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6/2/2023

The Honorable Chiquita Brooks-Lasure
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1785-P,
P.O. Box 8013,
Baltimore, MD 21244-8013

RE: **CMS-1785-P, Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and 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**

Dear Administrator Brooks-Lasure:

As Senior Vice President of Industry Relations for Sentry Data Systems, now The Craneware Group, I am pleased to have the opportunity to comment on the above referenced proposed rule specific to Disproportionate Share Hospital payments, rural hospital impact, hospital value-based purchasing, the intersection of 340B hospital eligibility, and the impact on managing hospital payments and coding implications.

In July 2021, Craneware announced the acquisition of Sentry Data Systems and Agilum Healthcare, optimizing an already-robust catalog of solutions. Now, after more than 20 years as the leading provider of revenue integrity solutions improving financial performance in U.S. hospital and health systems, together, we are The Craneware Group[1] and we deliver software applications across the value cycle.

The Craneware Group (AIM:CRW.L), the market leader in automated value cycle solutions, including 340B management, collaborates with U.S. healthcare providers to plan, execute, and monitor operational and financial performance so they can continue to deliver quality care to their communities. Customers choose The Craneware Group's Trisus data and applications platform as their key to navigating the journey to financially sustainable value-based care. Trisus combines revenue integrity, cost management, 340B performance, and decision enablement into a single, SaaS-based platform. Trisus Chargemaster secured top ranking in the Chargemaster Management category of the "2023 Best in KLAS Awards: Software & Services" and is part of an extensive value cycle management suite. The Craneware Group – transforming the business of healthcare.

[1] The Craneware Group accessed 5/15/2023 https://www.thecranewaregroup.com/company/our-story/

Impact of payments- ***The Craneware Group fully supports an increase in payments.***

In FY2023 hospitals saw a 4.3 percent increase in payment rates from CMS, and the proposed rate of 2.8% in a time of unprecedented inflation reaching 6.5% in 2022. While rural hospitals will see an overall 3.3% increase in payments, hospitals continue to be impacted by increased cost to staff, thereby increasing the cost of care above inflation rates. Any consideration to increase the payments would be appreciated and we believe that the current increase is not aligned to the current cost of care. DSH payments are declining creating gaps in funding, while rural hospitals will see an increase in uncompensated care payments, this shortfall creates financial instability. Adjustments that penalize hospitals for lack of meaningful EHR use or quality data reporting should be used in a budget neutral manner to supplement uncompensated care payments.

Impact on Rural Hospitals- ***The Craneware Group fully supports programs that reduce disparities in rural America***

Rural hospital impact has been evident over the years with

a. **Low-Volume Hospital Extension**
   We support seeing the extension of low-volume increases to payment for hospitals with less than 3,800 discharges.
b. **Hospital Wage Index**
   We support CMS continuing to evaluate wage index that is budget neutral and allows those hospitals below the 25th percentile who experience wage index inequalities in rural Americans to access providers.
c. **Rural Emergency Hospital**
   Designating payment under IPPS for certain Critical Access Hospitals or other rural hospitals for outpatient emergency services will support the continued care of vulnerable populations in rural communities. We encourage CMS, in collaboration with HRSA, to ensure continued access to the 340B Drug Discount Program and to not discriminate against these providers for reimbursement for medications obtained through the program. Their designation as both a CAH or other eligible 340B provider type should not preclude them from participation in 340B. Additionally, reimbursement under the Medicare program has protected rural 340B designated hospitals, and we encourage Rural Emergency hospital provider designations have the same protections.

Value Based Incentive Payments- ***The Craneware Group fully supports incentives for quality care and health equity***

We support the association of value-based programs (VBPs) connection to quality reporting and health equity. Improving performance and the addition of health equity to the Total Performance Scores provides incentives for provision of high-quality care. Combining value-based care programs with insight into costs is imperative. Understanding the true cost of patient care allows hospitals to identify areas for performance improvement and margin enhancement across the entire organization, or in specific areas such as pharmacy and supplies. This is an area our applications connect through the value-cycle – combining operational and financial areas of the hospitals that leads to improved clinical outcomes.

Impact to Safety Net Hospitals- The Craneware Group supports comprehensive safety net hospital evaluation

CMS requested feedback on defining safety-net hospitals. While we recognize an emphasis on this proposed rule relates to inpatient, there are many strong correlations to the outpatient care provided by safety-net hospitals that should also be evaluated. The evaluation of safety net indexes or the alternate area-level indices (area deprivation or social deprivation) could better target social determinants of health and assist prioritize communities that need funding. This is the first step to discussing what it means to be a safety-net hospital. In working in the 340B program for over 20 years, we have seen the

direct correlation to several factors that are not addressed in this proposed rule that should be given consideration. Safety-net hospital can be defined by more than one area on the Medicare Cost Report (MCR). The MCR can be used to account for charity care, underpayments, and uncompensated care. Collectively, all of these measures- not just one, should be considered when looking at the effect a hospital has on treating patients in their community.

a. Safety Net Index

It is laudable that CMS recognizes that safety-net hospitals provide care to our Nation's most vulnerable and underserved populations. CMS has traditionally recognized the additional costs of safety net hospitals through DSH uncompensated care payments or other payment designations for certain rural hospitals. It is important to note that while defining a "safety net index" (SNI) for the sole purpose of Medicare only, it may miss including other government programs that under reimburse providers and should therefore be more comprehensive. A safety-net index that does not incorporate Medicaid falsely projects that certain hospitals are not part of the "safety net". While the low-income beneficiary calculation incorporates dual-eligible patients, it lacks including the total underserved population. We would encourage Medicare to look at the synergies of existing safety-net programs, such as the 340B Drug Discount Program; "340B" to understand the correlation and not negatively impact participation in 340B from an SNI that does not look at the total safety net picture beyond Medicare. 340B safety-net hospitals provide criteria for disproportionate share percentage that demonstrates participation in the program because of serving a disproportionate share of low-income patients, including Medicare and SSI days in addition to Medicaid.

b. **Social Determinants of Health**

CMS recognizes the importance of social determinants of health (SDOH) on health outcomes and more specifically on homelessness and the resource utilization required to provide quality care to this vulnerable population. While SNI is one proposed mechanism, another area discussed includes area-level indices.

c. Health Equity

We are encouraged that CMS recognizes the importance of Health Equity. Specifically, as part of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, we strongly believe that rewarding hospitals for providing excellent care to underserved populations recognizes the added complexities in this population that requires hospitals to provide additional programs to address hardships patients face. We know that 340B hospitals serve a disproportionate number of patients that are impacted by social determinants of health and are often provided care in the inpatient setting and ultimate responsibility for follow up care in the outpatient setting. These patients may have Medicare, Medicaid, and in some cases commercial insurance that has high-deductible benefits or no coverage at all. 340B safety-net hospitals.

Impact on managing hospital payments and coding implications- ***The Craneware Group supports the use of new technology to help hospitals achieve the quintuple aim.***

a. **Discontinuing of add-on payments for FY 2024** – Aprevo [2] intervertebral body fusion device. It was approved for new technology add on payment (NTAP) payment in December 2020. We would ask for CMS to consider at least another year of add-on payments because in 2020 many surgeries weren't performed, due to the pandemic, and with hospital revenue trending negatively this is an opportunity for them to provide exceptional care with appropriate reimbursement.
    a. The FDA determined that it provides more effective treatment of an irreversibly debilitating condition, however this device is very expensive.

[2] Carlsmed accessed 6/2/2023 https://carlsmed.com/why-aprevo-healthcare-professionals/

b. Clinical evidence suggests that using a patient specific device to correct spinal disorders may reduce complications, improve outcomes, lower the cost of care and increase patient satisfaction
c. Hospital value includes improved operating room efficiency and a potential reduction in operative time. This is because it is one surgical sterile box for supplies (traditional implant trays often require one or multiple instrument trays that require sterilization) and it is designed to minimize infection risk and reduce reprocessing costs.

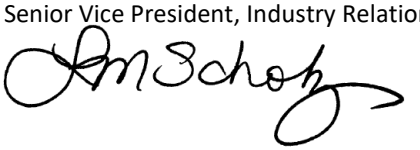
b. **Support the NTAP approval for Aveir[3] AR Leadless Pacemaker.**
   a. Aveir allows for mapping prior to fixation and reduces the number of repositioning attempts. Positioning capabilities may result in better long-term outcomes for patients. In addition to an increased battery life– twice the battery life of other leadless pacemakers it may lead to fewer procedures and reduce patient risk.

c. **Medicare Code Editor (MCE)**
   We would ask that CMS clarify age conflict edit. Hospitals will be unable to create edits when pediatric and adult ages overlap.
   a. Pediatric Age is 0-17
   b. Adult Age is 15-124

Thank you for the opportunity to provide comments on behalf of The Craneware Group. We would be happy to provide more real-world operational information or answer any questions.

Regards,

Lisa Scholz, PharmD, MBA, FACHE
Senior Vice President, Industry Relations



[3] Accessed Abbott 6/2/2023 https://www.cardiovascular.abbott/us/en/hcp/products/cardiac-rhythm-management/pacemakers/aveir-vr-leadless-pacemaker/why.html?utm_source=google&utm_medium=sem+ad+2&utm_campaign=Leadless+Pacemaker&utm_id=Abbott+CRM+LV+-+aveir+VR+-+Pacemaker&utm_term=single+chamber+ventricular+pacing&utm_content=leadless+pacemaker+cpt+code&gclid=EAIaIQobChMI6-fUtPuS_wIV-PPjBx1U0ARJEAAYASAAEgJ1u_D_BwE