

June 15, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
ATTN: CMS-1771-P  
P.O. Box 8016  
Baltimore, MD 21244 –1816

**Re: Comments on CMS-1771-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation**

Dear Administrator Brooks-LaSure:

The Society for Vascular Surgery (SVS) is a professional medical society composed of 5,800 specialty trained vascular surgeons and other medical professionals who are dedicated to the prevention and cure of vascular disease. We appreciate the opportunity to provide the following comments on the proposed Hospital Inpatient payment rates and the Quality Programs RFIs in the FY 2023 Hospital Inpatient Prospective Payment Systems proposed rule. (CMS-1771-P).

**Solicitation of Comments on the Current State of Health System Climate Change Efforts**

**Proposed Rule:** CMS is seeking comment on how hospitals, nursing homes, hospices, home health agencies, and other providers can better prepare for the harmful impacts of climate change on their patients, and how CMS can support them in doing so.

**SVS Response:** Vascular disease results from and is exacerbated by inflammation, which can be triggered by any number of adverse environmental conditions. We ask that CMS accommodate the inclusion of costs for monitoring the prevalence of conditions caused by adverse environmental conditions, allowing for early testing and detection of such conditions.

CMS can support healthcare facilities by supporting preventative programs such as smoking cessation and exercise and nutrition programs that enhance healthy living and decrease the environmental impact of daily living activities. Similarly, CMS should support hospital social services programs that decrease the patient's hospitalization days and therefore allow patients to recover at home, minimizing the environmental impact associated with prolonging hospitalization. With the anticipated increase in peripheral arterial disease, CMS should budget for an increase in spending on this condition.

We also support and appreciate CMS' willingness and forethought to support hospitals and facilities in the greater demands placed on them by climate change and the need to potentially mitigate any future national health emergencies. The power requirements and associated costs resulting from the observed global warming trend effect health care facilities disproportionately as the ability to tolerate environmental changes within these facilities is limited due to the impact on patients as well as the functioning of medical equipment, including imaging equipment. Various natural disasters will impact health facilities in unpredictable and seemingly random ways. Even at the completion of the current COVID-19 health emergency the need to maintain strict infection control protocols will persist and perhaps even increase in the face of another possible such emergency. Each of the aforementioned factors and their associated costs should be considered.

### **Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Programs**

**Proposed Rule:** One of CMS's goals in developing methods to measure disparities in care for beneficiaries is to provide actionable and useful results to healthcare providers. By quantifying healthcare disparities (for example, through quality measure stratification), we aim to provide useful tools for healthcare providers to drive improvements. We hope that these results support healthcare provider efforts to examine the underlying drivers of disparities in their patients' care and to develop their own innovative and targeted quality improvement interventions.

**SVS Response:** Quality reports must consider social determinates of health, access to care, and an actual risk stratification methodology that is based on these factors. Healthcare providers working in areas with disadvantaged and/or underserved patients are likely to be unduly penalized by CMS quality programs if these factors are not integrated into the methodology. This should apply to all quality measures, whether they are confidential or not.

The SVS believes that providers who care for marginalized patients should not be penalized after identification of disparities. Providers caring for disadvantaged patients in safety-net hospitals or specialized referral centers must dedicate unreimbursed, additional resources in the care of these patients to achieve comparable, acceptable treatment results. Not only are these resources frequently insufficient to meet the needs of these disadvantaged patients, but they also negatively disrupt the overall processes of care for all patients, which may result in underperformance across the board. Therefore, disparity measurement should aim to support the providers with resources that help them elevate the overall healthcare outcomes in a cost-efficient manner. When quantifying healthcare disparities, measures should define and consider the distribution of disadvantaged patients between providers, provider groups, specialties, or facilities and the impact this distribution has on such groups.

SVS is concerned that "within provider" measures place excessive responsibility on providers without adding the resources required to carry out these responsibilities. An individual provider's efforts in isolation will be insufficient to impact performance on quality measures to the degree desired by all. In addition, the degree to which a provider can impact a given measure will depend on the category of measure in question. For example, providers may not be able to overcome the patient's disadvantaged status and potentially inferior outcomes as measured by outcome measures, but a provider may be able to close the gap in quality care provided as evaluated by process measures, such as statin prescription on discharge.

SVS proposes that CMS begins with the patient, taking a patient first rather than provider first, approach, in evaluating differences in quality. Such an approach allows for enhanced risk stratification, aligning with a key CMS principle, by placing it at the forefront of the analysis. For example, outcomes for a group of patients based on a given geography – i.e., comparing different groups within a zip code - or using SES data and comparing across a given SES. Provider data could then be in the stratification analysis in both univariate and multivariate format to identify areas of potential improvement. The SVS is concerned that financial punishments in an already stressed economic healthcare environment may generate an unwillingness to care for disadvantaged or underserved patients.

### **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting Across CMS Quality Reporting Programs**

**Proposed Rule:** CMS describes considerations that could inform the selection of healthcare quality measures to prioritize for stratification

**SVS Response:** SVS agrees that CMS should prioritize existing quality measures. This will reduce the burden on specialty societies to develop, test, and implement new measures and eliminate redundancy in the system.

We also agree that CMS should prioritize measures with identified disparities and adequate sample size to allow comparisons. We also agree with prioritizing measures that seek to determine the availability and appropriate use of care. If there is poor access to care, and inappropriate care when accessed, outcomes are unlikely to be good.

SVS recommends prioritizing access to care measures with an emphasis on measures with known disparities in treatment or outcomes. We would also urge CMS to consider its methodology for measurement and quantification – i.e., how would the measure be “scored?” Would these scores reflect a weighed target goal that is adjusted based on the population treated or would it be looking at a specific, disparate population and achieving a target for that patient population in particular? Finally, CMS raises valid concerns around sample size, which is necessary but not sufficient to prioritize measures for stratification. For any measure, especially those targeting disparities, sample size alone does not equate to reliability.

### **Principles for Social Risk Factor and Demographic Data Selection and Use**

**Proposed Rule:** This section describes several types of social risk factor and demographic data that could be used in stratifying measures for healthcare disparity measurement.

**SVS Response:** SVS supports CMS efforts to improve data collection and methods that allow for improved risk-based stratification based on social risk factors, especially those reported by patients. We believe that the need for quality administrative data that reduces, or ideally eliminates, the reporting burden on physicians and practices is critical. SVS also believes that the current slate of administrative data available to CMS and physicians is insufficient and lacking the granularity for use in meaningful quality measures. We encourage CMS to continue developing a clear and coherent model that is both rigorous and validated in terms of weighing risk factors for use in stratified analysis in CMS quality programs.

SVS is concerned with statements regarding social risk factors and the lack of discussion regarding site of service to which they would be applied. We suggest that CMS include gender as a social risk factor. SVS believes that the CMS proposal that each quality program develops their own model could be very confusing for both providers and patients, given the encounters that occur between different healthcare facilities and sites of service. SVS would urge CMS to set up a framework of consistent definitions for social risk factors to be used by all parties in measure development. Also, we would ask CMS to work with specialty societies and healthcare providers to development a minimum methodology document that outlines how social risk factors are to be included in measure development for CMS supported quality programs.

SVS also encourages CMS to utilize mental health status as a risk factor in the social as well as medical domains. When patients with mental health challenges face a health crisis or do not have their basic medical needs met, they require more complex and intensive management, have worse outcomes, all at greater costs to themselves, their families, and the healthcare system than those without such challenges. These patients should be assigned to a higher at-risk status due to these attendant burdens and complexities of care as well as the corresponding poor outcomes.

### **Identification of Meaningful Performance Differences**

**Proposed Rule:** This section reviews several strategies for identifying meaningful differences in performance when measure results are stratified.

**SVS Response:** The SVS agrees with the principle of identifying meaningful differences. The SVS believes that the goal should be to allow providers to identify and act on any gaps impacting the care of populations with disparities. Rankings, or ordering, particularly when it impacts reimbursement, may lead to significant unintended consequences, especially when these are in large part due to factors outside the provider's control, and will likely defeat the purpose of an evolving quality program. The SVS believes the threshold model, properly applied, represents, and will bring forward the best current care practices, for that patient's disease. Benchmarking, depending on how it is applied, may also be effective. However, none of these methods will be meaningful in the absence of provider support to gain patients access to social service programs and health insurance. Relying on statistical differences is not enough.

### **Guiding Principles for Reporting Disparity Results**

**Proposed Rule:** This section reviews considerations CMS could consider in determining how quality programs will report measure results stratified by social risk factors and demographic variables to healthcare providers, as well as the ways different reporting strategies could hold healthcare providers accountable for identified disparities.

**SVS Response:** SVS supports a period of confidential reporting of results directly to the provider as these programs are implemented and would ask that the period of confidential reporting be long enough such that improvement could be demonstrated by the involved providers with the necessary social and structural supports in place allowing providers to achieve success. This will ensure that those dedicated clinicians who care for the disparate and disadvantaged populations are not negatively impacted and remain willing and able to continue serving and protecting these vulnerable populations.

SVS also believes that individual vascular surgeons' outcomes should be adjusted to account for the patient population (payer mix, race, urban versus rural) they serve with vascular surgeons being compared to other vascular surgeons in their region. Physicians who take care of "sicker" patients and as expected will have worse outcomes than physicians caring for healthier populations, such as urban high socioeconomic status areas. Examples of ways to monitor those disparities are the RUCA codes for rural/urban residence, as well as Chalon comorbidity index, as well as frailty scores for vulnerable patients.

Finally, the SVS believes that as long as quality programs continue to exist in a zero sum, budget neutral environment, the less enthusiasm there will be for innovation and progress within the quality space hampering the development and implementation of the initiatives proposed above.

### **2021 MedPAR data and FY 2020 HCRIS for analyzing MS-DRG changes and determining MS-DRG relative weights**

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS has relied on claims data captured in the Medicare Provider Analysis and Review (MedPAR) file and cost report data captured in the Hospital Cost Reporting Information System (HCRIS) file. In a traditional year, for rate setting purposes, CMS uses data that captures claims from discharges that occurred for the fiscal year that is two years prior to the fiscal year addressed in the rulemaking. For FY 2022, in light of the COVID-19 public health emergency, CMS used FY 2019 MedPAR claims data rather than FY 2020 MedPAR data.

For FY 2023, however, the Agency is proposing to return to its historical practice of using the most recent data available, including FY 2021 MedPAR claims and FY 2020 cost report data, with certain proposed modifications to its usual rate-setting methodologies to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries at IPPS hospitals as compared to 2021. It is also considering, as an alternative, to use FY 2021 data for purposes of FY 2023 rate-setting without the proposed modifications to their usual methodologies.

**SVS Response:** SVS agrees that it is appropriate for CMS to return to its historical practice of using the most recent data available. However, CY2021 data should be considered a 'transitional' data year because many hospitals were in the process of reopening their doors and resuming regular services when a new wave of COVID-19 began appearing around the country.

### **Proposed Permanent Cap on Wage Index Decreases**

CMS adjusts the IPPS standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level and updates the wage index annually based on a survey of wages and wage-related costs of short-term, acute care hospitals. In last year's comments for the FY 2022 IPPS Proposed Rule, a 5% cap policy to prevent large year-to-year variations in wage index values was recommended. As such, for FY 2023 and subsequent years, CMS is proposing to apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year, regardless of the circumstances causing the decline. Additionally, this proposal would be applied in a budget-neutral manner through a national adjustment to the standardized amount.

**SVS Response:** SVS encourages the Agency to adopt the application of a 5% cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year. A permanent cap on any decrease from year to year will provide a better sense of financial stability for many health care facilities.

### **Proposed Continuation of the Low Wage Index Hospital Policy**

In the 2020 IPPS Final Rule, CMS adopted a policy to increase the wage index values for certain hospitals with low wage index values (below the 25th percentile) and decrease the wage index values for hospitals above the 75th percentile in order to maintain budget neutrality. Low wage index value hospitals received an increase of half of the difference between each individual hospital's wage index value and the 25th percentile wage index value. A similar methodology was used to reduce the wage index value for hospitals above the 75th percentile wage index value, thus keeping the policy budget neutral.

At the time, CMS indicated the policy would be effective for at least four years, beginning in FY 2020, so that employee compensation increases implemented by these hospitals would have time to be reflected in the wage index calculation. For FY 2023, the Agency proposes to continue the low wage index hospital policy and will continue to do so in the budget neutral method by applying an adjustment to the standardized amounts.

**SVS Response:** SVS urges CMS to consider alternative data and methodologies to address the disparities between high and low wage index hospitals.

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The SVS appreciates the opportunity to provide comments on this Proposed Rule. If you have any questions or need additional information, please contact Kenneth M. Slaw, PhD, Executive Director of the SVS at [KSlaw@vascularsociety.org](mailto:KSlaw@vascularsociety.org) or 312-334-2301.

Sincerely,

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