of a PHE declaration for an infectious disease. CMS proposes several broad categories of data that it could ask hospitals to report. CMS also proposes that it would generally require hospitals to report person-level information on each applicable infection (confirmed and suspected) and if applicable, vaccination data at the person-level. This person-level data would need to include a medical record identifier, race, ethnicity, age, sex, residential county, zip code and relevant co-morbidities for affected patients. Finally, CMS would generally require hospitals to report request data to the CDC on a daily basis.

NJHA objects to the needlessly heavy-handed approach CMS and HHS have used to compel hospitals to report COVID-19 data to the federal government. We urge CMS to let its current COVID-19 data reporting CoP expire at the end of the COVID-19 PHE, and work in a collaborative fashion with hospitals to obtain a streamlined set of COVID-19 related data. Furthermore, we are deeply troubled by the unrealistic scale and scope of the data collection CMS seeks to require in future infectious disease-related PHEs. Just as with COVID-19, we expect that another infectious disease pandemic would require hospitals to be fully and rapidly engaged in saving the lives of those suffering from the infectious disease as well as those who need other types of emergent and urgent care.

We believe HHS, CMS and CDC should pursue further efforts to lower the data collection and reporting burden posed by PHEs so that hospitals can focus on delivering care, and hospitals and the federal government alike can focus on using the data to more effectively respond to pandemics.

We thank you for the opportunity to provide these, and further, comments on this proposed rule and look forward to working with you in the future to find solutions that will benefit all hospitals.

Sincerely,



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