Illinois Health and Hospital Association

June 16, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: FY 2023 Inpatient Prospective Payment System Proposed Rule (CMS-1771-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) proposed rule. While we support many of the proposed policies in this rule, **we are very concerned with CMS' proposed FY 2023 rate increase**, as well as other payment modifications and budget neutrality applications that result in a very small increase in estimated FY 2023 payments compared with FY 2022, given the significant costs hospitals have experienced due to COVID-19.

Specifically, CMS proposed an overall increase in IPPS payments of 3.2%. However, the proposed payment increases are offset by proposed decreases to outlier payments, negative policy adjustments to disproportionate share payments, and the expiration of the Low-Volume and Medicare Dependent Hospital programs. Combined with the 2% sequestration reduction, **these policies result in an estimated net decrease** of 0.4% for Illinois hospitals in FY 2023 compared with FY 2022. While many U.S. citizens see COVID-19 as an issue that ebbs and flows, our hospitals and the larger provider community have experienced a constant COVID-19 presence since March 2020. The ongoing pandemic has further shown the need for adequate hospital payment, and CMS must ensure hospitals are financially able to meet the growing demand for quality healthcare. We strongly urge CMS to reexamine the policies and rate update methodologies utilized in this proposed rule, and finalize a rate update that better reflects the economic reality hospitals currently face.

Proposed FY 2023 Rate Update

We are disappointed with CMS' proposed FY 2023 IPPS rate update. As stated above, after accounting for all proposed payment and policy changes and the sequestration reduction, we estimate that Illinois hospitals will experience a net decrease in IPPS

payments of 0.4% compared to FY 2022. This rate update is woefully inadequate given the fiscal realities of healthcare at present.

CMS relies on IHS Global Inc.'s fourth quarter 2021 forecast, which is based on historical data through the third quarter of 2021. While this methodology accounts for some of the economic realities of the COVID-19 pandemic, it clearly does not track with the realized increased cost of providing healthcare.

Consider a January 2022 analysis by Kaufmann Hall which found a 20.1% increase in hospital expenses per patient from 2019 to 2021.[1] This includes a 36.9% increase in per patient cost on drugs, a 19.1% increase in per patient cost on labor, and a 20.6% increase in per patient cost on supplies compared to pre-pandemic levels. All of these estimates vastly outpace the proposed FY 2023 rate update from CMS.

Further, as of May 11 the annual inflation rate for the United States is 8.3%.[2] Thus, CMS' proposed FY 2023 rate update does not even keep pace with inflation. Even without inflation and COVID-related price hikes, the Medicare program only reimburses hospitals about 88% of costs in Illinois. Without a more adequate rate increase, the margin between cost and reimbursement will only widen.

Finally, a recent analysis from McKinsey & Company indicates that by 2025, the U.S. will face three challenges to effectively meeting patient care needs. These include a decreased supply of the registered nurse workforce, an increased inpatient demand from or related to COVID-19, and continued work setting shifts and increased demand due to a growing and aging population.[3] This is our new reality, and considering the Medicare fee-for-service population is driving the third concern, now is the time for CMS to enhance healthcare resources, not limit them.

Given this evidence, it is clear that CMS' market basket update is inadequate as proposed. This is primarily because the market basket is a time-lagged estimate that uses historical data to predict the future. When historical data are no longer a good predictor of future changes, the market basket becomes inadequate. Indeed, more recent data indicate that the FY 2022 market basket should have been closer to 4.0%, well above the 2.7% CMS actually implemented last year. Additionally, the latest data indicate decreases in productivity, not gains.[4] To that end, IHA urges CMS to do everything within its statutory authority to increase payment rates to IPPS hospitals and other healthcare providers. **We suggest CMS reassess the data and methodology used for the annual market basket update, and formulate a rate update that better reflects**

---

[1] https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf
[2] https://www.usinflationcalculator.com/inflation/current-inflation-rates/#:~:text=The%20annual%20inflation%20rate%20for,10%20at%208%3A30%20a.m.
[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce
[4] U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. https://www.bls.gov/news.release/pdf/prod2.pdf.

the fiscal reality hospitals currently face. Additionally, we ask CMS eliminate the productivity cut for FY 2023. Hospitals simply have not seen an increase in productivity over the last two years, and given the extreme and uncertain circumstance in which our hospitals are currently operating, we find the productivity cut inappropriate for the coming fiscal year.

Disproportionate Share Hospital (DSH) Payments

IHA supports CMS' decision to use an average of two years of audited worksheet S-10 data to calculate Factor 3 of the DSH adjustment for FY 2023, and an average of three years of audited S-10 data in FY 2024 and onward. We have advocated for this approach for the last several years, and agree that averaging the data will smooth out anomalies that may introduce volatility to hospital payments.

That said, IHA is concerned about CMS' overall proposed FY 2023 DSH payments. As currently proposed, FY 2023 DSH payments would decrease by $0.654 billion. In Illinois, DSH payments are estimated to decrease by $51.3 million, 75% of which will affect one of our largest safety net systems in the Chicagoland area.

In particular, we are concerned about the calculation of Factor 2, which assumes an uninsured rate of 8.9% in calendar year (CY) 2022 and 9.3% in CY 2023. In the FY 2022 IPPS final rule, CMS assumed an uninsured rate of 9.5% for CY 2022, which in retrospect was an overestimate compared to this year's proposed rule which indicates the CY 2022 uninsured rate is 8.9%. This discrepancy exemplifies the uncertainty our healthcare system is operating through during the ongoing COVID-19 public health emergency (PHE). Additionally, while we appreciate that these uninsured estimates have been certified by the Office of the Actuary, we note that many offices within the U.S. Dept. of Health and Human Services (HHS) predict millions of Americans losing health insurance coverage over the next year.

For example, in this proposed rule CMS notes that Medicaid enrollment is estimated to decrease by 5.7% in FY 2023. Additionally, in a March 2022 report, HHS estimated that almost 3 million Americans will lose individual coverage and become uninsured if the American Rescue Plan Act's premium subsidies are not extended into 2023.[5] While many individuals losing healthcare coverage under one program may qualify under another, historically many individuals have foregone coverage even when eligible. In fact, a recent Kaiser Family Foundation analysis found that a majority of people that remained uninsured were eligible for financial assistance either through Medicaid, the Children's Health Insurance Program, or the Marketplace.[6] Thus, CMS' proposed FY 2023 uninsured rate is already an uncertain projection that is further exacerbated by the ongoing PHE.

Given this uncertainty, the ongoing PHE, and continued waves of high COVID-19 infection, we urge CMS to reexamine its assumptions when calculating FY 2023 DSH payments. We also ask

[5] https://aspe.hhs.gov/sites/default/files/documents/1647ad29528ee85a48d6ffa9e7bfbc8f/arp-ptc-sunset-impacts-03-22-22%20Final.pdf
[6] https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/

CMS to consider making temporary changes to its methodology to better account for individuals that may lose healthcare coverage as various waivers and premium support expire. CMS has taken similar action in other areas of Medicare payment affected by COVID-19, and doing so here will help to mitigate substantial decreases in DSH payments at this time.

Proposed Permanent 5% Cap on Wage Index Decreases

In the FY 2020 final rule, IHA supported CMS' adopted transition policy that placed a 5% cap on any decrease in a hospital's wage index due to the combined effects of policy changes in that fiscal year. Similarly, IHA supported CMS' extension of the 5% cap policy in FYs 2021 and 2022.

For FY 2023 and forward, CMS proposed adopting a permanent policy placing a 5% cap on all wage index decreases each year, regardless of the reason for the decrease. **IHA supports CMS' proposal to make permanent the 5% cap on wage index decreases**, and agrees that this policy will increase predictability of IPPS payments for hospitals moving forward.

However, we question CMS' belief that this policy must be budget neutral. Although the 5% cap will result in increased payment to these hospitals, most Illinois hospitals will only experience 40% of that increased benefit due to the impact of the budget-neutrality factor. The financial stability of hospitals continues to be impacted by the COVID-19 pandemic, and providers will continue facing uncertainty moving forward as demand for healthcare services may not be met with supply given current workforce shortages that are projected to get worse in the immediate future. **Therefore, we urge CMS to finalize this policy in a non-budget neutral manner. Doing so not only reflects the current financial reality of hospitals, but also aligns with the purpose of the 5% cap, which is to increase predictability of hospital payments and mitigate instability and significant negative impacts to providers resulting from large wage index changes.**

Low-Volume and Medicare Dependent Hospitals

Our rural hospitals are the backbone of their communities, often serving as the economic engine for the families living in the towns in which they are located. There are currently 11 Illinois hospitals that receive a low-volume adjustment (LVA) and nine Illinois hospitals that are Medicare Dependent Hospitals (MDH).

The expiration of the current LVA policy will result in an estimated $8.1 million decrease in IPPS payments to Illinois hospitals, with one rural hospital estimated to experience a $1.3 million decrease in IPPS payments next year. Similarly, the expiration of the MDH policy will result in an estimated $15 million fewer dollars flowing into the state, with one hospital estimated to receive $5.2 million less in FY 2023.

We understand it takes Congressional action to extend these programs, and we urge CMS to encourage members of Congress to ensure the LVA and MDH programs are extended. Now is

not the time to deplete healthcare resources, and extending these two long-standing programs is an easy way to provide more financial stability during an economically uncertain time.

Data Collection Condition of Participation (CoP)

Illinois hospitals understand the federal government's need for accurate, timely data, particularly during a PHE. In Illinois, our hospitals have done their best to comply with reporting requirements outlined at *85 FR 54820* and *85 FR 85866*. That said, a handful of varying Illinois hospitals are consistently on the Center for Disease Control and Prevention's (CDC's) reporting non-compliance list. Unfortunately, non-compliant hospitals are often Safety Net and Critical Access Hospitals. Illinois Safety Net hospitals and CAHs operate on consistently slim to negative margins while serving some of our most vulnerable Illinoisans. During the COVID-19 PHE, compliance comes down to the resource constraints experienced that week, and many times our hospitals have to devote staff to patient care over administrative tasks.

To that end, we ask that CMS work with the CDC to streamline the reporting process moving forward. For the current COVID-19 and Seasonal Influenza requirements, proposed for extension until April 30, 2024, we ask CMS to continue reviewing required data elements over time and remove any that are not serving the agency's goals.

Additionally, we ask CMS to consider reaching out to state health departments to ensure they are not requesting duplicative data. In Illinois, many of the data elements required by CMS are also captured by the state, requiring hospitals to report the same information in two places each week. Instead of burdening providers with duplicative reporting requirements, we ask CMS to work with its state partners to collaborate and streamline the reporting process.

Looking ahead, we understand CMS's desire to lay the groundwork for data reporting requirements during future PHE declarations. We agree that CMS should develop the infrastructure and processes now, and ask that CMS create a single data collection platform and process that allows for modifications to meet the needs of specific PHEs but does not drastically change over time. Once the platform and process is finalized, we ask CMS to create written guidance and plan for early and thorough technical assistance webinars that can be quickly aired at the outset of future PHEs. Finally, we ask CMS to work with its state partners now to set up data collection redundancy checks for the future. IHA and Illinois providers agree these data are important, but ask that CMS ensure that it is not asking providers to duplicate efforts during a time when providers are also on the front lines serving patients.

IPPS and Long-Term Care Hospital (LTCH) Proposed High-Cost Outlier Thresholds

The dramatic increase in the proposed high-cost outlier thresholds under both the IPPS and LTCH payment systems is concerning. The proposed FY 2023 IPPS high-cost outlier threshold is up almost 40% compared with FY 2022 ($43,214 and $30,988 respectively). Similarly, the

proposed FY 2023 LTCH high-cost outlier threshold is up about 34% compared with FY 2022 ($44,182 and $33,015 respectively).

These increases will significantly decrease the number of cases that qualify for an outlier payment. IHA appreciates that the IPPS and LTCH outlier pools are meant to allocate additional resources to high-need, higher-cost patients while ensuring adequate funding of remaining Medicare cases. However, we are concerned that CMS utilized atypical claims from FY 2021 to calculate the proposed outlier thresholds in this year's proposed rule, and that in practice these thresholds will actually hamper much needed additional resources for providers treating high-acuity, high-cost patients.

IHA asks CMS to reexamine its methodology and consider making temporary changes to the outlier pools to help mitigate substantial threshold increases and better respond to the fiscal challenges currently facing hospitals. As the PHE is ongoing, and CMS is using PHE data to develop the payment parameters set forth in this proposed rule, we ask that CMS better account for the data anomalies created by the pandemic until patient mix becomes more predictable and the data used for rate setting reflects a more stable healthcare environment.

Medicare Quality Reporting and Value Programs: Hospital Acquired Condition (HAC) Reduction Program, Hospital Readmissions Reduction Program (RRP) and Hospital Value-Based Purchasing (VBP) Program

IHA appreciates CMS' proposal to use its COVID-19 PHE measure suppression policy to suppress most of the VBP and all of the HAC measures for FY 2023. We also thank CMS for ensuring a neutral, or $0, fiscal impact of these program on participating hospitals for FY 2023. We agree that conditions beyond the control of providers may negatively impact hospital performance in these two programs, and therefore it does not make sense to hold hospitals financially accountable for those performance years.

IHA also supports CMS' proposal to include patient history of COVID-19 in the 12 months prior to the index hospitalization to allow for risk adjustment in the RRP and VBP for patients with pneumonia. We agree that a history of COVID-19 could affect a patient's risk for readmission and mortality, and thank CMS for its thoughtful approach to incorporating COVID-19 into Medicare quality programs.

Maternal Health Designation

IHA is generally supportive of CMS' proposal to establish a publicly reported hospital quality designation specific to maternal health. IHA agrees that making information on maternal health and hospital quality more accessible to patients should be a priority of the administration, and we support CMS' efforts to improve maternal health outcomes.

Further, IHA supports CMS' basic proposal to build the program off of quality measures that hospitals already submit. This approach will mitigate administrative burden by leveraging existing data, and support CMS' goal of connecting data across quality programs to better facilitate coordinated care. Thus, beginning the program with the structural measure adopted in the FY 2022 IPPS (hospital participating in a structured state or national Perinatal Quality Improvement Collaborative) makes sense.

IHA also appreciates CMS' plans to build out the program by adding more quality measures to the designation. That said, we caution CMS to ensure it only adds measures that are appropriately vetted and endorsed by the National Quality Forum (NQF). In this proposed rule, CMS proposed two obstetric measures for addition to the Hospital Inpatient Quality Reporting (IQR) program that could eventually be added to the Maternal Health Designation. If finalized, these measures, the Cesarean Birth electronic clinical quality measure (eCQM) and Severe Obstetric Complications eCQM, would be voluntary in the IQR program in CY 2023 and mandatory in CY 2024. However, neither eCQM is currently endorsed by the National Quality Forum (NQF).

While we understand that both of these measures have been submitted for NQF review, we highly encourage CMS to secure such endorsement for these and future measures before requiring reporting in IQR and using them for this Maternal Health Designation. We also ask that CMS continue using the comment and notice rulemaking process moving forward as it modifies this Maternal Health Designation and adds program specifications.

In response to CMS' specific question on how it can address the U.S. maternal health crisis through policies and programs, IHA suggests CMS explore ways to incentivize more providers to furnish perinatal care, with an emphasis on family practice physicians and nurse midwives. Additionally, CMS could leverage the 1,000 Medicare-funded full-time equivalent slots to further incentivize such providers to work in Health Professional Shortage Areas (HPSAs).

According to the American College of Obstetrics and Gynecology (ACOG), the U.S. will face a shortage of 9,000 obstetrician/gynecologists (OB/GYN) by 2030, a number that grows to 22,000 by 2050. A primary reason for this shortage is the fact that there has been a relatively static 1,200 OB/GYN residency slots since Medicare began reimbursing hospitals for graduate medical education, with the percentage of residency graduates who provide maternity care decreasing each year.

However, data from the American Association of Family Physicians (AAFP) indicates that the number of family physician residency slots offered and filled has grown over time, providing an ample opportunity to train a more diverse workforce in perinatal care. If CMS incentivized family medicine physicians to also provide Tier 1 or Tier 2 perinatal services, it could start addressing the OB/GYN shortage without relying on future doctors choosing to become OB/GYNs.

Additionally, we urge CMS to build upon its HPSA focus for the 1,000 Medicare-funded FTE residency positions under the Consolidated Appropriations Act, 2021 and incentivize such residents to permanently reside and practice in HPSAs post-residency.

Illinois has a long history of promoting maternal health, and more than 95% of our hospitals with obstetric units currently participate in a state Perinatal Quality Improvement Collaborative. IHA and Illinois hospitals would be happy to engage with CMS moving forward as it explores this hospital designation to lend our lessons learned and best practices.

Social Determinants of Health Diagnosis Codes

IHA agrees that better clinical awareness of social determinants of health (SDOH) could enhance quality improvement activities, assist in tracking factors that influence patients' health, and provide further insight into existing health inequities. Requiring the reporting of codes in categories Z55-Z65 (Z-codes) would be a good way to leverage a system that is already established.

However, as CMS is aware, Z-codes are not regularly captured on inpatient claims via current workflows. Such information would likely be collected upon registration or asked directly by a clinician during the patient visit. Implementing these changes would require time, training, and technical assistance from CMS.

We urge CMS to consider how it wants providers to capture SDOH data, and how that data will translate through the workflow into Z-codes appended to inpatient claims. If a questionnaire at registration or during the visit will be used, we ask CMS to develop a standardized tool with input from SDOH and clinical experts. The tool should clearly crosswalk to established Z-codes, fostering uniform collection and documentation of SDOH data. What we want to avoid is a meaningful initiative that unfortunately results in data that cannot be aggregated and analyzed across a community or other geographic area.

Health Equity

Illinois hospitals are deeply committed to improving health equity, and we share CMS' goals of reducing healthcare disparities for historically discriminated and underserved communities. IHA appreciates the opportunity to address CMS' request for information, as well as some of the specific proposed policies put forth by CMS. We also provide extensive background on IHA's Racial Equity in Healthcare Progress Report (Progress Report), a key tool developed by and for Illinois hospitals as we work with our members to ensure equity is a strategic priority. Data collection and analysis are in progress, with quality improvement serving as the lens through which we are working with hospital leadership across Illinois.

Regarding CMS' request for comments on overarching principles for measuring healthcare quality disparities across CMS quality programs, we offer the following. In Illinois, we work with cohorts of hospitals to see what process metrics our hospitals currently utilize and what metrics

or best practices should be targeted moving forward. After establishing industry consensus on what actions will move Illinois toward equitable healthcare, we will work with our hospitals to curate outcome metrics that truly measure equity.

Regarding social risk factor and demographic data selection, we ask CMS to reference some of the resources we have created and outline below. Specifically, our Guidance Document and conversation around data analytics will provide CMS a sense of the social risk factors we measure and the demographic data we are asking hospitals to provide via our Progress Report. In general, our stakeholders in healthcare, research, and community settings are looking for outcome measures. We urge CMS to explore the creation and utilization of universal clinical outcome measures validated by measurement experts, such as the National Quality Forum.

Further, we urge CMS to develop a core set of social risk factors that can be measured and tracked over time via CMS' quality program. That said, it is important that CMS not be overly prescriptive in the social risk factors it requires hospitals to report on. Rather, allowing hospitals to work with their communities to augment this core set of social risk factors to better align with the specific patient population they serve will allow this work to be efficient and effective, and better move the healthcare industry toward equitable access and outcomes.

Finally, IHA believes it is critical for CMS to begin this work with confidential reporting, with a future goal to evolve health equity work to a more public facing platform in the future. Almost 70% of IHA's membership has submitted data through our Progress Report. We would never have achieved this level of engagement unless we promised to safeguard the data and keep it confidential during these early stages. CMS should work with hospitals to ensure that the collected data and measurements are truly fostering health equity before making outcomes public or tying performance to payment. Fostering such trust will not only increase hospital compliance but will allow providers and CMS to work together toward true health equity.

Finally, we want to address CMS' request for feedback on specific metrics that should be considered in the development of health equity principles and process through quality programs. To address this request, we provide the following background on our Progress Report.

In 2021 IHA launched the Progress Report statewide and has since seen more than 130 hospitals engage in the assessment. In the first quarter of 2022, IHA refined questions in the Progress Report and solidified the scoring algorithm. For an in-depth overview of the genesis, structure and purpose of the Progress Report, please refer to our Guidance Document.

The Progress Report serves as a long-term accountability tool to document progress towards achieving racial health equity. Given the unique collaborative elements of this work, the Progress Report is a tool to promote collective improvement, not to drive competition. This baseline self-assessment is an opportunity to measure progress, understand provider and community assets in racial equity work, and outline areas of improvement for individual providers and the larger provider ecosystem. Together, providers in Illinois have the opportunity to dismantle systemic racism in a way that no individual provider could. We are

positioning the Progress Report as a scalable tool to measure and assess racial equity across healthcare settings in Illinois and eventually the nation.

The Progress Report is a quality improvement tool. This assessment is a gap analysis or an environmental scan of an organization's current policies and practices. The first time an organization completes the Progress Report the goal is to establish a baseline and to identify some priority areas to act on. IHA recommends that organizations engage in the Progress Report on an annual basis to be able to assess their progress.

Once an organization completes the Progress Report, they will receive analytics from IHA to provide a sense of where the greatest areas of opportunity are in their organization. Hospital level data from the progress report is not shared with anyone outside of an organization. From an analytic perspective, the Progress Report is organized into 10 key composite metrics that explore the demographic profiles of a hospital's board, management, workforce, and patients; diversity and inclusion within a hospital's workforce; the hospital's commitment to advancing racial equity; patient assessment and quality improvement practices; and investment into the hospital's wider community.

For an overview of the data analytic report that IHA provides to organizations that engage in the Progress Report, please see our Racial Equity in Healthcare Progress Report Data Analytic Guidance Document.

IHA has also designed a tailored learning collaborative specifically for organizations who have engaged in the Progress Report. IHA's first Equity Improvement Action Network (Equity IAN) learning collaborative was facilitated by IHA from November-December 2021. The purpose of the Equity IAN was to assist organizations in determining their health equity goals for 2022 and to create an implementation plan to achieve those goals.

The IAN was comprised of three 90-minute sessions designed to assist hospitals with:

- **Reflecting** upon their data from the Progress Report;
- **Focusing** on tangible best practices their organization can operationalize;
- Outlining a **plan** to execute those best practices; and
- **Committing** to action through an equity charter.

Hospitals from across the state that engaged in the first Equity IAN gained the tools and guidance needed to create a Racial Equity Charter outlining their equity goals for 2022. The Racial Equity Charter(s) serve as an organizational roadmap of the change teams will put in place this year. IHA is aiming to secure 100 Equity Charters from hospitals in 2022. These Equity Charters will demonstrate the practical work that healthcare organizations are engaged in.

IHA is planning to facilitate two Equity IANs in 2022 that are open to Illinois hospitals across the state. A national Equity IAN collaborative will also be held by IHA, in partnership with the Commonwealth Fund, in the coming year.

Finally, IHA has developed an Implementation Playbook that will help move organizations to action. The Playbook contains the human-centered design scaffolding organizations need to translate their data from the Progress Report into tangible next steps. The playbook outlines a 7-step process which will enable an organization to reflect upon its data, focus on tangible best practices, outline a plan to execute those best practices and commit to action through an equity charter.

The Implementation Playbook follows the programmatic cadence of the Equity IAN, providing organizations who are not able to engage in an 8-week human-centered design sprint the ability to replicate this process outside of the Equity IAN infrastructure.

IHA is looking forward to continuing to promote the Progress Report as a validated long-term accountability tool that documents progress toward achieving racial health equity across U.S. healthcare institutions both in Illinois and nationally.

In summary, IHA has embarked on the road toward health equity, partnering with Illinois hospitals to identify where they are today, and where they need to go. This path includes the collection of data, and the creation and implementation of validated clinical outcome measures that will demonstrate progress toward health equity. This work is ongoing, and IHA would be happy to discuss our work with CMS as the Administration considers how it will implement health equity strategies via its quality programs moving forward.

N95 Request for Information (RFI)

We appreciate the opportunity to discuss personal protective equipment (PPE) and the potential for CMS to cover some of the cost of PPE during future health crises. Our overarching comment is for CMS to rethink tying PPE payment to Medicare beneficiaries. The administrative cost and burden to track use of PPE by patient is onerous, particularly compared to past payments from agencies such as CMS or HRSA that would be similar to what CMS proposes here. Further, reducing provider burden will be essential should hospitals find themselves in situations similar to those experienced over the past two years where providers were forced to reuse PPE such as N95s across patients. It seems unrealistic and outside a patient's interest for providers to spend time tracking PPE use when they should be focused on patient care.

Instead, IHA suggests CMS develop a global, lump-sum payment that is made annually when cost reports are settled. The payment must be used for the purchase of approved, domestically manufactured PPE that is either utilized within the fiscal year or stored for future use. We suggest a methodology for determining the lump sum payment that is based on the percentage of Medicaid patients a hospital treats annually on average multiplied by the cost of supplies.

We also strongly suggest CMS expand the basket of eligible PPE to include gowns, gloves, surgical masks, and surgical caps in addition to N95s. All of these items were in short supply at some point during the pandemic, and ensuring our providers have the equipment they need to

optimize safety is paramount to ensuring Americans are able to access quality care at the right time in the right place.

Finally, we suggest CMS ascertain a way to make these payments regular and ongoing. It is clear that our interconnected world will continue to experience increased disease transmission. Just in the last decade our country has experienced widespread outbreaks of H1N1 Virus, Whooping Cough, MERS-CoV, Ebola, Zika Virus, and now COVID-19. There is no reason to believe the spread of viruses will curtail after 2023, and we strongly advocate on behalf of Illinois providers that it is in the best interest of the U.S. government to ensure we do not face mass PPE shortages in the future. Thus, we recommend that CMS finalize an annual, global, lump-sum payment with no specified end-date. Perhaps, instead, CMS might finalize a review process that not only examines use of funds, but allows flexibility in payment methodology in the future so that the agency can adapt as needs change.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association