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June 9, 2023

Submitted electronically via: https://www.regulations.gov/

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

Re: Medicare Program; Hospital Inpatient Prospective Payment System 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 (CMS-1785-P)

Dear Administrator Brooks-LaSure,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding the fiscal year (FY) 2024 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals (CMS-1785-P) (hereinafter, "Proposed Rule"). Many of the topics in the Proposed Rule have a significant impact on our members and the patients they serve. Given the financial uncertainty and increased costs that hospitals continue to endure, Vizient is concerned that inadequate Medicare payment rates and harmful policies are contributing to financial instability, especially as many other payers use Medicare rates and policies in contracts with hospitals and other providers. Vizient encourages CMS to advance payment policies that provide both stability and adequate reimbursement.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality, and market performance for more than 60% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

In our comments, we respond to various issues and proposals provided in the Proposed Rule and offer our responses to the agency's various requests for information. We thank CMS for the opportunity to share recommendations related to IPPS, quality programs, the Medicare Promoting Interoperability Program, and health equity, among other topics. In addition, we offer future recommendations for the agency's consideration as the Proposed Rule is finalized to inform future rulemaking.

Proposed IPPS Payment Rate Updates for FY 2024 and the Market Basket

CMS indicates that after accounting for inflation and other adjustments required by law, the Proposed Rule would increase IPPS operating payment rates by 2.8% in FY 2024 for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. In determining this increase, CMS estimated that the market basket update will be 3.0%. Vizient is concerned that the market basket update is inadequate and does not adequately reflect hospitals' financial challenges. Further, we urge CMS to consider opportunities to correct prior market basket updates which were also woefully inadequate.

FY 2024 Proposed Market Basket Update

CMS proposes to base the FY 2024 market basket update on IHS Global Inc.'s fourth quarter 2022 forecast of the 2018-based IPPS market basket rate-of-increase, with historical data through the third quarter of 2022. As noted by CMS, the market basket is an index that measures the change in price, over time, of the same mix of goods and services purchased in the base period.[1] Using forecast information, CMS estimates the FY 2024 market basket will be 3.0%, but acknowledges this value may change as more recent information becomes available. Vizient appreciates the efforts of CMS to gain additional stakeholder input regarding the market basket update and encourages the agency to carefully consider whether current trends are adequately accounted for in the data CMS relies upon.

For example, in the April 2023 Kaufman Hall Hospital Flash Report, one of the key takeaways was, "[i]ncreased material costs associated with drugs and supplies as a result of inflationary pressures continue to negatively affect hospital margins. Additionally, workforce shortages persist, driving up the cost of labor, albeit at a slower pace than material costs." Among other concerning trends, for 2023 (as compared to 2020), the report finds that total labor expenses are 19% higher, while non-labor expenses such as supplies, drugs, and purchased services saw increases from 17%-19%. Also, based on Vizient's Pharmacy Market Outlook, the projected overall drug price inflation rate for July 1, 2023 – June 30, 2024 is 3.78%, which is significant because it is an increase from our projections from early 2023 (3.26%) and well above the proposed market basket for FY 2024.[2] Given these drastic increases compared to the much lower proposed market basket, Vizient is concerned that hospitals will not be adequately reimbursed for services delivered, which can have far-reaching consequences to patient care. We encourage CMS to consider this information and to provide a more substantial increase to the market basket for FY 2024.

Vizient also encourages CMS to consider specific trends within the Producer Price Index (PPI). Vizient analyzed the U.S. Bureau of Labor Statistics (BLS) PPI data[3] and found that the PPI for surgical and medical instruments is at 3.9% for the last 12 months based on April 2023 findings. In contrast, in April 2022, the 12-month change for this category was only 2.0%, suggesting that costs may increase for these products but that the full impact of increasing costs may not have reached providers yet as the PPI may be used as an indicator of future costs that hospitals will incur when purchasing medical equipment and supplies. According to the BLS, "the Producer Price Index (PPI) program measures the average change over time in the selling prices

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf
[2] https://info.vizientinc.com/pharmacy-market-outlook-member-details
[3] U.S. Bureau of Labor Statistics, Producer Price Indexes, last updated May 11, 2023, available at: https://www.bls.gov/ppi/.

received by domestic producers for their output. The prices included in the PPI are from the first commercial transaction for many products and some services." As a result, we encourage CMS to consider PPI trends, particularly for surgical and medical instruments, to increase the market basket.

In addition, CMS notes that for the FY 2024 market basket update, the agency uses 2018 data as the base year for the market basket, which is well-before the COVID-19 pandemic and therefore, does not capture drastic shifts in care delivery that have occurred in recent years. For example, as described in a recent Vizient publication,[4] excluding COVID-19 diagnoses, overall inpatient utilization remains 9% below pre-pandemic levels, non-COVID emergency department volume is down 3%, and inpatient surgical volume is down 11% between Q2 2019 and Q2 2022. Though volume has not fully recovered, length of stay (LOS) and patient acuity (as measured by Case Mix Index (CMI)) are up 8% and 5% respectively from Q2 2019 – Q2 2022. Since the market basket measures the same mix of goods and services purchased in the base period,[5] Vizient encourages CMS to consider whether updates to the market basket are needed to reflect more recent care delivery trends.

Lastly, Vizient encourages CMS to consider using its special exceptions and adjustments authority to provide a more substantial increase to the market basket in the IPPS final rule for FY 2024. Given prior market basket rates have underestimated costs, hospitals are continuing to struggle financially and hospital cash reserves are diminishing.[6] While Vizient appreciates the significant effort and research considered in estimating the market basket, we believe it is imperative that the agency consider the financial circumstances of hospitals and increase the market basket so that hospitals can be financially stable.

Addressing Prior Market Basket Updates

In prior rulemaking, such as the FY 2022 IPPS Final Rule, CMS finalized a market basket of 2.7%, which is effectively a prospective estimate, but the actual update for the year was 5.7%.[7,8] In Vizient's comments regarding the FY 2022 IPPS proposed rule, we expressed concern regarding the process to update the market basket, as the impact of COVID-19 was not accounted for in the updated market basket. Similarly, regarding the FY 2023 IPPS proposed rule, we shared similar concerns, highlighting the impact of inflation and cost increases which did not appear to be adequately captured in the proposed market basket. Since it is now clear that prior market basket updates were woefully inadequate, Vizient urges CMS to consider opportunities to correct these underpayments, including using the agency's special exceptions and adjustments authority.

Medicare Productivity Adjustment

CMS proposes a productivity adjustment of -0.2% which drives down the estimated payment rate for FY 2024 to 2.8%. The productivity adjustment reduces the IPPS payment update as it reflects most economy-wide changes to productivity. As noted above, hospitals are facing

[4] https://newsroom.vizientinc.com/en-US/releases/blogs-beware-you-are-not-down-yet-margin-pressures-will-remain-challenging-in-2023
[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf
[6] https://www.beckershospitalreview.com/finance/health-system-cash-reserves-plummet.html
[7] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata
[8] https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

significant financial uncertainty and labor challenges, so broad economy-wide productivity trends may not apply to hospitals. For example, the high turnover rate in the healthcare system creates additional challenges to productivity. A recent Vizient report[9] notes that in 2022, advanced practice practitioner turnover was 9.3% in 2022, up from 7.7% in 2020. In addition, Vizient's May 2023 Workforce Intelligence Report[10] outlines key workforce trends that will ultimately impact productivity, including high nurse turnover rates, and that contract labor demand is projected to stay 15% above pre-pandemic levels due to inflation and other economic factors. The report also found that patients are staying in hospitals longer, despite volumes being below pre-pandemic rates. This information is important for CMS to consider, as it aligns with the Bureau of Labor Statistics' Productivity Highlights[11] which noted several reasons why productivity in the hospital industry is difficult to measure. Given such uncertainty and the significant financial and operational challenges hospitals are facing, Vizient recommends CMS provide a neutral Medicare Productivity Adjustment for FY 2024.

Outlier Payments

Costs incurred by a hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount. Using the same methodology from FY 2020, CMS finds the proposed outlier fixed-loss cost threshold for FY 2024 is $40,732, an increase from FY 2023 which was $38,859. Vizient is concerned the significant increase to the fixed-loss cost threshold will add to hospitals' financial pressures, as fewer high-cost cases would be eligible for outlier payments.

In the Proposed Rule, CMS notes that it has not adjusted the calculation of the fixed-loss threshold for FY 2024, as was done in FY 2023, to better account for the impact of COVID-19, which led to a lower, albeit still high, fixed-loss threshold. In contrast, the FY 2022 fixed-loss threshold was $30,988. Vizient encourages CMS to share more information regarding factors driving increases to the fixed-loss threshold so stakeholders can make more informed comments to CMS.

Proposed Changes Related to Medicare Severity Diagnosis-Related Group (MS-DRG) and Relative Weights

Reporting of Certain Social Determinants of Health Diagnosis Codes

In the FY 2023 IPPS proposed rule, CMS sought comment on how the reporting of diagnosis codes in categories Z55-Z65 (persons with health hazards related to socioeconomic and psychosocial circumstances) might improve the agency's ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRGs. CMS reiterated that Z59.00 (Homelessness) (and its subcategories Z59.01 and Z59.02) are more frequently reported codes that describe social determinants of health (SDOH). Vizient agrees with this analysis as it is also consistent with data Vizient shared in prior comments. Vizient believes that changes the severity level designation for the diagnosis codes related to

[9] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/6dfee41a74a2467c8104db018706ecd8; https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/6dfee41a74a2467c8104db018706ecd8 ; https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/6dfee41a74a2467c8104db018706ecd8
[10] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/c372877070484a40be8cde3b480606f9
[11] https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm

homelessness from non-complication or comorbidity (NonCC) to complication or comorbidity (CC) for FY 2024 will support documentation and reporting of these diagnosis codes. In addition, as provided in Vizient's prior comments, other commonly reported SDOH codes include Z56.0 (unemployment, unspecified), Z60.2 (problems related to living alone), and Z62.810 (personal history of physical and sexual abuse in childhood). Vizient is willing to share updated data, if of interest to the agency, to support future policy development. Generally, we appreciate the agency's interest in encouraging reporting and better recognizing how SDOH can impact care. As there are many different SDOH codes, we suggest CMS consider how it will make similar decisions for Z-codes in the future. Also, as CMS considers moving more codes from NonCC to CC for future years and aims to increase reporting, we encourage CMS to accept more diagnosis codes. Since Vizient receives up to 99 diagnosis codes (as opposed to CMS's 25 diagnosis code limit), more information is available regarding which codes are reported. As CMS aims to increase reporting, we suggest the agency consider removing the 25-diagnosis code limit.

As CMS is aware, SDOH codes are often underreported. Vizient encourages the agency to consider using an index, such as the Vizient Vulnerability Index™,[12] (VVI) as a resource when making determinations regarding whether certain Z-Codes are underreported and which should potentially be moved from NonCC to CC. Vizient has utilized the VVI to learn that the number of SDOH Z-Codes reported increases with neighborhood vulnerability, as shown in Figure 1. From January 2019 – December 2021, which shows only small increases of z code reporting, of the 6.6 million encounters with patients from neighborhoods with a VVI score > 1, 450,000 (6.8%) have at least one SDOH Z-Code. Of those reported codes, less than 1% of encounters have codes indicating education needs, food insecurity, or inadequate drinking water. This information is relevant, as shown in Figure 2, as the VVI could be used to help demonstrate whether there is a significant gap in reported Z-Codes and social vulnerability in a patient population because more vulnerable populations tend to have more Z-Codes recorded. Vizient welcomes the opportunity to further discuss potential approaches with the agency to use the Vizient Vulnerability Index as it determines different levels of CC severity.

[12] Vizient developed a unique vulnerability index that serves as a singular clinical data index for SDOH at the neighborhood level. The index integrates publicly available data from various U.S. government agencies including the Census Bureau, Department of Agriculture, Department of Housing and Urban Development and the Environmental Protection Agency to provide deeper insights regarding community needs. The VVI is scored in segments. High/Medium/Average/Low segments of the Vizient Vulnerability Index (Quantitative assessment of community social determinants of health (SDOH) factors that may influence a person's overall health). Low = overall VVI score < -1; Average = overall VVI score -1 to 1; Medium = overall VVI score >1 to 2; High = overall VVI score > 2.

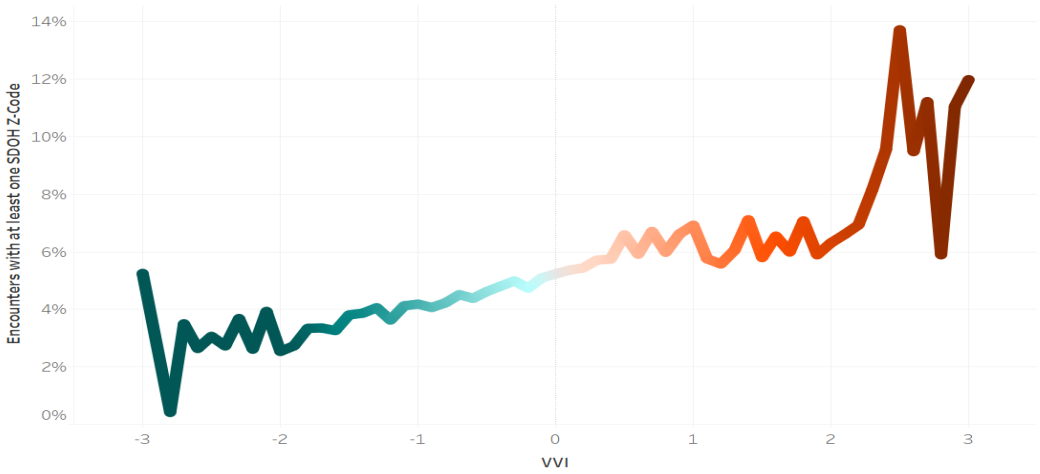

Figure 1 Application of the VVI to determine whether there is a relationship between more vulnerable neighborhoods (those with a VVI index score from 0-3) and whether encounter data includes at least one Z-Code.

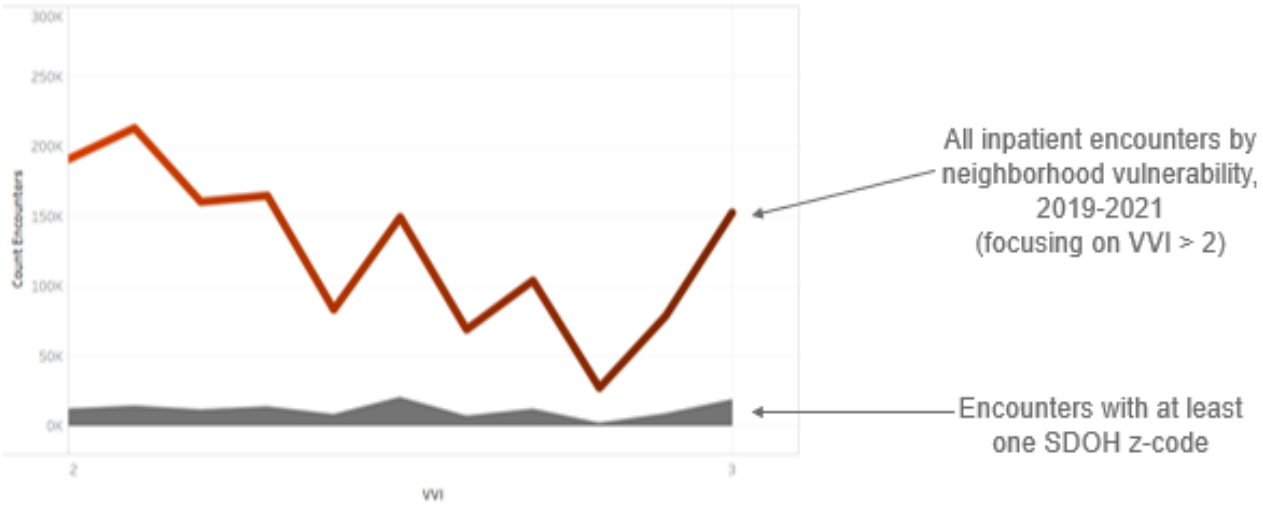

Figure 2 A comparison of the number of high-vulnerability encounters, where vulnerability is based on the VVI, compared to encounters with at least one SDOH Z-Code.

Lastly, as CMS considers approaches to improve documentation, we recommend CMS also account for provider burden and potential challenges in obtaining information from patients, particularly as patients may question why providers are asking for such information. Patients may also question why this information is being tracked and included on claims. We encourage CMS to identify opportunities to standardize screening efforts so that SDOH information can be more routinely collected, consistently captured, and, ideally, appropriate interventions are implemented. Also, additional resources and training may be helpful to improve communications and support providers seeking to collect SDOH data from patients.

Application of the Non-Complication or Comorbidity (NonCC) Subgroup Criteria to Existing MS-DRGs with a Three-Way Severity Level Split

In the Proposed Rule, CMS restates its FY 2021 IPPS final rule policy to expand the criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC)

subgroup within a base MS-DRG to include the NonCC subgroup for a three-way severity level split. This previously finalized criteria, when applied, would result in some MS-DRGs that are currently split into three severity levels shifting to a two severity-level split. As noted in Vizient's prior comments, we expressed concern with the policy's implementation, as it would result in significant coding changes, including changes to the relative weight of those codes.

Administrative Burden
Vizient appreciates that CMS has delayed implementation of the new NonCC subgroup criteria and that the agency has provided additional analysis in files associated with the Proposed Rule to help stakeholders better understand the significant implications of the policy (i.e., 135 MS-DRGs would potentially be subject to deletion while 86 MS-DRGs would potentially be created). Vizient emphasizes that deleting and adding such a large volume of MS-DRGs will create additional administrative burden and as such, providers will need additional time (e.g., more than is typically provided for IPPS implementation from the final rule release data) to implement changes to comply. Vizient urges CMS to work with stakeholders to better understand the administrative burdens associated with this policy and most appropriate implementation timeline.

Consideration of Policies to Promote Stability
Also, Vizient requests that CMS clarify how the policy to cap the reductions for MS-DRG relative weights to 10% would apply as CMS implements the NonCC subgroup criteria. For example, CMS states that several MS-DRGs would be deleted while others are created, so it is unclear whether there would be any effort to prevent substantial reductions as MS-DRGs are effectively consolidated. Such information may be helpful in considering ways to implement the NonCC subgroup criteria in a way that minimizes disruption.

Vizient thanks CMS for first making alternative implementation files available to inform policy for FY 2025 rulemaking. Vizient continues to believe that implementing the NonCC criteria, particularly implementing such criteria over one year, may cause significant disruptions as changes to relative weights would also causing more variability in reimbursement. For example, as there are more substantial differences in relative weights for codes that have effectively been consolidated, we are concerned that reimbursement will be inadequate, particularly for hospitals that have challenges in hiring and retaining staff to help with coding. Vizient encourages CMS to consider opportunities to provide greater stability to reimbursement rates should the agency move forward in implementing the policy. In addition, the agency could also consider implementing the policy in phases, over several years and potentially for fewer codes, as that approach may also help ease the transition. Just as CMS has provided alternative impact files with the Proposed Rule, we encourage the agency to take a similar approach in future rulemaking. For example, the agency could share alternative files demonstrating the potential effects of a multi-year implementation plan. Also, as noted above, Vizient suggests CMS work closely with providers in developing future implementation plans in advance of proposing policy, given the significant burdens and challenges that the policy may impose.

Relative Weight for MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell) and Other Immunotherapies)

In the Proposed Rule, CMS proposes changes to how it would identify cases that are included in the calculation of the relative weight for MS-DRG 018. While Vizient appreciates the

agency's efforts to consider policies to improve the accuracy of the relative weight calculation, we are concerned that CMS is not proposing changes that address ongoing financial challenges, including under-reimbursement, that hospitals face when they administer CAR T-cell therapies on an inpatient basis. Vizient is aware of several price increases and that the projected inflation rates for oncology products are 3.85%.[13] Further, the Vizient Clinical Database (CDB) was recently used in research showing that insurance coverage is one of several factors that can impact access to CAR T-cell therapies (e.g., patients with Medicare were less likely than those with commercial insurance to receive CAR T-cell therapy).[14] Given these access concerns for individuals with Medicare, Vizient recommends CMS work more closely with providers to support their ability to offer CAR T-cell therapy and consider strategies to address other underlying causes of access disparities, such as transportation challenges.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH) for FY 2024

Factor 2 Recommendations

To determine the uncompensated care payment, CMS considers three factors, including the ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to the implementation of the Affordable Care Act (Factor 2).[15] For Factor 2, CMS proposes to use a methodology similar to the methodology applied in rulemaking for FYs 2018-2023. CMS notes that projected rates of growth in enrollment for private health insurance and the uninsured are based largely on the Office of the Actuary's (OACT's) models and that greater detail is available in an OACT report. Also, CMS indicates it may consider the use of more recent data as it becomes available for estimating the rates of uninsurance for purposes of calculating Factor 2. For example, as the COVID-19 PHE unwinds, more insight regarding Medicaid enrollment may be gained as states have been able to actively disenroll those no longer eligible as of April 1, 2023. Vizient encourages the agency to use more recent data in the final rule, as numerous changes are not considered or adequately reflected in the OACT report which may result in the agency underestimating uninsured rates.

Factor 3 Recommendations

The third factor to determine the uncompensated care payment is a hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals (Factor 3). For Factor 3, for FY 2024 and subsequent fiscal years, CMS proposes to determine uncompensated care payments for all eligible hospitals using a 3-year average of the data on uncompensated care costs from Worksheet S-10 for three recent FYs (i.e., FY 2018, 2019, and 2020) for which audited data are available. CMS further clarifies that for the Proposed Rule, the agency used reports from the December 2022 Hospital Cost Report Information System (HCRIS) extract but intends to use the March 2023 update of HCRIS to calculate the final Factor 3 for the FY 2024 IPPS final rule. Vizient is supportive of using audited cost report data, and recommends CMS regularly assess and identify unusual or irregular trends in the data. In addition, we continue to encourage the agency to work with auditors to streamline the audit process and enhance consistency.

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[13] https://info.vizientinc.com/pharmacy-market-outlook-member-details
[14] https://pubmed.ncbi.nlm.nih.gov/35429662/
[15] See Center for Medicare and Medicaid Services, (March 2021). MLN Connects Medicare Disproportionate Share Hospital (DSH), available at: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf, last accessed May 26, 2023.

Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction
Although not outlined in the Proposed Rule, Vizient reiterates our concerns with CMS's proposal to change the way it counts patients covered by Section 1115 Demonstrations in the Medicaid fraction because of the potential consequences on hospitals' financial stability, which could impact patient access to care. As CMS may be considering finalizing this Section 1115 proposed rule in the FY 2024 IPPS final rule, Vizient urges CMS to minimize any potential disruption to care for beneficiaries.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires that the Secretary of Health and Human Services adjust the standardized amount for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. The proposed FY 2024 wage index values are based on Medicare cost report data for cost reporting periods beginning October 1, 2019, and until October 1, 2020 (FY 2020). Given the financial uncertainty and increased costs that hospitals continue to endure, as well as significant variation in staffing trends, Vizient is concerned that CMS's data sources do not capture these changes.

CMS states that it is aware of the concern that data from the first several months of 2020 might have been impacted by the immediate effects of COVID-19. The agency notes that it analyzed the FY 2020 data and found that the data is not significantly impacted by the COVID-19 PHE. However, based on the agency's description in the Proposed Rule, the specifics of this analysis are unclear, as the agency does not reference specific tables or files for the public to review to confirm the agency's conclusion. While CMS states that the data does not show a significant discrepancy from prior years' data, when compared to trends from the previous three fiscal years, the FY 2020 data does not follow the same trends. For example, CMS states that approximately 85% of hospitals had an increase in their average hourly wage from FY 2019 to FY 2020, as compared to a range of 76-77% of hospitals for the most recent three fiscal year periods.[16] At minimum, this shows that there is a deviation in FY 2020 when compared to the three prior FYs. Also, the extent of the wage increases is important to consider, not just the percentage of hospitals that saw an hourly wage increase. Without knowing what other sources of data are available for future wage index calculations or evaluating a comparison of other data sources to identify any potential discrepancies, Vizient is concerned that the impact of the COVID-19 PHE may not be easily parsed out of future years' data.

While CMS states that it does not believe the PHE alone is responsible for these changes, and that it is difficult to parse out what impact the PHE had versus other factors that may be driving up wages, Vizient is concerned that the agency does not provide any alternate methods for calculating the wage index to try to account for the impact of COVID-19. Although the impact of the PHE may not have been apparent on wage data until partially through FY 2020, we still believe the agency should consider approaches to best account for the wage spikes and changes that are a result of the pandemic. For example, as found in Vizient's May 2023 Workforce Intelligence Report[17] contract labor rates are expected to stay 15% above pre-pandemic levels due to inflation and other external economic factors.

In addition, as shown in Figure 3, numerous nursing workforce trends changed once the pandemic began in 2020, including those related to nursing overtime hours as a percentage of

[16] The FY 2020 data trends were compared to data trends from FY 2016 – FY 2017; FY 2017 – FY 2018; and FY 2018 – 2019.
[17] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/c372877070484a40be8cde3b480606f9

hours work, burnout, and turnover. These trends are not sustainable. Vizient has highlighted strategies to help hospitals and health systems address staffing challenges (e.g., ensure nurses are practicing at the top of their license, plan ahead for seasonable contract labor use, using technology as an enabler but not a standalone solution) and if such strategies were widely adopted, they would impact the wage index. As the wage index is proposed, such trends are not considered by the agency, without a clear explanation. Vizient encourages CMS to share additional information regarding its analysis and other information the agency needs so stakeholders can better understand the agency's position and respond accordingly. Vizient further encourages CMS to begin exploring alternate data sources and analyses to better understand how to account for the impact of the pandemic in the wage index given enduring employment trends that were triggered by the pandemic. CMS should work with stakeholders on further developing or refining such an approach to promote stability and accuracy.

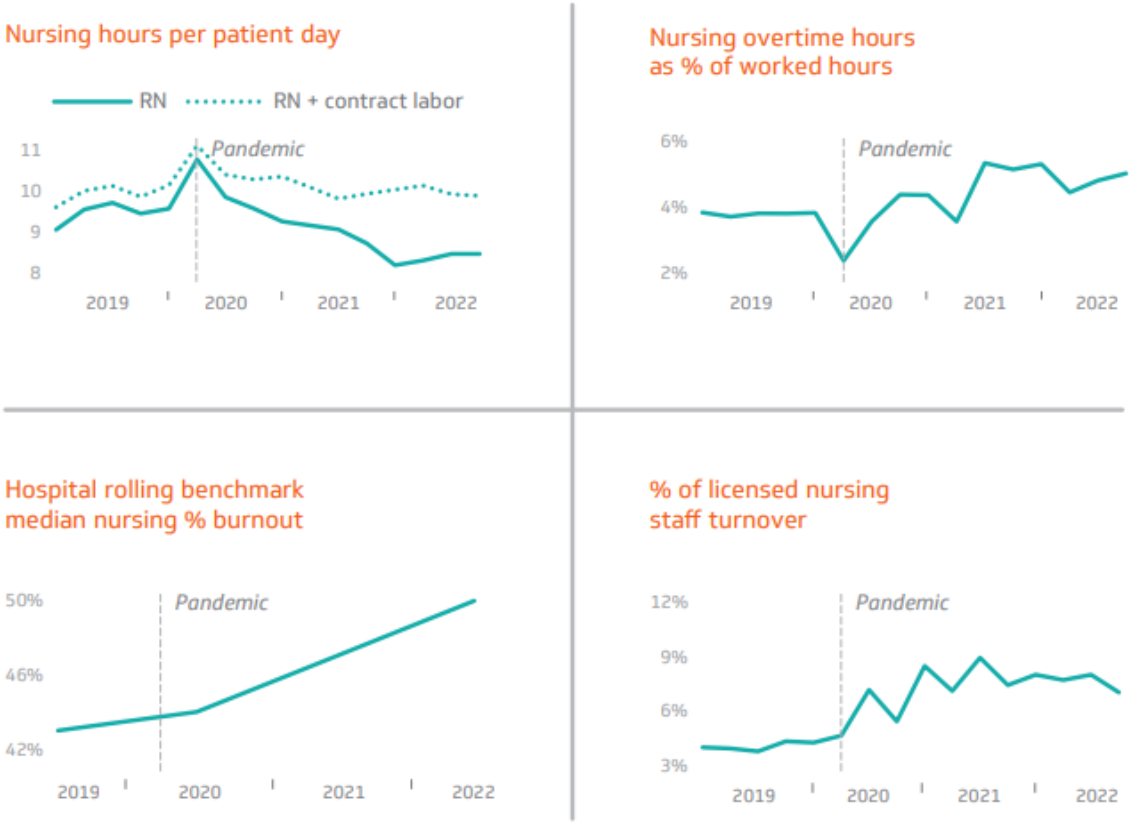

Figure 3. Multiple graphs showing nursing hours, overtime and turnover (Vizient ODB[18], 2019Q1 – 2022Q4) and burnout (Safe and Reliable Healthcare[19], 2019Q3-2022Q2).

Indirect and Direct Graduate Medical Education: Training in New Rural Emergency Hospital (REH) Facility Type

When CMS finalized the Rural Emergency Hospital (REH) facility Conditions of Participation (CoPs) in the CY 2023 OPPS final rule, the agency received requests to designate REHs as

[18] Data from the Vizient® Operational Data Base (ODB) used with permission of Vizient, Inc. All rights reserved. Values represent the median of the dataset. Vizient ODB houses department-level analytics and financial metrics for more than 650 hospitals.
[19] Data from Vizient Safe and Reliable Healthcare. 2022 Safety, Communication, Organizational Reliability, Physician, and Employee Burnout and Engagement (SCORE) survey domains of emotional exhaustion and emotional exhaustion climate. Survey responses include more than 26,000 nurses nationwide. Data updates on an annual basis

graduate medical education (GME) facilities, similar to the GME designation for Critical Access Hospitals (CAHs). In the Proposed Rule, CMS also states that because some CAHs may want to convert to the REH model, it understands the importance of making GME payments available to this new provider type. As a result, CMS proposes to treat REHs in a manner similar to CAHs for purposes of determining GME payments. Under this proposal, REHs would have the option to be treated as either non-provider sites, allowing another hospital to incur the costs of the resident training at the REH for Medicare payment purposes, or to incur the cost of the resident training and be reimburse by Medicare at 100% of the allowable costs. Increasing rural GME opportunities is beneficial both for rural facilities and the patients they serve. The REH would benefit from having additional physicians available to support care in otherwise potentially underserved areas, while the physician in training will gain important insights about the unique challenges and care needs in rural America. Vizient supports CMS's approach of allowing a facility to choose which payment approach to follow for GME participation.

As the REH model evolves, it will be helpful for CMS to evaluate and request feedback from participating facilities to help guide future policy. Vizient encourages CMS to continue working collaboratively to provide support for facilities converting, or considering converting, to the new REH status, as well as provide clarity and support for considering participating as a GME training facility.

Hospital Value-Based Purchasing (VBP) Program

The Affordable Care Act (ACA) established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. In the Proposed Rule, CMS proposes changes to the Hospital VBP Program scoring methodology to reward hospitals treating higher numbers of underserved patients. CMS also requests information on changes to the Hospital VBP Program that would address health equity.

Proposed Change to the Scoring Methodology – Health Equity Adjustment

In the Proposed Rule, CMS proposes to add the Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS) beginning with the FY 2026 program year (PY). The HEA bonus points, according to CMS, are designed to support those hospitals serving a high proportion of underserved individuals while also mitigating disparities in health care by encouraging hospitals to provide high quality care to underserved populations. Vizient supports the agency's efforts to consider scoring methodology adjustment options to promote health equity but offers additional recommendations for the agency's consideration. CMS proposes that the HEA bonus points would be calculated using a methodology that incorporates a hospital's performance across all four domains[20] for the PY and its proportion of patients with dual-eligibility status (DES)[21]. As discussed in more detail below, Vizient suggests that CMS consider other approaches besides DES to calculate HEA bonus points because other factors may be associated with health inequities and such factors would be overlooked by the proposed methodology.

[20] The four domains are (1) person and community domain; (2) clinical outcomes domain; (3) safety domain; and (4) efficiency and cost domain.

[21] CMS proposes to use an "underserved multiplier" for each hospital that would be determined using the proportion of dual-eligible individuals in a hospital's population. CMS would then multiply this underserved multiplier by a measure performance scaler to determine the provider's health equity adjustment bonus points. CMS proposes to use dual-eligibility status (DES) to identify underserved populations

Further, it is unclear to Vizient how the agency will make adjustments to the methodology in future years. Vizient recommends CMS consider the multiple dimensions that impact health care disparities, including systemic, community, institutional, interpersonal, and intrapersonal, as categorized by the National Academics of Sciences.[22] For example, factors such as Medicaid expansion or primary care coverage policies could be considered at the systemic level, whereas primary care provider shortages at the community level. Yet, all of these factors, among others, may contribute to an individual being underserved or facing other health inequities – but none would be captured by CMS's proposed methodology. While efforts are needed to address each dimension, for CMS's purposes, we believe it is important that the agency consider which aspects are within the provider's locus of control, such as availability of translators, outreach to vulnerable neighborhoods, and efforts to improve provider listening and communications, and tailor policies accordingly. Vizient welcomes the opportunity to discuss future long-term approaches with the agency.

Underserved Multiplier Considerations

CMS proposes to use an "underserved multiplier" for each provider that would be determined using the proportion of dual-eligible individuals in a provider's population. CMS would then multiply this underserved multiplier by a measure performance scaler to determine the provider's HEA bonus points.

As noted in these and in prior comments, Vizient has significant concerns regarding the ADI and recommends that CMS reconsider its use. Although the ADI includes seventeen different factors related to education, income, employment, housing, and household characteristics, the relationships among the specific variables chosen result in an index that is heavily weighted toward income and home values with very little contribution from the other variables. The estimates provided by this algorithm can underestimate the vulnerability of neighborhoods where housing prices do not reflect broader trends and other specific obstacles to health and health care. In particular, much of the rural South and rural Midwest are estimated as less vulnerable than their life expectancy would suggest, while the northeast and parts of the Midwest are estimated as more vulnerable. Additionally, as shown in Figures 5, 6, and 7, cities with extreme housing costs are broadly estimated to be of very low vulnerability regardless of actual variability in specific neighborhoods. Among these are neighborhoods with some of the lowest life expectancies and highest burden of chronic disease in the nation.

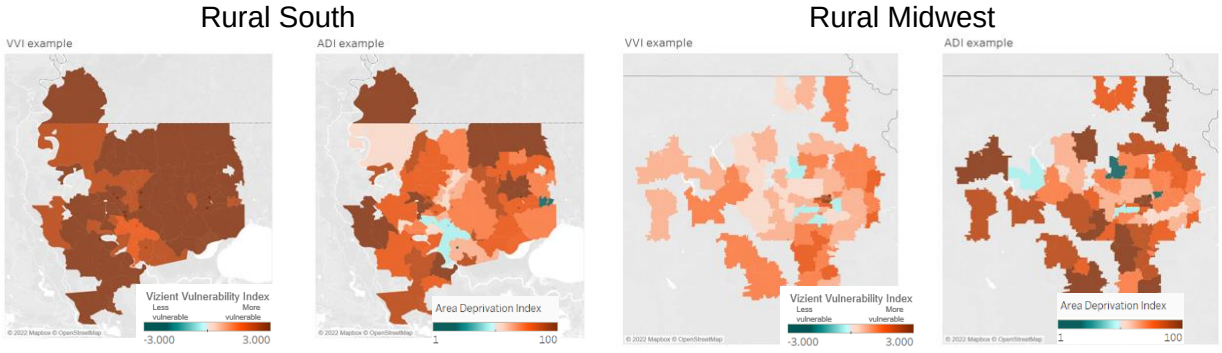

Figure 4. Maps comparing the Vizient Vulnerability Index's insights with the Area Deprivation Index's insights.

[22] National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/2462, sourcing, a concept from McLeroy, K. R., D. Bibeau, A. Steckler, and K. Glanz. 1988. An ecological perspective on health promotion programs. Health Education Quarterly 15:351–377

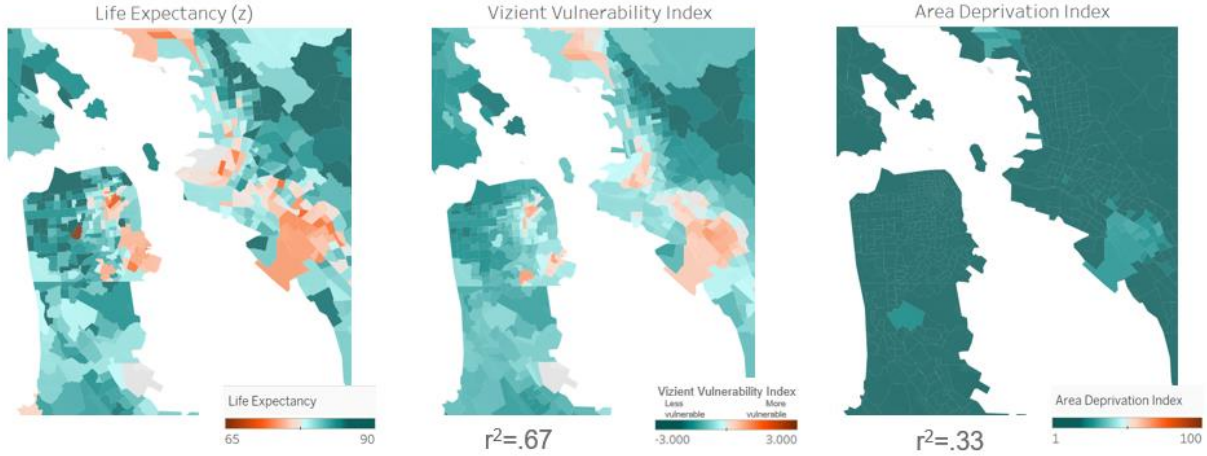

Figure 5. Maps showing San Francisco's life expectancy and insights from the Vizient Vulnerability Index and ADI.

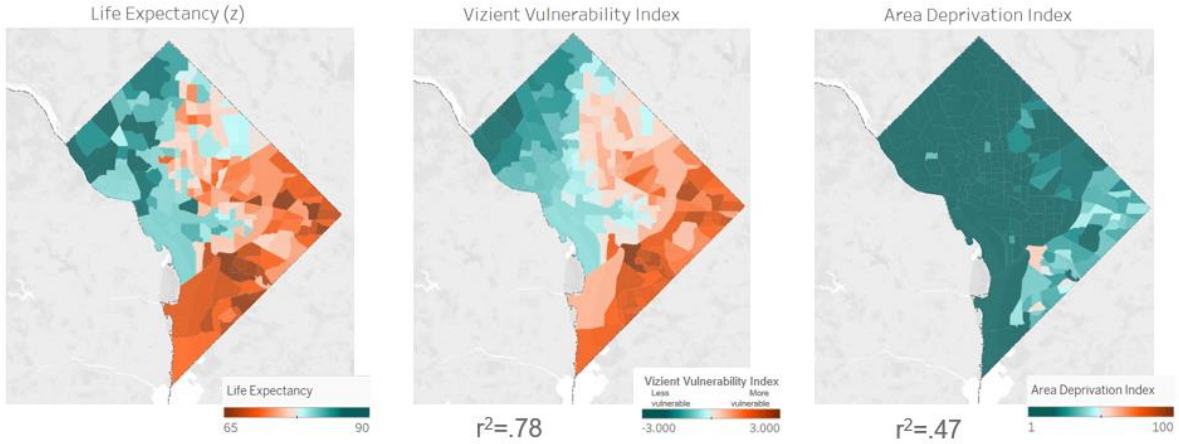

Figure 6. Maps showing Washington, D.C.'s life expectancy and insights from the Vizient Vulnerability Index and ADI.

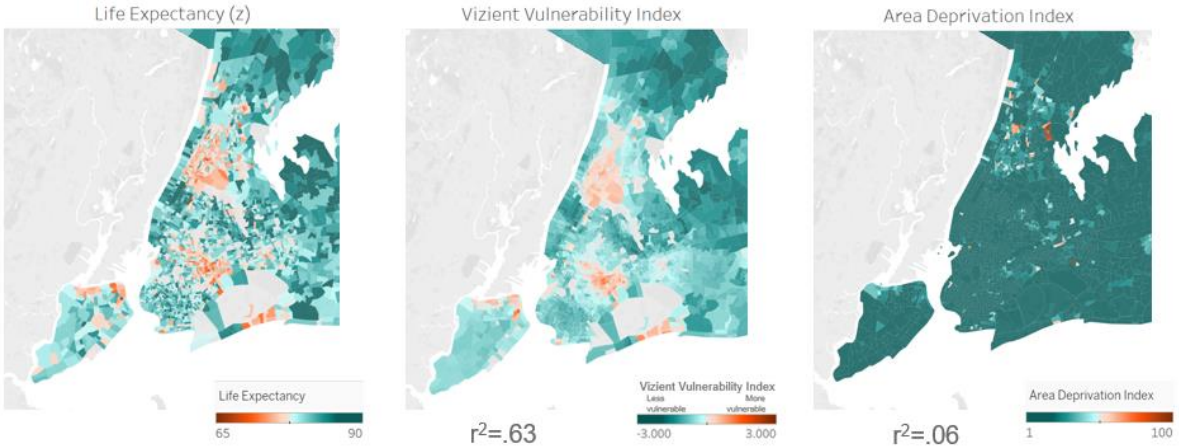

Figure 7. Maps showing New York City's life expectancy and insights from the Vizient Vulnerability Index and ADI.

Dual-Eligibility Status

In the Proposed Rule, CMS proposes only to use DES to identify underserved patients because, as noted by CMS, it is readily available and already in use in the Hospital

Readmissions Reduction Program. Although CMS acknowledges that DES is variable across states because of eligibility differences, because the agency has limited access to neighborhood-level data, it believes DES the best indicator to use in the HEA bonus points at this time. Vizient concurs with CMS's concerns about DES variability across states, and how that may inadvertently impact hospitals in states with lower Medicaid eligibility requirements. Such variable impacts, which are beyond the hospital's control, are concerning because the VBP Program is a limited pool of funding. Vizient's analysis of hospitals by state Medicaid eligibility limits shows that hospitals in non-expansion states were more likely see increased penalties due to the proposed methodology changes. Vizient encourages CMS to postpone implementation of the HEA bonus points until a more comprehensive approach can be developed that can identify underserved populations without inadvertently penalizing hospitals in states that did not expand Medicaid.

Use of the Area Deprivation Index (ADI) as an Additional Indicator
CMS requests feedback on including additional indicators of social need, such as area level index (e.g., ADI) in the HEA bonus point methodology. As noted in these and prior comments, Vizient has significant concerns regarding use of the ADI for health equity purposes. Although the ADI includes seventeen different factors related to education, income, employment, housing, and household characteristics, the relationships among the specific variables chosen result in an index that is heavily weighted toward income and home values with very little contribution from the other variables. This masks inequities, particularly in cities where home values tend to be higher.[23] Vizient recommends that CMS reconsider its use in the HEA bonus point methodology and in other policies, including the Medicare Shared Savings Program. Also, since use of the ADI risks underestimating the vulnerabilities of neighborhoods where we see the lowest life expectancies and highest burden of chronic disease, we encourage the agency to broaden the scope of indices considered and to clarify how it will evaluate additional indicators. In addition, Vizient encourages CMS to work with stakeholders, including hospitals, to better understand how they are identifying health inequities in their communities and patient populations as this may also help inform the agency's approach. Lastly, Vizient appreciates the agency's efforts to consider additional indicators of social need, such as an area level index. However, Vizient is concerned that CMS does not appear to be considering other potential indices that would be better indicators of social need given the significant attention paid to the ADI in the Proposed Rule. Vizient urges CMS to provide greater transparency regarding the process it is using to validate additional indicators of social need, including the ADI, given the significant concerns raised by Vizient and other stakeholders.[24]

Proposed Substantive Measure Updates to the Medicare Spending per Beneficiary (MSPB) — Hospital Measure (CBE #2158) Beginning with the FY 2028 Program Year (PY)
CMS proposes to adopt substantive measure updates to the MSPB Hospital Measure beginning with the FY 2028 PY in the Hospital VBP Program. This includes three refinements that are intended to ensure a more comprehensive assessment of hospital performance including: an update to allow readmissions to trigger new episodes and costs currently not included in the measure but that are within the hospital's reasonable influence; a new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to the episode start date; and an updated MSPB amount calculation. Although these

[23] "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?source=email
[24] https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities

updates were finalized for use in the Hospital IQR Program in the FY 2023 IPPS final rule, Vizient continues to receive feedback from members about the change allowing readmissions to trigger a new episode of care. Although CMS stated in the FY 2023 IPPS final rule that this would not penalize a hospital twice, the explanation of how services are allocated to an episode is unclear. Vizient requests that CMS clarify the impact of this change around new episodes of care both for the Hospital IQR program and, if finalized, for the VBP Program.

Proposed New Measure Beginning with the FY 2026 PY: Severe Sepsis and Septic Shock: Management Bundle (CBE #0050)

CMS proposes to adopt the Severe Sepsis and Septic Shock: Management Bundle (SEP-1 Bundle) measure in the Hospital VBP Program under the Safety Domain beginning with the FY 2026 PY. According to CMS, this measure supports the efficient, effective, and timely delivery of high-quality sepsis care. Since its adoption into the Hospital IQR Program in FY 2017, CMS indicates performance rates have increased, so CMS believes that additional incentives will support continued improvement in measure performance. While Vizient recognizes the importance of sepsis prevention, Vizient is concerned that the SEP-1 Bundle measure may not be appropriate for inclusion in the Hospital VBP program. For example, because the measure is bundled, the measure has limited utility in quality improvement, as it is does not produce actionable data on the individual elements of the measure. In addition, hospitals have expressed concern that the SEP-1 Bundle measure is not supported by compelling evidence.[25] Collecting data to calculate the measure is extremely resource intensive on hospitals (e.g., hiring staff to collect data), especially high-volume tertiary care hospitals and it can be difficult to interpret elements of the measure, such as time of presentation, especially if patients are transferred from another facility. As such, Vizient encourages CMS to reconsider including the measure in the hospital VBP Program. As CMS considers opportunities to improve care through the hospital VBP Program, we encourage the agency to provide additional resources to hospitals or ease financial penalties to allow them to invest in quality improvement efforts. For example, a Vizient Case Study highlights the various steps one health system took to improve performance on this measure, and several early intervention approaches were implemented along with having a dedicated sepsis program manager and several sepsis subcommittees (e.g., nursing, education, data display and emergency room). However, hospitals already facing financial challenges may be limited in their ability to implement such changes. To help hospitals engage in sepsis prevention, Vizient encourages CMS to look for ways to support hospitals or to ease their financial burden so they are in a position to implement new policies and initiatives.

Request for Information (RFI) on Potential Additional Changes to the Hospital VBP Program That Would Address Health Equity

CMS seeks comment on ways to address health disparities through the Hospital VBP Program. Specifically, CMS seeks input on whether there are additional approaches the Hospital VBP Program could propose to adopt to address health disparities outside of the proposed HEA bonus points.

In addition to Vizient's recommendations in response to the HEA bonus points methodology, we continue to encourage the agency to consider various dimensions that influence inequities, opportunities to improve data collection and standardization, measurement of community social needs and structural inequities, provider-care equity assessments, and, more broadly,

[25] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787262

the need for a longer-term plan to collect patient-specific social needs factors and encourage community engagement.

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

CMS proposes several changes to the HCAHPS survey administration for both the Hospital VBP and the Hospital IQR Programs. These changes include updated modes of administration to include online survey administration, removal of the ban on proxy respondents, an extended data collection period, a limit on the number of supplemental HCAHPS survey items, requirements to use the Spanish translation for Spanish-language preferring patients, and removal of two administration methods that are no longer in use. CMS cites a study it conducted to test out many of these changes which showed higher response rates when these changes were applied. These proposed changes to the HCAHPS survey administration also resulted in better representation of younger, Spanish language-preferring, racial and ethnic minority, and maternity care patients in the survey results. Vizient supports updating the HCAHPS survey guidelines to increase participation in the HCAHPS survey. Vizient applauds CMS for working to increase response rates and improve representation of different populations. Also, Vizient supports expanding the requirements for Spanish-language preferring patients to include all languages the HCAHPS survey is currently available in and encourages the agency to continue to explore other languages for survey administration.

Hospital-Acquired Conditions (HAC) Reduction Program

RFI: Advancing Patient Safety in the HAC Reduction Program

In the Proposed Rule, CMS includes an RFI on opportunities to advance patient safety and integrate equity into the HAC Reduction Program. In the same RFI, the agency seeks input on more specific topics such as certain electronic clinical quality measures (eCQMs). As such, it is unclear to Vizient the degree to which CMS is looking to change the HAC Reduction Program. For example, Vizient has several recommendations that would result in more significant changes to the program design, to try to encourage a broader array of hospitals to work to address HACs in their facilities. Should CMS be considering more substantial changes to the program, we suggest the agency provide more clarity regarding its future plans. Vizient would welcome the opportunity for further discuss potential changes to the HAC Reduction Program with the agency. For purposes of these comments, we address the questions CMS included in the RFI below.

Inclusion of Equity in the HAC Reduction Program

Vizient supports CMS's ongoing commitment to reducing health inequities by enabling providers to make more informed decisions and promoting accountability across the healthcare system. As with Vizient's response to CMS's RFI in the FY 2023 IPPS Proposed Rule regarding equity performance in the Hospital Readmissions Reduction Program, Vizient recommends CMS consider broader recommendations related to measurement and performance improvement.

Use of Digital Quality Measures in the HAC Reduction Program

As part of the ongoing effort to evaluate and strengthen the HAC Reduction Program, CMS seeks input on the addition of new program measures, specifically on patient safety focused electronic clinical quality measures (eCQMs), a type of digital quality measure, to promote

further alignment across quality reporting and value-based purchasing programs. CMS also seeks feedback on adopting eCQMs that are used in the Hospital IQR Program, including the patient safety related eCQMs added in previous years, and the three eCQMs CMS proposes to add in FY 2024.[26] Though Vizient is not commenting on the eCQMs individually, we note the importance of taking a gradual approach to the adoption of new measures, and that real-world testing of metrics can help identify unanticipated issues. Thus, if in future rulemaking CMS adopts eCQMs in the HAC Reduction Program, Vizient recommends that the agency provide a period whereby measures that are not yet implemented could be tested in a real-world setting before officially being included in either program.

As CMS is aware, the agency's quality strategy notes the agency's desire to shift to digital quality measures. Vizient notes that there may be additional provider burden based on the need to validate algorithmic determinations. While digital measures may reduce manual data collection, we recommend CMS provide measure accuracy and specificity performance to better understand the additional time hospitals may spend on reporting such measures, such as time spent reviewing inaccurately identified cases.

Measure Inclusion Considerations
In the RFI, CMS seeks feedback on the appropriateness of adding various new measures in the HAC Reduction Program. As noted above, Vizient encourages CMS to clarify the degree of changes the agency is considering related to the HAC Reduction Program, as this may impact which measures could be appropriate for inclusion. Generally, Vizient has concerns with selecting measures for the HAC Reduction Program solely because such measures are already used in other quality programs.

Hospital Inpatient Quality Reporting (IQR) Program

For the Hospital IQR Program, CMS proposes to adopt three new measures, remove three measures, and make substantive modifications to three measures, including the COVID-19 Vaccination Among Healthcare Personnel Measure. As noted in previous comments, Vizient requests clarity regarding several aspects of the COVID-19 Vaccination Among Healthcare Personnel measure.

Quality Program Proposal to Adopt the Up-to-Date COVID-19 Vaccination Among Healthcare Personnel Measure

The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure is a process measure developed by the Centers for Disease Control (CDC) to track COVID-19 vaccination coverage in healthcare settings. The measure was originally finalized in the FY 2022 IPPS final rule. When the measure was originally finalized, it focused on the primary series of COVID-19 vaccines that were on the market at the time. Since then, guidance on vaccines has and continues to evolve, such that CMS proposes to update the language of the measure to reflect changing guidance on COVID-19 vaccination. CMS is also proposing that public reporting of the modified COVID-19 vaccination measure would begin with the October 2024 *Care Compare* refresh, or as soon as is technically feasible.

[26] These measures include: Hospital Harm—Opioid-Related Adverse Events eCQM (added in the FY 2023 IPPS/LTCH PPS final rule); Hospital Harm-Severe Hypoglycemia eCQM (added in the FY 2022 IPPS/LTCH PPS final rule); Hospital Harm-Severe Hyperglycemia eCQM (added in the FY 2022 IPPS/LTCH PPS final rule); Hospital Harm-Acute Kidney Injury eCQM (proposed in FY 2024 IPPS/LTCH PPS rule); Hospital Harm-Pressure Injury eCQM (proposed in FY 2024 IPPS/LTCH PPS rule); and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eCQM (proposed in FY 2024 IPPS/LTCH PPS rule).

Implementation Timeline
CMS proposes updating the measure's numerator to specify the timeframes within which HCP are considered up to date with recommended COVID-19 vaccines, beginning with Q4 of the 2023 reporting period/FY 2025 payment determination. CMS is also proposing that public reporting of the modified COVID-19 vaccination measure would begin with the October 2024 *Care Compare* refresh, or as soon as is technically feasible. The COVID-19 vaccine and relevant guidance have evolved with our understanding of the virus. With the end of the PHE, the future depletion of the federally purchased supply of vaccine, and upcoming FDA and CDC advisory committee meetings on future COVID-19 vaccine strains, it is unclear what vaccination recommendations will be in place in Q4 2023. The proposal to update the measure's language to include those future changes is an important step in this process but we are concerned that it could be premature to update a measure on the COVID-19 vaccine while the vaccine guidance is expected to change.

Vizient is also concerned that implementing the change to the definition of fully vaccinated beginning with data collected immediately after the publication of the final rule will result in an administrative burden to hospitals. Because of the unknown changing guidance on who is considered "fully vaccinated," planning for this change will be difficult. As routine vaccine events are often held around the late summer or early fall, changing the definition of fully vaccinated in the third quarter of the year could render a hospital's scheduled vaccination campaign irrelevant potentially weeks or months after the vaccination event has occurred. Vizient recommends CMS consider delaying implementation of this change until further decisions on the seasonality and nature of the more routine COVID-19 vaccination have been established. This will allow hospitals and vaccinated individuals to be able to plan an effective transition into the new measure specifications and minimize confusion for staff making vaccination decisions.

Vizient also emphasizes the importance of clear communication regarding COVID-19 vaccination guidelines for health care staff. With the end of the PHE and the publication of a Final Rule withdrawing the mandatory COVID-19 vaccination requirements established under the PHE, there may be confusion about the distinction between requiring vaccinations and measuring vaccinations for quality program requirements of facilities.

Potential Future Inclusion of Two Geriatric Care Measures and Publicly-Reported Geriatric Care Designation

In the Proposed Rule, CMS proposes to establish a hospital quality designation related to geriatric care that would be publicly reported on a CMS website and modeled after the birthing-friendly designation finalized in the FY 2023 IPPS final rule. Vizient supports efforts to improve the quality of geriatric care and efforts to improve consumer awareness of healthcare through designated metrics. However, Vizient is concerned that the decision to model the geriatric care designation after the birthing-friendly designation is premature given how recent the birthing-friendly designation policy was finalized. Vizient encourages CMS to first learn from the implementation of the birthing-friendly designation prior to adding another designation. Vizient also recommends CMS clarify long-term plans regarding the establishment of the geriatric care designation. Given that individuals 65 years of age and older seem to be the population that would be most interested in this designation, beneficiaries may confuse this new designation with existing programs that identify high

quality Medicare providers. For example, the Medicare Overall Star Ratings program is designed to help consumers make more informed decisions about health care.

RFI: Safety-Net Hospitals

CMS seeks input on how it can support safety-net hospitals and ensure care is accessible to those who need it. In the Proposed Rule, CMS defines safety-net providers as "health care providers that furnish a substantial share of services to uninsured and low-income patients." More specifically, CMS is seeking public input on two potential approaches to targeting safety-net providers, as well as general information on safety-net providers that the agency should consider as it develops policy related to safety-net hospitals. Vizient offers feedback to CMS regarding several of the questions included in the RFI, and in addition, we recommend the agency clarify how it envisions using a safety-net definition in its policies and programs, as this could help stakeholders provide more specific feedback.

Potential Applications of a Safety-Net Definition
Vizient applauds CMS for its commitment to addressing health equity and seeking input from providers who serve vulnerable populations before advancing policy. Including stakeholder feedback in future policies related to safety-net providers is an important step and Vizient appreciates the opportunity to provide feedback. Although CMS provides numerous questions and references to MedPAC's recent work to consider alternatives to DSH and uncompensated care payments, it is unclear from the RFI how CMS anticipates using a safety-net definition, including whether the agency is considering changes to DSH and uncompensated care payments, whether this definition would be used in other CMS programs such as the quality programs, and whether the agency's goals to support access to care are specific to certain patient populations (e.g., Medicare beneficiaries, Medicaid beneficiaries). In addition, CMS provides a wide range of questions in the RFI implying that CMS may be considering different applications of safety-net definitions without clarifying the greater context regarding the agency's goals. As a result, more clarity regarding the CMS's overarching goals will help stakeholders provide more meaningful comments. Vizient asks that CMS clarify its intended use of the safety-net definition or identification prior to future RFIs or rulemaking, such that stakeholders may provide more targeted feedback. Vizient looks forward to commenting on more specific questions or proposals in the future.

MedPAC Safety-Net Index Approach
CMS seeks comment on a proposal from MedPAC to replace the DSH and uncompensated care (UC) payments with a payment using a targeted approach to identifying safety-net hospitals called the Medicare Safety-Net Index (SNI). Although the Medicare statute supports safety-net hospitals through DSH and UC payments, MedPAC previously raised concerns about whether these payments were appropriately targeting safety-net hospitals. In its March 2023, Report to Congress, MedPAC proposed a methodology for identifying safety-net hospitals.[27] CMS states that it is able to calculate all pieces of the calculation for the SNI, but expresses concern about new hospitals, hospital mergers, hospitals with multiple cost reports, and/or cost reporting periods that are shorter or longer than 365 days, cost reporting periods that span fiscal years, and aberrant data.

[27] The SNI is calculated as the sum of: (1) the share of a hospital's Medicare volume associated with low-income beneficiaries; (2) the share of its revenue spent on uncompensated care; and (3) an indicator of how dependent the hospital is on Medicare.

Vizient supports CMS's efforts to ensure that DSH and UC payments are adequately supporting hospitals that provide care to underserved populations. However, Vizient would be concerned if CMS adopted the MedPAC proposal because it relies entirely on Medicare claims and data, without considering the role Medicaid, uncompensated care and other public programs may have in a hospital's costs and expenses. If CMS is considering replacing DSH and UC payments, Vizient urges CMS and all involved federal agencies to convene stakeholders, including hospitals and other providers, to develop a more comprehensive solution. In addition, Vizient is concerned that a safety net index based solely on payer data will miss a larger set of variables that provide much more specific and actionable information on obstacles to health and health care that might be available in an area-level index.

Neighborhood-Level Index Approach
The second approach CMS seeks comment on would involve using an area-level index, such as the ADI, to identify safety-net hospitals. Based on a report commissioned by the Assistant Secretary for Planning and Evaluation (ASPE), CMS believes that an area-level index might be useful in helping identify beneficiary populations that are underserved. CMS states that since the ADI is used in existing Medicare policies, it may be appropriate to also use the ADI to identify safety-net hospitals.

Vizient remains concerned about the use of the ADI in CMS policies, and as such, urges CMS to reconsider its use more broadly and discourages the agency from considering the ADI to identify safety-net providers. The ADI would be a poor choice to identify safety-net hospitals because of the significant weight it places on income and home values in determining an area's deprivation. For example, providers in large urban areas could be mischaracterized a "non-safety-net provider" because home values tend to be higher in these areas despite hospitals in these communities playing the critical role of meeting patient care needs. Additionally, as shown in Figures 5, 6, and 7, cities with extreme housing costs are broadly estimated to be of very low vulnerability regardless of actual variability in specific neighborhoods. Among these are neighborhoods with some of the lowest life expectancies and highest burden of chronic disease in the nation.

In selecting an area-level index to provide the neighborhood social needs context that can distinguish specific, actionable factors that constitute obstacles to health and healthcare for a neighborhood, Vizient encourages CMS to consider the ability of that index to specify relevant social needs, such as transportation obstacles, risk factors for housing insecurity, food deserts, and broadband access. This specificity can identify actionable interventions to which funding may be directed.

Additionally, Vizient suggests that a correlation to life expectancy would ensure that the index methodology reflects the factors that influence health in each neighborhood.
While Vizient believes area-level indices provide important information, we have concerns about CMS using only an index to identify safety-net hospitals. If an index is to be used in some form, Vizient urges CMS to consider using the VVI as it more accurately accounts for disparities than the ADI and others the agency may be contemplating as described in Appendix 1.

In an analysis of safety-net hospital definitions using our Clinical Data Base[28] data for July 2020 through June 2022, Vizient found that hospitals with substantially different payer mixes will also

[28] Data from the Vizient® Clinical Data Base (CDB) used with permission of Vizient, Inc. All rights reserved.

have area-level differences as well as different patient characteristics, even when they draw patients from overlapping areas.

As an example, in Figure 8, we show two hospitals from Chicago, Hospital A and Hospital B. Although Hospital A and Hospital B are located within a mile of each other and serve many of the same zip codes, their payer mix is entirely different, such that by most definitions Hospital B would be a safety-net hospital.

Among the area-level differences, Hospital A extends its catchment area slightly further into the least vulnerable neighborhoods, while Hospital B extends slightly further into the most vulnerable neighborhoods, as indicated by the VVI.

Similarly, as shown in Figure 9, the overall distributions of Hospital A patients' neighborhood vulnerability and Hospital B patients' neighborhood vulnerability have a similar range, but Hospital A sees many more patients from the less vulnerable side of the distribution. Considering payer mix, as shown in Figure 10, Hospital A sees many more commercial payer patients and many more Medicare patients than Hospital B. Hospital B sees many more Medicaid patients, uninsured, and charity care patients.

Also, as shown in Figure 11, the age distributions of adult patients from Hospital A and Hospital B show a dramatic shift at 65. Younger adult patients make up a much larger proportion of Hospital B's adult patients than they do at Hospital A, while patients over 65 make up a much larger proportion of Hospital A's patient population.

Based on this analysis of different aspects of patient populations, Vizient recommends CMS look more broadly than just the demographics of a patient population to identify safety-net hospitals. While providing services to vulnerable populations is an important factor, the tools available for defining patient demographics lead to vastly different outcomes, meaning that a safety-net hospital may be missed by an analysis, despite its role serving vulnerable patients in a community. Vizient recommends CMS look at multiple aspects of a patient population in conjunction with factors specific to the hospital, such as services provided.

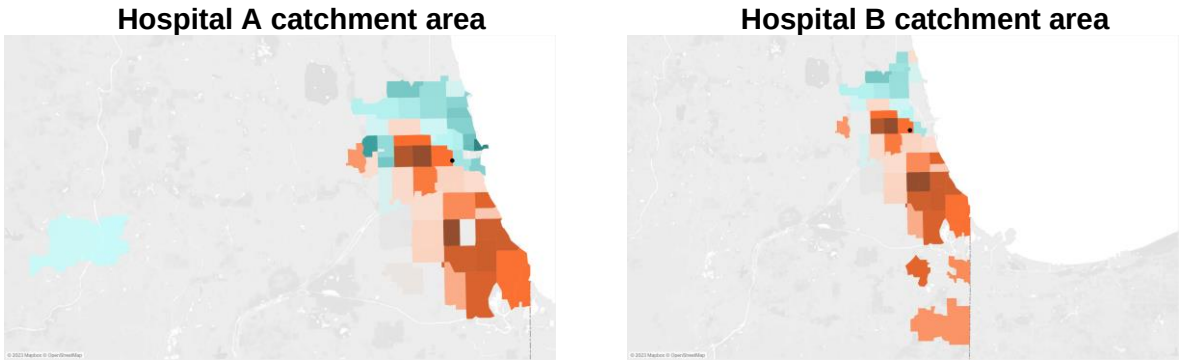

Figure 8. Comparison of two hospitals located within a mile of each other, but serving different neighborhoods.

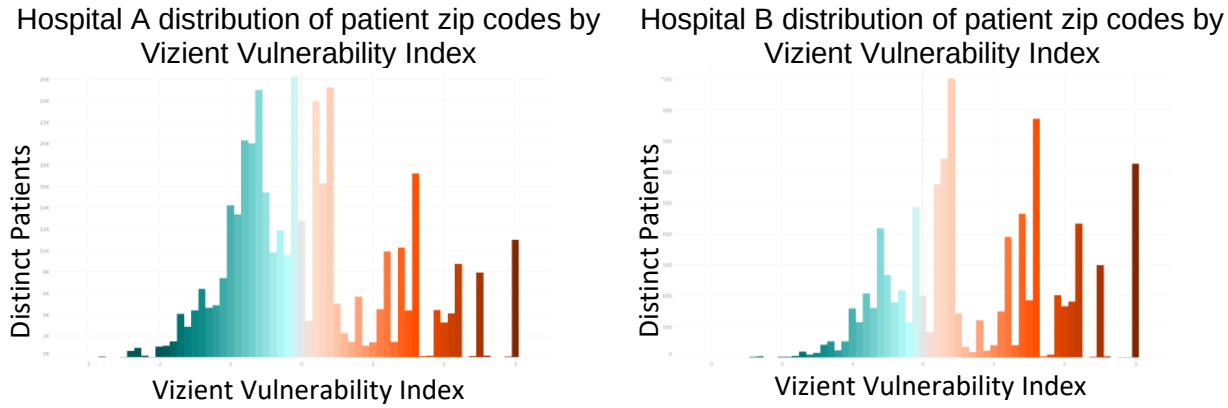

Figure 9. Comparison of two Chicago hospitals' patient's neighborhood vulnerability.

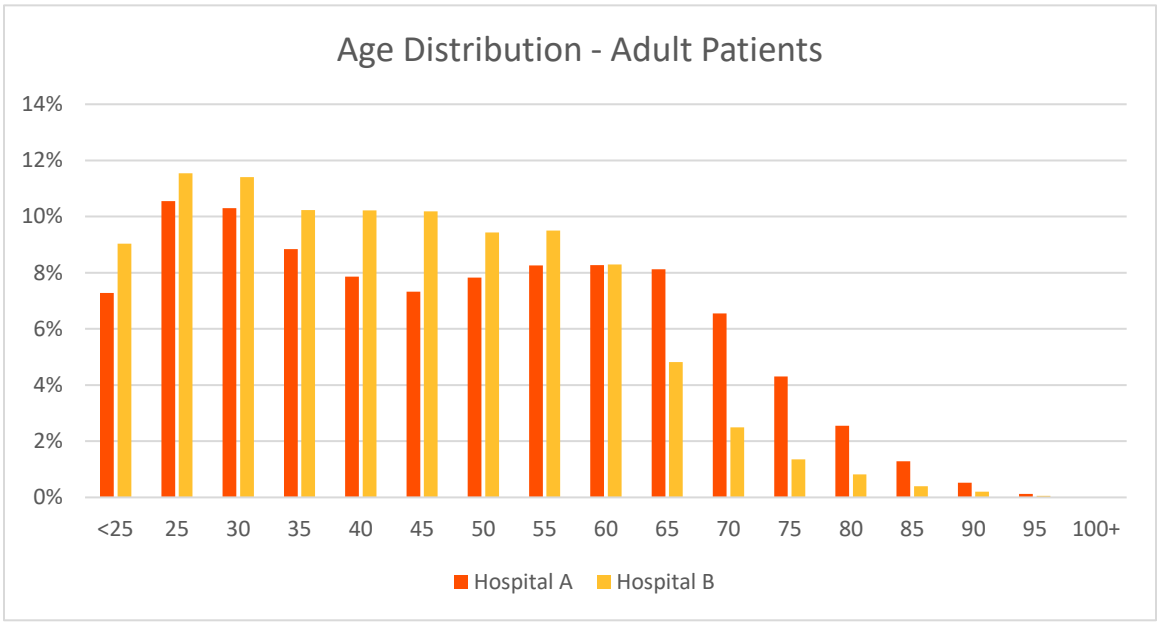

Figure 10. Comparison of payer mix between two hospitals.

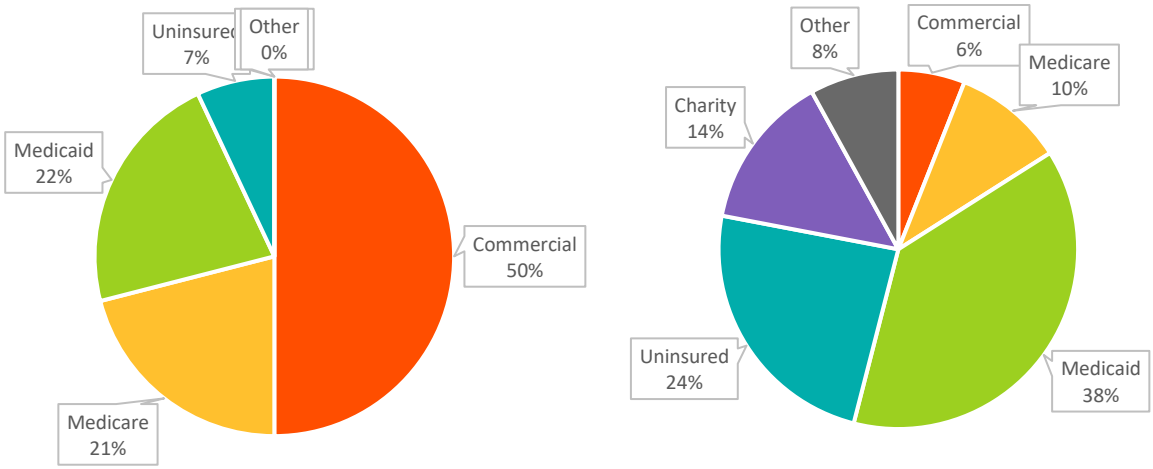

Figure 11. Age distributions of adult patients from Hospital A and Hospital B

How Should Safety-Net Hospitals be Identified or Defined? What factors should not be considered when identifying or defining a safety-net hospital and why?
Vizient believes that any definition of safety-net hospitals will need to take into account a more nuanced view of patient characteristics, conditions, and neighborhood social needs, beyond an exclusively payer-based approach. Vizient suggests that CMS consider the following when designing a safety-net hospital definition:

- Knowing the overall vulnerability and specific social needs of each neighborhood that a hospital serves can provide actionable detail about overall and specific obstacles to health and healthcare, confirmed by the relationship these factors have with life expectancy.
- When two hospitals serve some of the same neighborhoods, but payer restrictions or lack of insurance guide patients to choose one over the other, the patients that come from each neighborhood may not be a random subset of the neighborhood population.
- It is likely that patients from one neighborhood who lack insurance may seek care at a safety-net hospital until they qualify for Medicare at age 65. The patients from that neighborhood who seek care at a non-safety-net hospital may then tend to be older and may have different medical needs appropriate to their advanced age.

How helpful is it to have multiple types or definitions of safety-net hospitals that may be used for different purposes or to help address specific challenges?
CMS requests information on whether multiple definitions of safety-net hospitals may be appropriate. Vizient believes it is important not to take a one-size-fits-all approach to determining what is actually considered a safety-net hospital. Healthcare delivery is complicated by the unique challenges of the different settings where hospitals are geographically located, and the variety of patients they serve. Isolated CAHs, small rural hospitals, small community hospitals, and large urban institutions are all critical to their communities and the healthcare system as a whole. They are also unique and the challenges they face are as diverse as their communities and patients they serve. Given those factors, Vizient encourages CMS to consider focusing on hyper-local factors as it considers potential definitions of safety-net hospital. Whether this is multiple definitions or a more nuanced approach to the definition that accounts for geographic variability, Vizient encourages CMS to consider identifying safety-net providers by reviewing hyperlocal and regional characteristics to determine how best to account for such characteristics in a definition or definitions of a safety-net hospital.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the FY 2024 IPPS Proposed Rule. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In closing, on behalf of Vizient, I would like to thank CMS for providing the opportunity to respond to this Proposed Rule. Please feel free to contact me, or Jenna Stern at jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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Appendix 1

Table 1. Comparison of VVI with existing area-level indices

	Area Deprivation Index	Social Deprivation Index	Social Vulnerability Index	Community Resilience Estimates	Vizient Vulnerability Index
Data granularity	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code ✓ Census Tract × Block Group	✓ County ● Zip Code possible ✓ Census Tract ● Block Group possible	✓ County × Zip Code ✓ Census Tract × Block Group	✓ County ✓ Zip Code ✓ Census Tract ✓ Block Group
Timeliness	Updated in 2015 and 2019	2012 and 2015	Updated every two years	Updated annually	Updated annually
Social Determinants of Health Domains	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Access to Health Care ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Access to Health Care ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Access to Health Care × Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing ✓ Access to Health Care ✓ Transportation ✓ Social Environment ✓ Physical Environment ✓ Public Safety
Intent	Mortality rate prediction	Health resource allocation	Disaster planning & evacuation	Assessing potential impact of disasters including COVID-19	Describes differences in life expectancy representing differences in chronic disease incidence and management
Health Care Focus	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence × Readmissions × ED utilization ✓ Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence ✓ Readmissions ✓ ED utilization ✓ Maternal Health
Measurement Focus	17 components 2 components account for almost all of the variation (income and housing) Poor fit to life expectancy[e] (r^2 0.25)	9 components, including race (Black), gender and age (women 15-44) No serious issues with partial correlations Moderate fit to life expectancy[y] (r^2 0.56)	14 components in 4 domains, 2 components account for almost all of the variation (income and education) Intended for disaster management planning; poor fit to life expectancy (r^2 = 0.20)	7 household risk factors and 3 individual risk factors, including age (>64) Population with ≥3 risk factors has a moderate fit to life expectancy (r^2 0.44)	43 components in 9 domains. A are significant in different locations Good fit to life expectancy[e] (r^2 0.87)
Geospatial Adjustments	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country	Index adapts to local relevance each domain as it correlates wit life expectancy