



June 25, 2021

Chiquita Brooks-Laure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1752-P
P.O. Box 8013
Baltimore, MD 21244-1850

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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access hospitals; proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program (CMS-1752-P)

Dear Administrator Brooks-LaSure,

On behalf of its 122 member hospitals, the Kansas Hospital Association offers the following comments in response to the Centers for Medicare & Medicaid Services' proposed payment and policy updates for the fiscal year 2022 Medicare Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems.

CMS PROPOSED UPDATES TO HOSPITAL INPATIENT QUALITY REPORTING AND ELECTRONIC HEALTH RECORD INCENTIVE PROGRAMS

Duplicate reporting of vaccination rate among health care personnel

CMS is proposing hospitals report the COVID-19 vaccination rate among health care personnel. The measure would be reported for at least one week of each month. Each quarter, the Centers for Disease Control and Prevention would calculate a summary measure that would be published in Hospital Compare.

KHA encourages the efforts of health care providers to ensure their employees have access to COVID-19 vaccinations. KHA understands the need to collect vaccination rate data to enable patients to make an informed decision about where to receive care. However, the rule as proposed appears to encourage duplicative reporting.

CMS has pointed out that hospitals can voluntarily report health care employee vaccination rates within the COVID-19 Module of the National Healthcare Safety Network. CMS also has noted the lack of a mandated system for reporting vaccination rates for health care employees. KHA is concerned that hospitals will be asked to report the same data in multiple reporting systems, as HHS currently requires COVID vaccination data be reported into Teletracking (HHS Protect) as well. KHA recommends the use of the COVID-19 Module of the



NHSN to report health care employee vaccination rates in lieu of a separate reporting process through HHS Protect. We encourage federal agencies to coordinate their data systems and expectations so that the data need only be reported once.

COVID-19 Health care personnel performance should not be tied to pay-for-performance

Several state legislatures have considered legislation that would prohibit an employer from forcing employees to be vaccinated for COVID-19. Other state legislatures are considering legislation to specifically authorize employer-mandated vaccinations. As these legislative debates are resolved, hospital performance on employee vaccination rates could significantly vary based on differing state laws. KHA supports the disclosure of data on COVID-19 vaccination of health care personnel; however, the potential for interstate regulatory differences raises concerns about a future employee vaccination metric within a pay-for-performance program. KHA appreciates CMS for not recommending the inclusion of the employee vaccination metric in the hospital Value-Based Purchasing or Hospital Acquired Conditions programs.

Inpatient PPS pay-for-performance programs

Because of the COVID-19 public health emergency and the effect on both patients and hospitals, CMS is proposing to establish suppression policies for many of the mandatory pay-for-performance program metrics. KHA supports the establishment of the suppression policies within the Value Based Purchasing, Hospital Acquired Conditions and the Readmission Reduction programs.

Hospital quality reporting program

CMS is proposing to compel hospitals to use certified technology that has been updated consistent with the 2015 Edition Cures Update and is clarifying that certified technology must support the report requirements for all available encumbrances. The electronic health record vendors will be required to meet the 2015 Edition Cures Update standard by December 31, 2022. KHA is concerned about the lack of time for hospitals to implement the change and test the EHR systems for data accuracy. Due to this, KHA is urging CMS to allow more time for hospitals to operationalize and test the system updates for accuracy before implementing the requirement for hospitals to use only certified technology updated consistent with the 2015 Edition Cures Update.

Promoting Interoperability Program

CMS is proposing hospitals adopt the Health Information Exchange Bi-Directional Exchange measure as part of the health information exchange objective. KHA is concerned with the affordability of such interfaces to rural and independent hospitals. This is a duplicative of information already available on WebIZ in Kansas and is not a necessary part of clinical work.

WAGE INDEX REVISIONS

CMS has proposed to continue the policy of increasing the wage index for hospitals with wage indices in the bottom quartile, which is calculated to be at or below 0.8418. Wage indices in the bottom quartile would be increased to be halfway between the initial wage index value and the 25th percentile. Funding to support this



increased payment rate is generated by applying a uniform multiplicative budget neutrality factor of 0.998108. While KHA supports the intent and application of the wage index redistribution, we prefer that CMS revisit how the rule is funded. As proposed, those hospitals that fall between the 22nd and the 25th percentile are receiving a reduction to the wage adjusted standardized rate because the amount of benefit received is less than the cost to fund the benefit. KHA recommends those hospitals who fall under the 25th percentile be held harmless. The continued effort by CMS to reexamine and adjust the wage index is appreciated by KHA. Continuing the wage index policy will create greater equity among providers who provide care for a disproportionately high number of seniors.

ORGAN ACQUISITION PAYMENT

CMS is proposing to make major changes as to how transplant centers, specifically hospitals, are paid for organ acquisition costs. Based on Medicare-reasonable cost principles, the cost of organ acquisition must be allocated to the appropriate payer source. Currently, CMS pays its share of organ acquisition cost based on the payer source of the patient donating an organ. CMS also treats cadaver procured organs as Medicare patients. CMS is proposing to change the percentage of cost Medicare pays based on the payer source of the patient receiving the organ. KHA does not support the proposal and believes that the change will eliminate an intentional incentive to increase organ supply that has been in place for decades.

Deceased donor organs surgically procured by an OPO at a hospital currently are counted as Medicare organs for the purpose of determining the portion of that transplant center's organ acquisition cost payable by Medicare. This policy was designed to incentivize hospitals to assist their OPOs in retrieving organs. This incentive has worked. According to the American Society of Transplant Surgeons, transplant centers currently constitute only 6 percent of donor hospitals but retrieve 36 percent of deceased organs suitable for transplantation. The proposed rule would eliminate this incentive.

The proposed rule also would force the transplant centers to obtain the insurance status of all recipients of organs recovered in their hospital by the OPO, whether the organ is given to a patient in the procuring hospital or whether the organ is transported to another hospital. OPOs report that the payer source currently is not information that is retained or shared with the procuring hospital. KHA believes that without significant changes in information sharing requirements between the procuring transplant centers, the organ placement centers will be forced to identify the patients receiving the organ which will lead to increased administrative burden and cost. It also is unclear as to what information is allowed to be shared to procuring hospitals under HIPAA. OPOs report that it may be possible to share whether the patient was covered by Medicare, but may not be able to share additional details. While this would help hospital ascertain the payer source, additional information would need to be provided to hospitals to pass future Medicare audits.

For these reasons, KHA urges CMS to not finalize the proposed organ procurement reimbursement policies.

DISTRIBUTION OF ADDITIONAL RESIDENCY SLOTS

Congress enacted the Consolidated Appropriations Act of 2021 that contains instructions for CMS to expand the access to, and the number of residency slots. CMS is proposing to add 200 GME-funded FTEs to the



program in FFY 2023 with an additional 200 added in each subsequent year until a total of 1,000 FTEs have been added. The amount of new residency slots would be limited to at most 1.0 full time equivalent position per hospital per year, with no hospital receiving more than 25 FTEs over the course of the program. Each resident must have at least 50 percent of their training time occur at locations that serve underserved populations. Priority for these positions is given to four statutorily specified categories. At least 10 percent of the new residency slots are prescribed to go to each of the following designations: teaching hospitals in rural areas, hospitals that currently are training residents over their cap, hospitals in states with new medical schools and hospitals that care for underserved communities. The CAA also eliminates the requirement for a separate accreditation to be eligible for rural training tract funding that can provide more flexibility for rural and urban hospitals to partner to help with physician shortages in rural areas.

KHA has long supported health equity in all communities that hospitals serve. The legislatively directed distribution of residency slots to rural areas and underserved communities are appreciated. KHA urges CMS to count training time for IME/DME purposes (such as critical access hospitals, rural health clinics, and FQHC's).

KHA applauds efforts by Congress and CMS to increase the number of available residency slots.

Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,

A handwritten signature in black ink that reads 'Shannan Flach'. The signature is written in a cursive, flowing style.

Shannan Flach
Vice President of Healthcare Finance and Reimbursement