



June 9, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Blvd  
Baltimore, MD 21244

***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 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: Proposed Rule (Vol. 88, No. 26658), May 1, 2023.; CMS-1785-P***

Dear Administrator Brooks-LaSure:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, we are pleased to present CMS with the following comments on the Fiscal Year 2024 Hospital Inpatient Prospective Payment System ("IPPS") Proposed Rule (88 Fed. Reg. 226658) (May 1, 2023) (referred to herein as the "Proposed Rule"). Given the number of comments we have, this letter will focus simply on the Hospital IPPS for Acute Care Hospitals portion of the rule; we will be addressing the LTCH portion of the rule in a separate letter.

#### **IPPS PAYMENT UPDATE**

For FY 2024, CMS proposes a market basket update of 3.0% less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. This update, especially when taken together with the FY 2022 payment update of 2.7%, continues to be woefully inadequate. These payment updates ignore the fact that hospitals and health systems have continued to face unprecedented increases in labor costs and other supply costs. They fail to account for the fact that labor composition and costs have not reverted to "normal" levels and that as a result, the hospital field have continued to face sustained financial pressures. **We, once again, urge CMS to use its "special exceptions and adjustments" authority to implement a retrospective adjustment for FY 2024 to account for the difference between the market basket update that was implemented for FY 2022 and what the currently projected market basket is for FY 2022. Specifically, the current projected market basket for FY 2022 is 5.7% — a full 3.0 percentage points higher than what hospitals actually received in 2022. Additionally, we also urge CMS to eliminate the productivity cut for FY 2024, as we detail below.**

## Financial Context

After battling near historical inflation and the COVID-19 crisis, hospitals and health systems are facing a new existential challenge — sustained and significant increases in the costs required to care for patients and the communities they serve. **We urge CMS to consider the changing health care system dynamics, the unlikelihood of these dynamics returning to “normal” trends and their effects on hospitals. As we detail below, these shifts in the health care environment are putting enormous strain on hospitals and health systems, which will continue in FY 2024 and beyond.**

Throughout 2022, hospitals battled historic inflation and rising labor and supply costs. These financial pressures have continued into 2023 and will not abate soon. For example, overall hospital expenses increased by 17.5% from 2019 through 2022, yet Medicare IPPS reimbursement grew at less than half that rate.<sup>1</sup> In fact, over half of hospitals ended 2022 operating at a financial loss.<sup>2</sup> So far, that trend has continued into 2023 with negative median operating margins in January and February. According to a recent analysis, the first quarter of 2023 saw the highest number of bond defaults among hospitals in over a decade.<sup>3</sup>

Workforce shortages continue to create outsized pressures on hospitals and health systems.<sup>4</sup> As the demand for hospital care increased, hospitals were increasingly forced to turn to health care staffing agencies to fill necessary gaps, especially for bedside nursing and other critical allied health professionals such as respiratory and imaging technicians. **As a result, contract labor full-time equivalents (FTEs) jumped 139% from 2019 through 2022.<sup>5</sup> Accordingly, hospitals’ contract labor expenses increased a staggering 257.9% in 2022 relative to 2019 levels.<sup>6</sup> This, in part, drove up overall hospital labor expenses during the same time period by 20.8%. These increases are particularly challenging because labor on average accounts for about half of a hospital’s budget.** Our members indicate that while contract labor use has eased somewhat in 2023, they do not see the hospital field reverting to pre-pandemic labor composition or cost structure — changing workforce dynamics will continue to play out in the future.

At the same time, non-labor expenses have also continued to increase due to a historic rise in inflation. Since 2019, non-labor expenses, such as those for drugs, medical supplies and

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<sup>1</sup> American Hospital Association (April 2023). The Financial Stability of America’s Hospitals and Health Systems is at Risk as the Costs of Caring Continue to Rise. <https://www.aha.org/costsofcaring>

<sup>2</sup> Kaufman Hall (January 2023). National Hospital Flash Report. [https://www.kaufmanhall.com/sites/default/files/2023-01/KH\\_NHFR\\_2023-01.pdf](https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf)

<sup>3</sup> Becker’s Hospital Review (April 2023). Hospitals See Most 1<sup>st</sup>-Quarter Defaults Since 2011. <https://www.beckershospitalreview.com/finance/hospitals-see-most-1st-quarter-defaults-since-2011.html>.

<sup>4</sup> McKinsey & Company (September 2022). The Gathering Storm: The Transformative Impact of Inflation on the Healthcare Sector. <https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector>

<sup>5</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. [https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

<sup>6</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. [https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

equipment, and purchased services, have increased 16.6% on a per patient basis.<sup>7</sup> For example, hospital supply expenses per patient increased 18.5% from 2019 through 2022, outpacing increases in inflation. Hospitals also rely on a global supply chain for access to these supplies and equipment, and ongoing supply chain disruptions have led to higher manufacturing, packaging and shipping costs, which translate into higher prices for hospitals. In fact, the National Academies recently released a report highlighting the ongoing challenges that supply chain disruptions place on providers needing to access medical supplies.<sup>8</sup>

**Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.** Indeed, Medicare only pays 84% of hospital costs on average according to a recent American Hospital Association (AHA) analysis.<sup>9</sup> In 2021, Medicare margins fell to *negative* 8.2% without COVID-19 relief funds,<sup>10</sup> after hitting an all-time low of *negative* 12.3% in 2020. Inadequate payment updates that have not accounted for inflation have caused this underpayment to become even worse since 2021. Specifically, the Medicare Payment Advisory Commission (MedPAC) projects 2023 Medicare margins will fall below *negative* 10%, the *20th straight year* of Medicare paying below costs.

### **Market Basket**

For FY 2022, CMS finalized a market basket of 2.7%, based on estimates from historical data through March 2021. Because the market basket was a forecast of what was *expected* to occur, it missed the *unexpected* trends that actually did occur in the latter half of 2021 into 2022 with hospitals combatting high inflation and workforce shortages. **Indeed, including data through September 2022 yields a CMS estimate of 5.7% for the actual FY 2022 market basket — a staggering 3.0 percentage points higher than the IPPS payment update that was given to hospitals.**

The rationale for using historical data as the basis for a forecast is reasonable in a typical economic environment. However, when hospitals and health systems continue to operate in atypical environments, the market basket updates become inadequate. This is, in large part, because the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs. This is exactly

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<sup>7</sup> American Hospital Association (April 2023). The Financial Stability of America's Hospitals and Health Systems is at Risk as the Costs of Caring Continue to Rise. <https://www.aha.org/costsofcaring>

<sup>8</sup> National Academies Sciences Engineering Medicine (2022). Building Resilience into the Nation's Medical Product Supply Chains. <https://nap.nationalacademies.org/catalog/26420/building-resilience-into-the-nations-medical-product-supply-chains>

<sup>9</sup> American Hospital Association (February 2022). Underpayment by Medicare and Medicaid Fact Sheet. <https://www.aha.org/system/files/media/file/2022/02/medicare-medicare-underpayment-fact-sheet-current.pdf>

<sup>10</sup> MedPAC. (2023). March 2023 Report to the Congress: Medicare Payment Policy. Chapter 3 – Hospital inpatient and outpatient services. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)

what had occurred at the end of the calendar year 2021 into calendar year 2022, which resulted in a large forecast error in the FY 2022 market basket update.

**In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction does not fully capture the labor dynamics occurring in the healthcare field.** Specifically, CMS uses the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.<sup>11</sup> However, the ECI may no longer accurately capture the changing composition and cost structure of the hospital labor market given the large increases in short-term contract labor use and its growing costs. By design and as we describe in detail in the Appendix, the ECI cannot capture changes in costs driven by shifts between different categories of labor. Yet, as mentioned above, this comes at the exact time that hospitals have had to dramatically turn to contract labor in order to meet patient demand. Contract hours as a percentage of worked hours rose 133% in 2022 compared to 2019<sup>12</sup> and contract FTEs grew in all clinical departments, ranging from surgical, imaging, emergency to nursing. The largest growth was in nursing where contract FTEs grew 180% from 2019 to 2022.

Indeed, CMS itself recognizes that the ECI does not capture these shifts in occupation.<sup>13</sup> This is because the ECI holds the composition of labor fixed between salaried and short-term contract based on a point in time using weights.<sup>14</sup> In fact, from December 2013 through September 2022, the ECI was based on the composition of labor in 2012. This means that in the FY 2022 and FY 2023 market basket payment updates, which used ECI data through March 2022,<sup>15</sup> the price changes in labor compensation were based on the composition of salaried and contract labor from 2012, more than a decade ago. Said another way, *the FY 2022 and 2023 market basket updates used ECI changes that measured the percent increase in the cost of hiring a 2012 labor force*. Clearly, this would not have been an accurate reflection of labor cost growth in FY 2022 or FY 2023 when contract labor use and expense has shifted dramatically.<sup>16</sup>

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<sup>11</sup> 86 Fed. Reg. 25401 (May 10, 2021). “We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes.”

<sup>12</sup> Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends.  
[https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf)

<sup>13</sup> 86 Fed. Reg. 25421 (May 10, 2021). CMS stated that ECI measures “the change in wage rates and employee benefits per hour... [and are superior] because they are not affected by shifts in occupation or industry mix.”

<sup>14</sup> U.S. Bureau of Labor Statistics. National Compensation Measures.  
<https://www.bls.gov/opub/hom/ncs/calculation.htm#computing-the-employment-cost-index-eci>

<sup>15</sup> 87 Fed. Reg. 49052 (August 10, 2022). CMS uses IGI’s second quarter 2022 forecast with historical data through first quarter 2022 to finalize the FY 2023 IPPS market basket.

<sup>16</sup> While we recognize that CMS updates the composition of labor relative to other hospital inputs through its rebasing process, this was last done in FY 2022 using FY 2018 hospital cost reports. CMS rebases the cost categories between wages and salary, employee benefits and contract labor costs and assigns cost weights every four years. However, adjusting the composition, otherwise known as cost weights, in the overall market basket does not address the problem in measuring labor cost growth, known as price proxies, that are due to a stagnant labor composition in the ECI.

Indeed, when an alternative labor cost index, the Employer Costs for Employee Compensation (ECEC), is examined, it shows just how much bias is created by ECI's lag in updating the labor composition. The ECEC uses current employment weights, as opposed to fixed employment weights used in the ECI, to reflect the changing composition of today's labor force.<sup>17</sup> Since the fourth quarter of 2019, ECEC-based wage and salary costs rose 6.7 percentage points more than ECI-based costs (20% vs. 13.3%) with a large proportion of the gap attributable to 2022 Q4 alone. This all suggests that because the ECI does not account for the change in labor composition, it fails to accurately capture the changing dynamic of the current healthcare workforce. Specifically, the ECI fails to capture that labor costs have increased more rapidly due to 1) hospitals using a more expensive mix of labor and 2) that the cost of contract labor is increasing more rapidly than the cost of salaried workers. **These additional shortcomings are yet another reason that we urge CMS to use its "special exceptions and adjustments" authority to correct for the market basket forecast error that occurred in FY 2022 — the 3.0 percentage point difference in what was finalized in FY 2022 at 2.7% and what the market basket actually is at 5.7%.** Additionally, we ask that CMS expeditiously examine its rebasing and revising methods for the hospital market basket so that it can more accurately reflect the changing labor dynamics. For example, while the ECI has been updated to reflect the composition of labor in 2021,<sup>18</sup> this still means that price changes in the labor compensation category of the market basket going forward measures the *percent difference in the cost of hiring a 2021 labor force*. Again, we do not believe this would be an accurate reflection of labor cost growth going forward.

## Productivity

Under the Affordable Care Act (ACA), the IPPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).<sup>19</sup> This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2024, CMS proposes a productivity cut of 0.2 percentage points.

**AzHHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate. As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2024.** The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. However, in an economy marked by great uncertainty due to workforce shortages and demand and supply shocks, this assumption generates significant departures from

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<sup>17</sup> U.S. Bureau of Labor Statistics. National Compensation Measures.

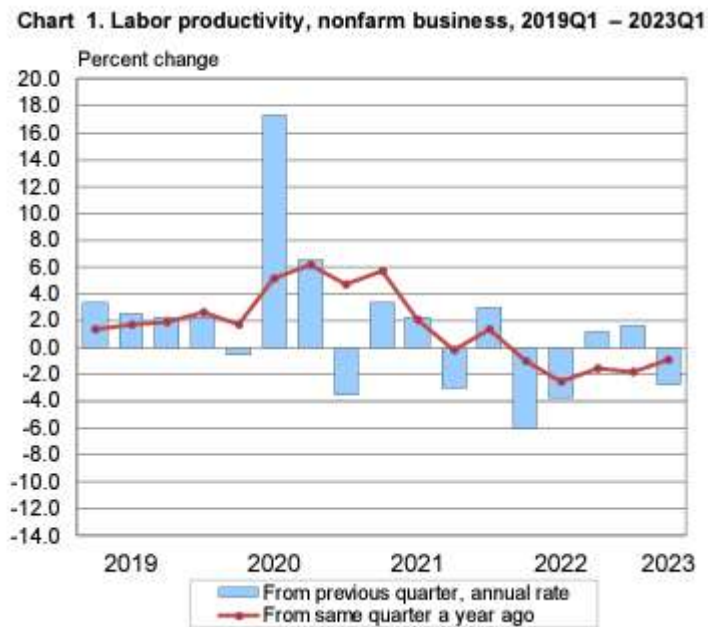
<https://www.bls.gov/opub/hom/ncs/calculation.htm#employer-costs-for-employee-compensation-ecec>

<sup>18</sup> In December 2022, the ECI was updated to weights using the composition of labor in 2021.

<https://www.bls.gov/eci/notices/2022/eci-2021-fixed-weights-and-2018-soc-update.htm>

<sup>19</sup> Centers for Medicare & Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf>

economic reality. Indeed, the nonfarm business sector labor productivity decreased 2.7% in the first quarter of 2023 compared to the previous quarter.<sup>20</sup> Compared to the same quarter a year ago, it has decreased 0.9%, the first time since 1948 that the four-quarter change series has remained negative for five consecutive quarters, as shown in the graph below. Although the productivity adjustment uses a 10-year moving average, the consistent declines in this metric is also noteworthy enough that they should be given particular consideration when deciding upon the appropriate productivity adjustment for FY 2024.



Source: U.S. Department of Labor Bureau of Labor Statistics

Productivity and Costs News Release, First Quarter 2023, Preliminary

### ATRA/MACRA Documentation and Coding Adjustment Restoration

In FY 2008, CMS adopted MS-DRGs under the IPPS. CMS indicated that the adoption of the MS-DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. CMS finalized a policy to maintain budget neutrality by adjusting the national standardized amount to eliminate the estimated effect of changes in coding or classification that did not reflect real changes in case-mix. CMS estimated that an adjustment of -4.8% to the national standardized amount was necessary and phased in this adjustment over 3 years (-1.2% in FY 2008, -1.8% in FY 2009, and -1.8% in FY 2010). Congress then enacted the Transitional

<sup>20</sup> U.S. Bureau of Labor Statistics. (May 4, 2023). Productivity and Costs, First Quarter 2023, Preliminary. <https://www.bls.gov/news.release/pdf/prod2.pdf>, <https://www.bls.gov/opub/ted/2023/labor-productivity-rose-at-1-1-percent-annual-rate-from-fourth-quarter-2019-to-first-quarter-2023.htm>

Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (TMA) that reduced the adjustment to -0.6% for FY 2008 and -0.9% for FY 2009. However, the TMA further required that CMS estimate the change in expenditures in these years due to documentation and coding and make additional adjustments to IPPS rates between FY 2010 and FY 2012 to ensure that aggregate spending in FY 2008 and FY 2009 was neither higher nor lower than otherwise would have occurred had CMS not adopted the MS-DRGs.

Subsequently, the American Taxpayer Relief Act of 2012 (ATRA) required the Secretary to make a recoupment adjustment totaling \$11 billion by FY 2017. This adjustment represented the amount of the increase in aggregate payment that occurred as a result of not completing the prospective adjustments for additional spending in FY 2008 and FY 2009 between FY 2010 and FY 2012. CMS had planned to make annual recoupment adjustments of -0.8 percentage points each year for four years from FY 2014 to FY 2017 consistent with ATRA for a cumulative reduction of -3.2 percentage points.

For FY 2018, CMS planned to restore +3.2 percentage points to the IPPS standardized amounts consistent with section 7(b)(2) of the TMA that states “an adjustment made under paragraph (1)(B) for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges in a subsequent year.” However, MACRA was enacted in 2015 and required CMS to make adjustments of +0.5 percentage points annually to the IPPS standardized amounts over 6 years from FY 2018 through FY 2023 or 3.0 percentage points in total over this period. The remaining 0.2 percentage point difference, therefore, would be restored to the standardized amounts beginning in FY 2024 under the requirements of section 7(b)(2) of the TMA.

After MACRA was enacted, CMS adopted an FY 2017 recoupment adjustment of -1.5 percentage points rather than -0.8 percentage points making the cumulative recoupment adjustment -3.9 percentage points while MACRA only allowed 3.0 percentage points to be returned to IPPS rates from FY 2018 through FY 2023. The 21<sup>st</sup> Century Cures Act later changed the first-year restoration adjustment from 0.5 to 0.4588 percentage points. **Therefore, as a result of the -3.9 percent ATRA adjustment and a 2.9588 percent MACRA and Cures Act restoration, 0.9412 percentage points has not been restored to IPPS standardized rates through FY 2023.**

We appreciate that CMS does not dispute this fact. Indeed, in the FY 2023 final rule, the agency stated “[a]long with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.”<sup>21</sup> As indicated above, section 7(b)(2) of the TMA requires any adjustments for documentation and coding not be carried forward into subsequent years. The TMA was originally enacted in 2007 and paragraph (7)(b)(1)(B) was subsequently amended by the ATRA, MACRA and the 21<sup>st</sup> Century Cures Act to

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<sup>21</sup> 87 Fed. Reg. 48800 (August 10, 2022).



modify the adjustments for documentation and coding occurring between FY 2013 and FY 2023. However, section 7(b)(2) remains unchanged in stating that any of the adjustments made for documentation and coding shall not be included in the determination of the standardized amounts for discharges occurring in a subsequent year.

In addition, section 7(B)(4) of the TMA indicates that “nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.” Again, the statute requires that CMS not continue the adjustments made under paragraph 7(b)(1)(B) into IPPS rates after FY 2023. Just as CMS fully restored prior recoupment adjustments made in FY 2012 for FY 2013<sup>22</sup>, CMS must fully restore the prior recoupment adjustments made since FY 2013. **Therefore, as required by paragraphs 7(b)(2) and 7(b)(4) of the TMA, we ask that CMS fully restore the current 0.9412 percentage point shortfall in updating the FY 2024 standardized amounts. At the very least, CMS should fully restore the 0.9412 percentage point shortfall using its special exceptions and adjustments authority.**<sup>23</sup>

#### **HOSPITAL IQR PROGRAM**

While CMS has proposed a modification of the COVID-19 Vaccination Coverage among HCP, **AzHHA recommends that CMS remove the measure to reflect the end of the PHE and recent announcements that CMS will soon be removing the COVID-19 vaccination mandate for healthcare workers. If, instead, CMS chooses to move forward on the measure, we recommend a number of changes.**

The evidence around the optimal cadence for booster doses of COVID-19 vaccination, as well as the seasonality of the virus itself, is evolving rapidly. Over the past several months, CDC and FDA have indicated they are seriously considering the adoption of a once-yearly regimen for COVID-19 vaccinations comparable to the well-established approach used for influenza vaccination. AzHHA is concerned that the administrative complexity of collecting CDC’s current definition of “up to date” status may outweigh its benefit. For these reasons, if CMS continues to use this measure, we recommend CMS continue to collect up to date vaccination status on a voluntary basis and implement required reporting of up to date status after FDA and CDC have completed their recommendations on an updated vaccination schedule.

We encourage CMS to learn from the experience of implementing the previous version of this measure and take into account the foreseeable logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs. As CMS notes in the proposed rule, health care facilities are collecting and reporting data on “up to date” COVID-19 vaccination status, though the “up to date” data field cannot be

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<sup>22</sup> 77 FR 53266 (August 31, 2012)

<sup>23</sup> See 42 U.S.C. § 1395ww(d)(5)(I); *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 699 (D.C. Cir. 2014) (explaining that the secretary had authority under 42 U.S.C. § 1395ww(d)(5)(I) to adjust the hospital-specific rate for payments).



used for public reporting unless CMS finalizes the proposed measure specification change. However, facilities have reported that this collection process is administratively burdensome under CDC's current "up to date" definition. This is because the collection protocol uses a reference time period for determining up to date status that changes every quarter. Practically speaking, this means that an HCP who counted as "up to date" in a given quarter may no longer be up to date in the next quarter.

Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCPs may need an additional booster. In fact, collecting accurate data on HCP's underlying risk factors likely would require hospitals to both obtain permission to have such data and a mechanism to keep the data fully secure. AzHHA is concerned that the resource intensiveness of collecting data under CDC's current definitions may outweigh its value.

AzHHA believes that the adoption of a once-yearly vaccination regime would alleviate much of the administrative complexity of collecting up to date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as fall 2023. By delaying the required reporting of "up to date" vaccination status, CMS could align its reporting requirements around this more efficient approach. In practical terms, we believe the soonest facilities could report up to date status based on a once-yearly vaccination regimen is the second quarter of CY 2024, but we recognize that more time may be needed.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we continue to urge that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS' stated goals of encouraging vaccination).

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among healthcare personnel. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of healthcare personnel who are up to date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects. Similarly, the measure under consideration is inconsistent with CMS's recently sunset Condition of Participation (CoP) requiring vaccination among health care personnel in terms of its exceptions for sincerely held religious beliefs. To maintain continuity with the CoP and align

with HHS Office of Civil Rights guidance, we recommend that CMS develop an additional exclusion for this measure to account for sincerely-held religious beliefs.

#### **REQUEST FOR PUBLIC COMMENTS: SAFETY-NET PROVIDERS**

Safety-net hospitals serve as a critical access point for primary care and specialized health care services. Yet, despite their vital roles and the complex needs of the patients they serve, many face significant financial challenges. **We thank CMS for its interest in exploring ways to support safety-net hospitals providers so they can continue to provide crucial services and act as access points for many communities in need.**

While we know that there are a number of different ways to define safety-net hospitals, we believe that one recent approach missed the mark - the Coronavirus Aid, Relief, and Economic Security (CARES Act). The CARES Act used three eligibility requirements to determine what was classified as a Safety-Net Hospital: A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater, average uncompensated care per bed of \$25,000 or more, and profitability of 3% or less, as reported to the CMS in the most recently filed cost report. While those items were not necessarily problematic in and of themselves, the section of the Medicare Cost Report used was highly problematic. Public hospitals that met all of those criteria but had a Bond Tax Levy support missed out on receiving tens of millions of dollars, even when the Bond Tax Levy was restricted by statute from being used for operations. The calculation also unfairly included the Bond Interest Income (both realized and unrealized) even when also restricted and prohibited from being applied towards operations. In Arizona, one public hospital lost out on tens of millions of dollars in CARES Act funding despite having a DPP of 56.8%, an average uncompensated care per bed of \$79,608, and negative profitability because the Bond Tax Levy was included. This, coupled with other funding inequities caused them to be unable to compete with other area hospitals which used their CARES funding to provide raises to staff. The result was that the public hospital had to close a number of inpatient beds which then resulted in longer emergency department stays for individuals awaiting beds and some patients not receiving needed care. **AzHHA kindly requests that CMS not include restricted Bond Tax Levy in determining what qualifies as a safety-net hospital.**

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Amy Lupton".

Director of Financial Policy and Reimbursement, AzHHA