Washington State
Hospital Association

June 28, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

RE: CMS-1752-P: 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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment

Dear Ms. Brooks-Lasure:

On behalf of the Washington State Hospital Association's more than 100 hospital and health system members, we appreciate the opportunity to comment regarding proposed inpatient prospective payment hospital rule. We are commenting on a few of the proposed rule's provisions that we believe are of greatest impact for our members.

WSHA supports CMS's proposal to repeal the requirement for hospitals to provide their median negotiated rates with Medicare Advantage plans as part of the hospital's cost report filing. CMS's rule requiring reporting of median payor-specific rates would have created significant administrative burden for hospitals but would but not provide CMS with meaningful information regarding relative weights for hospital services provided to Medicare Advantage enrollees**.** The requirement assumes hospital payment arrangements with MA payors reflect differences in costs of providing specific services from Original Medicare. In most cases, MA plans apply the same set of DRG relative weights calculated by CMS for Original Medicare for their Medicare plans, without regard for differences in the distribution of costs for a particular service among hospitals. As a result, the information would likely only mirror the cost and weight information CMS has already calculated. We believe the MA plans themselves would be better sources of the information, particularly if they base their weights on sources other than CMS' calculations.

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WSHA supports CMS's proposal to use 2019 data for weight-setting purposes. We support CMS' proposal to use 2019 data rather than 2020 data for purposes of DRG weight-setting. We agree that the 2020 data would likely be significantly influenced by changes in utilization and relative costs due to the COVID-19 emergency and would not be reflective of the cost of care once care patterns return to a measure of normalcy. As we continue to see impacts to patient care in 2021, we recommend CMS also consider if adjustment is needed to the data used for 2023.

WSHA supports CMS's proposal to extend New COVID-19 Treatment Add-on Payments. We support CMS's proposal to extend the add-on payments through the fiscal year in which the public emergency ends to ensure that to the degree possible, CMS' payment methodology reflects the additional costs to hospitals to provide these treatments.

WSHA supports CMS's proposal to apply temporary adjustments to its hospital quality measurement and value programs to avoid undue penalties due to the emergency. We support CMS's proposal to suppress the data for specific quality measures that have broadly and negatively impacted due to the COVID-19 emergency. Hospitals have provided care for patients under extraordinary conditions at a time of unprecedented volumes and severity. As a result, resources that would normally be available to measure and report certain quality measures have by necessity been used for patient care. We do not believe it appropriate that hospitals should be financially penalized for lapses in quality reporting or results during this period. We recommend CMS continue to monitor the situation and consider further extensions if data indicates the emergency has a prolonged impact on quality results.

WSHA strongly supports CMS's proposal distribute additional residency slots. WSHA supports and appreciates CMS's proposals to implement several provisions of the Consolidated Appropriations Act, in particular distribution of 1,000 additional physician residency slots to qualifying hospitals to address workforce shortages. Physician workforce shortages are a critical issue for hospitals, particularly hospitals in rural areas. While we understand the slots will be phased in over time, when they are distributed they will help qualifying hospitals address their current workforce needs, as well as provide hospitals needed assistance in supporting future workforce.

While the additional 1000 slots are needed and greatly appreciated, for hospitals to meet the workforce needs of the future many more will be needed. We encourage CMS' efforts to increase the number of residency slots in future years.

We appreciate that the new slots are targeted toward rural/underserved areas. We would ask that CMS also develop criteria to ensure equitable geographic distribution among rural and

underserved regions. In our state there has been a historic geographic disparity in the allocation of residency slots.

WSHA requests CMS does not finalize its proposal to modify organ transplant payment. We are concerned CMS's proposal to change the calculation for organ acquisition costs will significantly impact harvesting of available organs and reduce the number of lives saved through organ transplantation. The proposal is a significant change to long-standing policy and would have impacts to availability of organs to transplant well beyond the Medicare program. In particular, it would have significant impact on children's hospitals that serve few Medicare patients, but provide a significant amount of organ acquisition. The timing of the proposed rule does not allow for replacement of this funding through other payors and would compromise hospital's ability to procure organs for transplant. We request that CMS does not finalize this proposal and instead conduct a study of the impact and potential alternatives.

Reporting of graduate medical education full-time equivalents on Medicare cost report. Childrens hospitals are not paid under IPPS, and as a result do not receive IME and do not complete Worksheet E of the cost report. We ask that CMS clarify that children's hospitals are either exempt from this requirement or receive alternative support in order to comply with the requirement.

We appreciate your consideration of our comments. If you have questions, please contact Andrew Busz at andrewb@wsha.org.

Sincerely,

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Washington State Hospital Association

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