A Passionate Voice for Compassionate Care

June 17, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1771-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) 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 Ms. Brooks-LaSure:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule published in the *Federal Register* on May 10, 2022. (87 Federal Register 28108). We appreciate the ongoing efforts of CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **Proposed Changes to Payment Rates under IPPS**

CMS is proposing to update hospital IPPS rates by 3.2 percent. This rate update equals the hospital market basket of 3.1 percent less 0.4 percentage points for total factor productivity and the addition of 0.5 percentage points for documentation and coding. The addition of the documentation and coding adjustment is 6th step in a six-year process of restoring prior year downward adjustments to IPPS payment rates required by the American Taxpayer Relief Act of 2012 and the Medicare Access and CHIP Reauthorization Act and the 21st Century Cures Act.

CHA believes that CMS' estimate of the market basket of 3.1 percent for FY 2023 is too low and inconsistent with the inflation currently being experienced by hospitals. Upward pressure on hospital costs that has been occurring throughout the pandemic has not been well represented in the past two years of hospital market baskets. For instance, hospitals received an update based on

a market basket of 2.4 percent for FY 2021 and 2.7 percent for FY 2022. Historical data on the hospital market basket show that hospitals experienced inflation of 3.0 percent in FY 2021 and an estimated 4.0 percent for FY 2022 based on partial year data (0.6 and 1.3 percentage points respectively more than market basket upon which the update was based).

Inflation is continuing to trend upwards in 2022 and expected to continue. The CPI was 8.3 percent for the 12-month period ending in April 2022.[1] This is a significantly higher rate of growth than is reflected in the market basket for inpatient services. In a recent Senate Finance Committee hearing, U.S. Secretary of the Treasury Janet Yellen said she expected inflation to remain high and the Biden administration would likely increase the 4.7% inflation forecast for this year in its budget proposal.[2]

CHA respectfully requests that CMS consider incorporating a higher market basket into its estimate of the FY 2023 IPPS payment update. One way of doing this would be to account for the understatement of the FY 2021 and FY 2022 market baskets of 1.9 percentage points (the sum of 0.6 and 1.3 percentage points for each year respectively). Another way of doing this would be to use a lower or no offset for total factor productivity. The use of the 10-year average in economy-wide total factor productivity is intended to recognize that hospitals should be able to recognize the same level of productivity improvements as the economy generally. However, CMS's Office the Actuary (OACT) has questioned the validity of this assumption. An OACT analysis from 2016 indicated "hospitals are unable to achieve the productivity gains of the general economy over the long run."[3]

Revising the market basket for past understatements or applying a different total factor productivity offset may not be within CMS' statutory authority to adopt. However, section 1886(d)(5)(I)(i) of the Act authorizes the Secretary to "provide by regulation for such other exceptions and adjustments to such [IPPS] payment amounts… as the Secretary deems appropriate." CHA believes the extraordinary circumstances of the pandemic these past two years and the very high rates of inflation currently being experienced by hospitals are sufficient reasons to invoke this authority as a one-time policy to ensure hospitals receive an appropriate update for FY 2023**.**

- **FY 2023 Outlier Threshold**

CMS proposes an FY 2023 outlier threshold of $43,214, an increase of $12,266 and 39.5 percent over the FY 2022 outlier threshold of $30,988. An increase in the outlier threshold of this

[1] *"Consumer Price Index Summary - 2022 M04 Results." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, May 11, 2022. Consumer Price Index Summary - 2022 M04 Results (bls.gov).*
[2] *Yellen says inflation to stay high, Biden likely to up forecast | Reuters.*
[3] *Paul Spitalnic, Steve Heffler, Bridget Dickensheets and Mollie Knight, Hospital Multifactor Productivity, An Updated Presentation of Two Methodologies, page 2 (Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies (cms.gov))*

magnitude is extraordinary. For a case to qualify for outlier payments, a hospital must lose $43,214 before being paid 80 percent of its costs above this amount.

CHA asks CMS to explore in more detail the reasons for the large increase in the outlier threshold. We believe a likely reason for the large increase in the threshold may be the high number of people that were hospitalized with COVID-19 in FY 2021—the year of utilization that CMS is using to set the threshold.

CMS itself has acknowledged that COVID cases are highly expensive and may not be as intensive or as common in FY 2023 as they were in FY 2021. For this reason, CMS is proposing to set the MS-DRG relative weights based on a 50 percent blend with the COVID cases and 50 percent without the COVID cases assuming that the number and intensity of these cases will be less in FY 2023 than in the FY 2021 utilization that is being used to set the MS-DRG relative weights.

CHA recommends that CMS apply the same assumption to COVID cases when determining the FY 2023 outpatient threshold. That is, rather than fully weight each COVID case at 1.0, CMS can effectively adopt the analogous policy to the 50 percent weighting of COVID cases when determining the MS-DRG relative weight by weighting each COVID case at 0.5 (or an even lower weight if CMS changes the weighting factor on the relative weight in the final rule).

- **MS-DRG Relative Weights**

CMS revises the MS-DRG groups and weights annually to reflect changes in technology, medical practice, and other factors. Using FY 2021 claims data, CMS has observed that COVID-19 cases are increasing the relative weights for the MS-DRGs where these cases are grouped. For instance, MS-DRG 870 (Septicemia or Severe Sepsis with MV >96 hours) has a 9 percent higher relative weight including COVID-19 cases relative to excluding them.

As CMS believes there will be fewer COVID-19 cases in FY 2023 than FY 2021, CMS is proposing to determine the relative weight for the MS-DRGs where COVID cases are grouped by averaging the relative weights calculated with and without COVID-19 cases. By averaging the relative weights, CMS believes the result will reflect a more accurate estimate of the relative resource use for the cases treated in FY 2023 than if no special adjustment were made. **While we do not oppose this approach, we urge CMS to carefully monitor its impact to ensure that it does not lead to underpayment for COVID-19 cases**. While the severity of the pandemic is waning there are still cases in which COVID-19 infection has an impact on clinical conditions. CMS has also proposed a permanent 10 percent annual cap on the reduction in a MS-DRG's relative weight beginning with FY 2023 to improve payment stability from year to year, particularly in low volume MS-DRGs where the weights can fluctuate by large amounts from one year to the next. **CHA supports the proposed cap.**

- **Changes to the Wage Index**

In FY 2021, CMS made significant changes to labor market areas based on Office of Management and Budget (OMB) core-based statistical area (CBSA) delineations. The new CBSA delineations resulted in significant wage index changes for some hospitals. In its public comments, CHA urged CMS to adopt a transition that minimized annual reductions to the wage index. In the final rule, CMS adopted a policy that limited reductions in the hospital wage indexes to 5 percent for any reason.

For FY 2022, CMS also limited reductions in a hospital's wage index to 5 percent but only if the reduction resulted from the adoption of the new OMB CBSA delineations for FY 2021. CHA supported this proposal but recommended that the 5 percent cap on reductions to a hospital's wage index be for any reason, not just revisions to the CBSA delineations.

For FY 2023, CHA is gratified to see that CMS is adopting our recommendation. CMS proposes adopting a 5 percent cap on a hospital's wage index for any reason. **CHA supports this proposal**.

- **Disproportionate Share Hospitals (DSH)**

Determining the Aggregate Pool of Uncompensated Care Payments

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The amount received by a given hospital from this aggregate pool of uncompensated dollars is based upon that hospital's share of national uncompensated care costs using Worksheet S-10 of the Medicare cost report.

CMS estimates that the amount available to distribute as uncompensated care will decrease from $7.1 billion in FY 2022 to $6.5 billion in FY 2023, a decrease of 9.1 percent or $654 million. The calculation of aggregate uncompensated care, once determined, is not changed to reflect subsequent updates to the data sources. For this reason, it is critical that CMS' estimates accurately reflect the latest information available.

Factor 1 is determined by taking CMS' estimate of Medicare DSH payments from FY 2019 (if Medicare were to have paid 100 percent of the formula) and applying increase factors to estimate FY 2023 DSH payments and multiplying the result by 0.75. The increase factors account for the IPPS update, changes in fee-for-service discharges, case mix and an "other" or residual of all other factors affecting Medicare DSH payments including changes in Medicaid enrollment.

Of these factors, the reduction in Medicare discharges for FY 2021 (-6.7 percent) and FY 2022 (-5.2 percent) explain in large part why Factor 1 is showing a decrease from FY 2022 to FY 2023. The proposed rule indicates that these figures are based on the Office of the Actuary's (OACT) January 2022 Medicare DSH estimates, which were based on data from the September 2021 update of the Medicare costs reports and the FY 2022 IPPS final rule impact file. CMS states these figures will updated using "more recent data that may become available for purposes of projecting the final Factor 1 estimates for the FY 2022." (87 FR 28383).

As CMS is using data for the Factor 1 estimate for FY 2023 from September of 2021 and March of 2021 (as that is the data source for the FY 2022 IPPS impact file), it is critically important that these data be updated to reflect the latest discharge information for FY 2023 to ensure that hospitals are accurately paid for their uncompensated care costs. For FY 2022, the discharge figures changed substantially between the proposed and final rules (+0.4 percentage points for FY 2020 and +4.5 percentage points for FY 2021). Other factors such as case mix (+3.1 percentage points) also changed substantially between the proposed and final rules. **CHA urges CMS to update the data used to forecast Factor 1 for FY 2022 in the IPPS final rule.**

Also, because of the large difference in some of the factors that are used to estimate Factor 1 between the proposed and final rules, **CHA requests that CMS consider the possibility of using later estimates of historical data for the FY 2024 IPPS proposed rule to avoid as much change between the proposed and final rules.**

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2023 to the number of uninsured in calendar year 2013, before the Affordable Care Act went into effect. OACT uses estimates of the uninsured from the National Health Expenditure Accounts (NHEA) based on the latest historical data through 2023 (87 FR 28386). Further, OACT states "we may also consider the use of more recent data that may become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2022." (87 FR 28386) **CHA urges OACT to update Factor 2 with more timely and accurate data to reflect the increase in FY 2022 and FY 2023 in uninsured patients.**

It seems highly likely that the public health emergency will end during FY 2023. The end of the PHE could materially affect eligibility for Medicaid, and, therefore, the number of uninsured individuals. The Family First Coronavirus Response Act (FFCRA) authorized a 6.2 percentage point increase in the federal medical assistance percentage (FMAP) to help states enroll more people in Medicaid. The FFCA includes maintenance of eligibility requirements (MOE) for states to receive these matching funds including continuous Medicaid coverage for current enrollees. The increase in the FMAP percentages and MOE requirements will expire at the end of the calendar quarter in which the PHE ends. **CHA requests that CMS consider the impact of the end of the PHE and the MOE requirements on Medicaid enrollment and the number of uninsured for determining Factor 2 of the uncompensated care calculation.**

Distributing Uncompensated Care Payments

For FY 2023, CMS proposes to use two years of audited Worksheet S-10 data from FY 2018 and FY 2019 for distributing uncompensated care payments. In the past, CHA has commented that CMS should only use audited cost report data in the distribution of uncompensated care payments. CHA thanks CMS for being responsive to our concerns regarding auditing Worksheet S-10 data. **CHA supports CMS using FY 2018 and FY 2019 audited Worksheet S-10 data in the uncompensated care distribution**.

In the past, CMS used three years of data to distribute uncompensated care payments. During the transition from using unaudited to audited Worksheet S-10 data to distribute uncompensated care payments, CMS reverted to using only a single year of data for the FY 2022 distribution. For the FY 2023 distribution, CMS proposes to use two years of Worksheet S-10. For the FY 2024 and subsequent year distributions, CMS proposes to use a three-year average of the uncompensated care data from the three most recent fiscal years for which audited data are available consistent with a request CHA made to CMS on the FY 2022 proposed rule. **CHA supports CMS' proposals and thanks the agency for listening and responding to public input on this issue.**

Puerto Rico, Tribal and Indian Health Service Hospitals

In the past, CMS has not used Worksheet S-10 data to distribute uncompensated care payments for Puerto Rico, Tribal and Indian Health Service (IHS) hospitals. Rather, because of special reporting issues that make Worksheet S-10 inaccurate for these hospitals, CMS continued to use low-income patient days as a proxy for uncompensated care for these hospitals. **CHA supported these proposals because of the special issues faced by these hospitals and the vulnerable populations they serve.**

For FY 2023, CMS proposes to discontinue use of low-income patient days for Puerto Rico, Tribal and IHS hospitals and instead use Worksheet S-10 to determine their uncompensated care payments. On its own, this proposal would be expected to result in large reductions in uncompensated payments to these hospitals. However, CMS further proposes making a non-budget neutral supplemental payment to these hospitals that makes their total uncompensated care payments equal to the amount received in FY 2022 adjusted by the percentage change to national uncompensated care payments. **CHA supports this proposal and thanks CMS for developing a permanent policy that will ensure sufficient uncompensated payments for Puerto Rico, Tribal and IHS hospitals that does not require reductions in uncompensated care payments for other hospitals.**

- **1115 Waiver Days in the Medicaid Fraction for Medicare Disproportionate Care**

Some states extend medical coverage benefits under a Section 1115(a) demonstration project to populations otherwise not eligible for medical assistance under the Medicaid state plan. While

CMS argues that its regulations only allow inpatient days for such populations to be counted in the numerator of the Medicaid fraction for Medicare DSH when these patients have Medicaid inpatient benefits, federal courts have found otherwise. In response to these adverse court decisions, CMS proposes to only allow patients to be regarded as eligible for Medicaid through a section 1115 demonstration where:

- State expenditures to provide the insurance may be matched with funds from Medicaid; and
- Patients receive health insurance that provides essential health benefits as that term is used for purposes of the Affordable Care Act.

CHA opposes this proposal. These patients are clearly low-income needy patients that should be considered to be Medicaid eligible when hospitalized regardless of whether Medicaid is providing inpatient hospital benefits. CHA further understands there are questions regarding the legality of CMS' proposed policy and we encourage to CMS to carefully review the statute and other public comments before finalizing this proposal.

- **Payments for Indirect and Direct Graduate Medical Education Costs**

Counting Residents for Direct Graduate Medical Education

Medicare pays hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs based on the number of full-time equivalent (FTE) residents they train. For DGME, resident FTE counts are weighted 1.0 during the initial residency period and 0.5 beyond the initial residency period. The initial residency period is the number of years required for a resident to obtain an initial Board certification. By law, residents are counted at 1.0 FTE for the period of their initial residency Board certification and at 0.5 FTE when in subspecialty training.

Since 1997, the law has limited the number of residents a hospital may count for DGME and IME (other than dental and podiatric residents) to the amount they counted in 1996. The caps are on the unweighted resident counts. However, Medicare makes DGME payment based on the weighted resident count. This created an implementation issue for CMS for how to apply the caps on the unweighted count but make payment based on the weighted count. To resolve this issue, CMS applied a ratio of the resident cap to the unweighted count of residents to the weighted count of residents when the unweighted count of residents exceeded the cap.

While this method was in place for many years without complaint, it was stricken by the U.S. District Court for the District of Columbia on May 17, 2021 in *Hershey v. Becerra* as being inconsistent with the 0.5 weighting factor required by the statute. The plaintiff in that case successfully argued to the Court that CMS' ratio method effectively results in subspecialty

training being counted as less than 0.5 FTE when the hospital is above its resident cap—or applied a penalty if a hospital above its cap trained additional subspecialty residents.

In the FY 2023 proposed rule, CMS proposes only to make an adjustment to the resident cap when the hospital's unweighted and weighted resident counts are above a hospital's unweighted cap of residents. As the District Court struck down CMS' rule for past periods, CMS proposes to make its new rule effective retroactive to October 1, 2001. The rule would not be a basis for reopening any final settled cost reports. Only those past cost reports that remain open and subject to appeal would be able to take advantage of the new rule. As the rule would also have prospective effect, all hospitals would be able take advantage of the new rule on a going forward basis. **CHA supports CMS' proposal.**

Rural Training Tracks and Medicare Graduate Medical Education (GME) Affiliation Agreements

Hospitals are limited to the number of FTE residents they may count for DGME and IME payment to the number counted in 1996 (or a later year if they first begin training residents in new medical residency programs after 1996). There are provisions of regulations that allow the caps to be aggregated among hospitals that jointly train residents (known as affiliated groups).

Rural track programs (RTP) are designed to encourage the training of residents in rural areas although some of the training will take place an urban area. Urban and rural hospitals are able to receive upward adjustments to their resident caps when participating in newly established RTPs. The newly adjusted caps are established 5 years after new RTP begins operation. However, resident caps associated with RTPs may not be aggregated in affiliated groups of hospitals that jointly train residents.

CMS proposes to allow urban and rural hospitals that participate in the same separately accredited family medicine RTP to enter affiliation agreements for the RTP once the final caps are established. Prior to this point, the programs are allowed to grow and expand absent any cap limitation and limitations on affiliation are not applicable. The limitation to family practice programs distinguishes these RTPs from others that, subject to section 127 of the Consolidated Appropriations Act (CAA, 2021), are exempt from FTE caps for 5 years beginning October 1, 2022. **CHA supports this proposal.**

- **Condition of Participation: Reporting COVID-19 and Influenza Infections**

During the PHE CMS has required hospitals and critical access hospitals (CAH) to report specific information about COVID-19 as a condition of participation (CoP) in Medicare. CMS is proposing to revise the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements and to

establish new reporting requirements for any future PHEs related to a specific infectious disease or pathogen until April 30, 2024.

Under this proposal, a hospital or CAH must electronically report information about COVID-19 and seasonal influenza in a standardized format specified by the Secretary such as the Center for Disease Control's (CDC) National Health Safety Network, or other CDC-supported surveillance systems. CMS aims to create a framework for hospital and CAH reporting that would ensure the federal government has the information necessary to identify and respond to hospitals and CAHs in need of additional support and guidance and to monitor and assess the capacity of hospitals and CAHs to provide safe care during a declared PHE (national, regional, or local).

CHA appreciates and understands CMS' needs and interests to be prepared for future PHEs like the world has experienced during the past two years with COVID-19. Nevertheless, **CHA requests that CMS balance the needs of these additional reporting requirements with burdens the requirements place on hospitals.** For example, we encourage CMS to ensure these requirements are aligned with state and local public health reporting requirements and to consider carefully whether daily reporting continues to be necessary.

- **Payment Adjustments for Domestically Made N95 Respirator Masks**

CMS requests public comment on potential ways to use its inpatient and outpatient hospital payment systems to facilitate access to domestically manufactured National Institute for Occupational Safety and Health (NIOSH) approved N95 surgical masks. The rule indicates that these masks are critical to controlling the spread of respiratory diseases like COVID-19 but those domestically produced and less vulnerable to supply chain interruptions are more expensive to produce.

CMS requests comment on two potential options:

- o Biweekly interim lump-sum payments to hospitals that would be reconciled at cost report settlement that account for the marginal difference in costs between NIOSH-approved surgical N95 respirators that are wholly domestically made and those that are not; or
- o A claims-based approach where Medicare could establish a MS-DRG add-on payment when hospitals meet or exceed a threshold of purchasing 50 percent or more wholly domestically sourced surgical N95 respirators.

CHA commends CMS for its forward thinking to ensure the availability of medical supplies that will be needed to control the spread of viral infections. Of these two options CMS discussed, **CHA supports using the cost report to subsidize the purchase N95 respirator masks.** We believe such an approach will be simpler for both hospitals and CMS to administer and be effective in accurately recognizing higher hospital costs associated with domestically manufactured N95 respirator masks.

- **Request for Information on Social Determinants of Health Diagnosis Codes**

CMS is soliciting public comments on how the reporting of diagnosis codes in categories Z55-Z65 (i.e. persons with potential health hazards related to socioeconomic and psychosocial circumstances) may improve CMS's ability to recognize severity of illness, complexity of illness, and/or utilization of resources. CMS is also interested in receiving feedback on how it might otherwise foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each health care encounter and improve the reliability and validity of the coded data including in support of efforts to advance health equity. CMS notes that examining the severity level designation of diagnosis codes is just one area to possibly support documentation and reporting of SDOH in the inpatient setting.

CHA supports the goals of collecting SDOH data for inpatients as a way to better understand their health drivers and social needs. We are extremely cautious, however, in any roll-out of mandatory use of Z codes or other SDOH diagnosis codes for two reasons: availability of social resources and patient sensitivity. Our members have found that patients are often hesitant to share SDOH data, especially if they do not understand how it will be used or why it is being collected. It is counterproductive to collect SDOH data without having resources and procedures in place to offer help. Our members work closely with clinical social workers, community organizations, and others, but solutions are not available in all communities for all social drivers of health. **We strongly urge CMS to avoid mandating the use of Z codes for all inpatient providers. Instead, we believe a provider-specific roll-out of voluntary Z code use is more appropriate.** We urge CMS to educate providers about the use of SDOH codes and how they can be used to improve an individual's care. We strongly recommend that instead of establishing requirements based on a Z code platform, CMS consider developing a broader strategy for collecting SDOH data that leverages technology available across multiple settings and does not impose an additional data collection burden on providers. CHA fully supports efforts to improve and increase the collection of SDOH data; however, we believe that these options can and should be designed in a way that would make it feasible for hospitals of all sizes and types to consistently collect data in a standardized manner without creating undue burden when better data sources may already be available.

- **Hospital Pay-for-Performance (P4P) Programs**

Measure Suppression, Scoring Changes, and Payment Adjustments

In response to the continuing COVID-19 PHE, CMS proposes to continue prior and add new measure, scoring, and payment adjustments to the three hospital P4P programs: Hospital Readmissions Reduction (HRRP), Hospital Value-Based Purchasing HVBP), and Hospital-Acquired Condition (HAC) Reduction. CMS also announces several modifications to the technical specifications of selected measures. The prior and proposed changes are based on the cross-program measure suppression policy established during FY 2022 rulemaking, which was

adopted as an approach to preserving fair and equitable payments across hospitals under the P4P programs. CHA remains grateful to CMS for its prior and ongoing attention to COVID-19 impacts on hospitals as the pandemic continues to evolve.

The proposed changes fall into four categories:

- Identifying measures for which suppression will continue or newly apply;
- Accounting through risk adjustment for downstream effects of patients with previous COVID infections;
- Continuation or modification of scoring and payment adjustments adopted for FY 2022; and
- Operational changes such as adjusting baseline and performance period to be consistent with availability of reliable data.

CHA generally supports the proposed changes and the technical specification modifications, the net outcomes of which will enable our members to continue their mission to serve vulnerable patients. We strongly agree with the continuation of special scoring policies for the HVBP and HAC Reduction programs that result in net-neutral payment effects on hospitals by those programs. We also appreciate the measure modifications proposed for the HRRP. However, we are unclear on why CMS has chosen not to make scoring and payment adjustments to this program that would render it net-payment neutral for hospitals, as the overwhelming majority of the COVID-19 PHE impacts on hospitals apply to all three P4P programs.

CHA appreciates that the proposed risk covariate for previous COVID-19 infection if finalized could allow tracking and better understanding of the effect of “long COVID” on hospital performance and lead to further P4P program changes if indicated by the data generated. We also support confidential reporting of hospital-specific performance results to providers for the suppressed measures as an adjunct to performance improvement planning, but we disagree with public reporting of those results. The potential for misunderstanding of the complexities of the PHE’s effects on quality and the limitations of the available data and results far outweigh the utility of those data and results for use by patients and families.

Finally, CMS refers several times to its plan to resume “normal” P4P program operations beginning with the FY 2024 payment determination year. This appears to mean ending measure suppression as well as the application of special scoring and payment adjustments. While we appreciate CMS signaling its intentions a year early, given the volatility of COVID-19 transmission, infection, and severity rates along with continued geographic and temporal differences in pandemic effects CHA is less confident than CMS about the timetable for a return to pre-pandemic policies and operations. We strongly encourage CMS to make data-driven decisions rather than adhering to an arbitrary date for ending suppression. Should CMS continue to regard FY 2024 resumption as feasible, we strongly recommend that CMS engage in dialogue

on this subject with the hospital community well in advance of proposed rulemaking, such as town hall meetings, listening sessions, focus groups, and other means of interaction.

- **Request for Public Comment on Possible Future Inclusion of Health Equity Performance in the Hospital Readmissions Reduction Program**

CMS notes that the Hospital Readmissions Reduction Program (HRRP) currently uses dual eligibility for Medicare and Medicaid as a proxy for a beneficiary's social risk and uses dual eligibility, as required by the statute, to divide hospitals into peer groups for comparison under the program. In keeping with the agency's enterprise-wide focus of health equity and disparities, CMS requests comment on variables associated with or measures of social risk and beneficiary demographics as well as on broader definitions of dual eligibility for potential future incorporation into the Program.

CHA supports many of the ongoing initiatives by CMS to advance health equity in its quality reporting and value-based programs. However, we have some reservations about the potential actions outlined in this request for comment that would impact the HRRP.

CHA does not find the balance of benefits, risk, and unintended consequences of incorporating hospital performance for beneficiaries with social risk factors into the HRRP to be positive at this time and in the manner implied through the questions posed by CMS. The hospital P4P programs are designed by statute to focus on reducing Medicare payments for high-profile, high-cost, and partially avoidable events. CMS appears to be redirecting the focus of the HRRP to reducing payments for observed disparities that may be associated with some of the readmissions captured through the program. We question whether the use of reduced HRRP payments to reduce patient-level risk factors is an appropriate use of the Program. The Program's statutory requirement for peer grouping is designed to facilitate equitable payments to hospitals not patient-level equity in clinical outcomes.

CHA observes that that hospital readmission is the far downstream result of many interlocking factors that are often outside of hospitals' control. We believe that the path to health equity would be much better defined by efforts based on measures applicable to specific, actionable, upstream factors. For example, reducing disparities in timely provision of percutaneous coronary intervention for acute coronary syndromes seems a better-focused target than readmission after acute myocardial infarction.

We also note that the HRRP formula and its associated calculations are complex and complicated. Changes to the Program's methodology run the risk of unintended payment consequences.

Finally, CHA notes that confidential reporting of hospital-specific HRRP performance results in which hospitals are stratified into quintiles based on dual eligibility as a proxy for social risk has

a very short track record, a large part of which has occurred during the atypical times of a public health emergency. An early evaluation of the effects of the first three years of hospital peer grouping has recently been published.[4] The authors found significant reductions in penalties assessed on rural hospitals and hospitals caring for a high share of patients in poverty or from racial or ethnic minority backgrounds and conclude that improved equity is underway in the Program. **We recommend that the Program's current, statute-compliant structure be left undisturbed for several more years to allow these early findings to be confirmed.**

- **Request for Information: Current Assessment of Climate Change Impacts on Outcomes, Care and Health Equity**

CMS notes that climate instability resulting from global warming introduces a combination of catastrophic weather events and chronic disease impacts that creates serious burdens for healthcare organizations. CMS also cites evidence that climate change disproportionately harms underserved populations. The agency requests input about hospitals' responses to climate change and its downstream effects on their operations and the populations they serve, as well as ways for CMS to support hospitals in their climate change response efforts.

Catholic health care is committed to protecting the environment, to minimizing environmental hazards and to reducing our contribution to the problem of climate change. We care for those who are harmed by the environment, we strive for internal practices to ensure environmental safety and we advocate public policies and private actions that bring solutions. With our members, CHA is working to raise the issue of environmental stewardship as a mission– based clinical and public policy imperative. We act as responsible stewards of God's creation as we respond as a ministry to building healthier communities.

CHA shares concerns voiced by CMS about impacts of climate change on hospitals and health systems as well as nursing homes, home health agencies and other types of health care facilities. Our members are particularly attentive to these concerns, as our mission as Catholic healthcare providers leads us to serve a large population of historically disadvantaged and vulnerable patients. We believe that developing and implementing responses to climate change impacts is an essential part of our preparedness to protect the patients we serve by keeping them safe and maintaining our operations during emergencies.

There are already substantial public and private effort underway in the health care sector to address both the effects of climate change on patients and communities and the effects of health care operations on the climate. As only one example, several CHA members have been voluntarily working on reducing their greenhouse gas emissions for the past several years, driven by their commitment to care for creation and vulnerable populations the least prepared to deal

[4] Shashikumar SA, Waken RJ, Aggarwal R, et al. Three-Year Impact Of Stratification In The Medicare Hospital Readmissions Reduction Program. Health Affairs 2022; 41:375-382.

with climate change. They have joined initiatives such as the U.N.'s Race to Zero, the America Is All In coalition of leaders in support of climate action in the US, Health Care Without Harm's Health Care Climate Council and Health Care Climate Challenge, the National Academy of Medicine's Action Collaborative on Decarbonizing the US Health Sector, the new HHS Office of Climate Change and Health Equity pledge to reduce carbon emissions and strengthen resilience and the Vatican's Laudato Si' Action Platform which calls the global Catholic Church, including Catholic health care, to take action on the causes of climate change and its impacts.

CHA notes that the ongoing work of our members to meet CMS' Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers serves as the foundation onto which they are grafting activities that specifically respond to the healthcare threats posed by climate change. Climate change impacts vary by geographic regions, and CHA members are tailoring their preparedness efforts to their respective environments (e.g., increased frequency of coastal flooding). Our hospitals and health care facilities are also extending our existing disaster preparedness partnerships with community-based entities to coordinate responses to events triggered by climate change impacts. Cooperation and coordination are especially important when patient evacuations become necessary.

We appreciate CMS's commitment to addressing the health impacts of climate change and believe the appropriate role for CMS is to support the health care sector in the work it is already doing. Sustainability initiatives, such as converting hospitals from natural gas heat to renewable energy sources, will be challenging from an operational reliability and financial standpoint. Federal and state funding will be important to drive adoption and offset the expense of initiatives that are the right thing, yet do not yield a positive return on investment. We urge CMS to bear this in mind when making reimbursement policy decisions that affect hospital financing.

CMS can also support health care systems by working with other federal and state agencies to provide integrated health and climate data to better understand how climate impacts health and health care utilization and by removing regulatory barriers that can hamper climate action by hospitals and systems.

CHA recommends that CMS and other federal agencies take actions that encourage prompt, coordinated, and effective local and regional responses to emergencies such as those triggered by climate change. Actions could include convening planning sessions, providing technical assistance, and offering grant programs that help hospitals and health care organizations bear the cost burdens associated with climate change responses. Finally, CMS can also play a role in educating the public about how climate change, the social drivers of health, health outcomes and health equity are all interrelated.

CHA's members have taken a leading role in addressing climate change and are developing a deep understanding of what approaches are most effective. We urge CMS to work with our members and other stakeholders to learn how the agency can best support this crucial work.

- **Request for Information: Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs**

General Considerations

CMS requests input into key principles and approaches to be considered as the agency further develops its strategy for advancing health equity across its quality reporting and value-based programs.[5] This RFI focuses on consistent measurement of disparities and routine reporting of stratified measure results as strategic tools to closing equity gaps in its programs. CMS plans to employ these tools to provide actionable information about disparities to providers across the continuum of care through applications of the tools tailored to accommodate the contextual and structural variations across its quality enterprise. In this RFI, CMS defines health equity as *the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes*. CMS also adopts a definition of measure stratification as the calculation of measure results for specific groups or subpopulations of patients.

CHA welcomes the opportunity to respond to this Equity Measurement RFI on behalf of our hospital and health system members. The Catholic health ministry is committed to achieving health equity, eliminating racial and ethnic disparities in health outcomes and improving access to quality health care for all, a commitment that is deeply rooted in our mission. In 2021 CHA and our members launched our Confronting Racism by Achieving Health Equity pledge/We Are Called initiative to recommit to ending health disparities across our country and to dismantling the systemic racism that remains ever-present in our society. The initiative is our shared effort to achieve equity in our own health systems and facilities and to advocate for change in the wider health care sector and our society. Almost 90% of our members have signed on to the four pillars of the pledge: working to achieve equity in covid-19 testing, treatment and vaccination; putting our own houses in order; building just and right relationships with our communities; and advocating for change at the federal, state and local levels to end health disparities and systemic racism.

We very much welcome efforts by CMS to advance health equity and support proposals that are valid, reliable, and feasible for hospitals. Our members are willing to take additional, reasonable steps to advance strategies that will make a real difference in ending health disparities and achieving health equity. This is work that the entire health care community should be working on together. While measurement and reporting are powerful tools, we urge CMS to proceed in manner that prioritizes collaboration over competition.

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[5] Described at https://www.cms.gov/cms-strategic-plan.

Key Considerations For Cross-Setting Use Of Quality Measures And Results Stratification

Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification

CHA agrees with CMS that hospital-specific stratified results from the Within-Provider and Across-Provider Disparity Methods can support meaningful self-directed analysis by a hospital of its care for patients with and without specific sociodemographic risk factors associated with outcomes disparities. We also agree that care must be taken to avoid the inadvertent introduction of measurement and selection biases during stratification. We recommend that results be routinely examined for internal inconsistences (e.g., highly improbable results) and for consistent directional trends for interrelated stratification variables (e.g., low income and full Medicaid eligibility).

Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting

CHA recommends the following as essential characteristics of measures focused on issues of health equity and disparities:

- Data-driven -- be developed based upon well-documented outcome disparities with clear associations to well-defined social risk factors;
- Actionable – be designed to yield performance results for which change is possible;
- Have utility -- in the near-term, process measures may be more feasible and could point the way to meaningful outcome measures
- Give feedback -- be constructed for timely performance scoring and prompt provider feedback; and
- Feasible – based on considerations of provider burden and CMS operational capabilities.

Principles for Social Risk Factor and Demographic Data Selection and Use

CMS notes the challenges of selecting from the myriad factors for which associations with disparities have been suggested and the limited availability of high-quality (i.e., self-reported) data sources for certain variables. CMS describes proxy variables (e.g., neighborhood indices) and tools (imputation for missing data) for possible use when self-reported data are scarce.

While imputation of data could be helpful in providing insights when addressing topics dependent on community factors, such as readmission, mortality and cost, patient level data would be preferred for measures focused on hospital practices and outcomes. CMS should engage in extensive testing on specific measures and scoring methodologies before using data imputation on measures with respect to things like risk adjustment and comparative performance.

CHA recommends that CMS begin disparity analyses and stratified reporting with demographic and social risk variables for which CMS already has large data sets (e.g., Medicare enrollment and claims data) containing potentially relevant information (e.g., diagnoses, dual-eligibility status).

We further recommend strongly that all variables to be analyzed for disparities be required to have clear, standardized definitions and that practical barriers to the number of variables to be studied be taken into account, including reporting burden created for providers and optimal allocation of finite provider and CMS resources.

CHA recognizes that patients may be reluctant to share sensitive personal information, contributing to the challenge of missing data points for the gold standard, self-reported data. We support the judicious use of substitute variables being considered by CMS, such as neighborhood-based variables (e.g., Area Deprivation Index). We encourage CMS to seek out alternative sources of social risk factor data in other HHS initiatives and other federal programs and as part of activities underway outside of HHS.

Identification of Meaningful Performance Differences for Use in Stratified Results Reporting

CMS briefly describes multiple potentially useful methods for identifying meaningful performance differences (i.e., disparities) and sharing them with providers through stratified results reports: confidence intervals, standard deviation-based cut points, clustering algorithm use, rank ordering, categorization using thresholds or fixed intervals, benchmarking, and peer grouping. Comments are solicited about preferred methods.

CHA believes that the preferred method(s) will vary with the quality measure and the program in which it is being used, the sociodemographic variable being studied, the disparity method being used, provider type, care setting, and intended audience for the results. Decision making should most often rest at the program level though domain, subgroup, and measure level decisions could be appropriate in select circumstances. We advise CMS to consider first if stratified results calculation and reporting of a given measure-sociodemographic variable combination is appropriate and the likelihood that the ensuing results when presented to providers will incent them to conduct self-directed analyses that could lead to effective interventions to reduce disparities.

CHA advises that methods such as thresholds or fixed intervals and rank ordering be used with particular care as they carry a relatively high risk for creating subgroups that could be inappropriately characterized as practicing discrimination. Labeling of providers as discriminatory, even though unintentional, when based on poorly chosen statistical methods and/or inappropriate application of stratified reporting results could cause long-term and nearly irreparable harm to beneficiaries, providers, and the Medicare program. The same risk appears even higher for the method of regression decomposition, not included in this RFI but described

in some detail by CMS in recent rulemaking for other Medicare sectors (e.g., Inpatient Rehabilitation Facility Prospective Payment System FY 2023 proposed rule).

Guiding Principles for Reporting Disparity Results

CMS observes that the agency typically begins with confidential reports to providers before transitioning to public reporting of results from its quality reporting and value-based programs. CMS believes that initial confidential reporting is especially beneficial when new programs, measures and/or measurement methodologies are being introduced. The agency also believes that public results reporting enables market forces to incent improvement by providers in order to remain competitive. CMS states that the statute requires public reporting of results from all its quality programs and strongly implies that stratified results would be similarly subject to mandatory public reporting.

CHA believes that confidential reporting to providers is entirely appropriate for measures and initiatives involving stratification for demographic and social risk factors. Results reporting should be accompanied by a review and correction process and be subject to data validation. Any transition to public reporting should be planned and implemented in a deliberate and unhurried manner, and only after the data collected have demonstrated a high degree of reproducibility and after a period of confidential reporting that is sufficient to identify unintended consequences. CHA also reminds CMS of the need to structure any public reporting of disparities comparison results in a way that avoids the risk of further disadvantaging providers who serve populations and areas with limited resources (e.g., located in low-income and rural communities). Finally, we note that statute provides the Secretary with considerable discretion and flexibility regarding public reporting.

Conclusion

CHA continues to strongly support the essential work being done by CMS related to healthcare disparities and inequities as represented by this Equity Measurement RFI. Identifying and reporting disparities within CMS programs remains a worthy goal to which the Federation recommends a deliberative, consistent, coordinated approach be taken by the agency. Some of the tools and methods described in this RFI appear promising for use in CMS programs. CHA remains fully committed to working with CMS, HHS, and others on additional principles, tools, and methods for disparities reporting that seem likely to be feasible, practicable, and lead to improved health outcomes.

- **Hospital Inpatient Quality Reporting (HIQR) Program**

Hospital Commitment to Health Equity (HCHE) structural measure

CMS proposes to add a structural measure *Hospital Commitment to Health Equity* to the Hospital IQR Program, with required reporting to begin with the FY 2025 payment determination year. CMS intends for the HCHE measure to assess a hospital's commitment to health equity across five domains: Equity as a Strategic Priority, Data Collection, Data Analysis, Quality Improvement, and Leadership Engagement. Each domain contains multiple elements (e.g., training staff in culturally sensitive collection of demographic and/or social determinant of health (SDoH) information is an element under the Data Collection domain). To received credit for the measure, a hospital would attest affirmatively to all five domains, receiving one point per domain. All elements within a domain must be completed to attest affirmatively and receive the point for that domain. The HCHE measure was conditionally supported for rulemaking by the Measure Applications Partnership after considerable discussion. It has not been submitted for NQF endorsement and CMS does not state an intent to do so.

CHA and our members are fully committed to eliminating health disparities and to achieving equity in the provision and quality of health services. Our member hospitals have considerable experience with the delivery of culturally competent care as well as care that meets the special needs of patients whose social risk factors complicate their care, such as physical and sensory disabilities, housing and food insecurity, and limited English proficiency. Our hospitals have successful programs to increase the presence of underrepresented groups in their organizational leadership. We support the deployment of EHR capabilities in our hospitals that enable improved collection; our members routinely collect race, ethnicity, and language preference data and are expanding their efforts to link those data to quality measurement.

CHA supports inclusion of this type of measure in the IQR program and looks forward to working with the agency on health equity improvement now and in the future. The measure has not yet been endorsed by the NQF and we urge CMS to submit it for endorsement as soon as possible. We also recommend that CMS consider giving partial reporting for systems that are committed to health equity but are in the process of implementing new policies and procedures. We also urge CMS to develop guidance documents and other forms of technical assistance to provide needed clarification so that reporting is consistent across hospitals.

Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures

CMS proposes to add a pair of complementary measures focused on screening by hospitals for Social Drivers of Health to the HIQR Program, beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination. Together the measures would require hospitals 1) to seek information from all adult patients admitted about five health related social needs (HRSN): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and 2) to calculate positivity rates for each HRSN among the screened population. CMS states that the measures are intended to promote adoption of HRSN screening by hospitals and to

provide information upon which a hospital can develop an action plan reflective of its population's needs and available community-based services.

CHA members are firmly committed to providing holistic and compassionate care to all patients, including attention to their health-related social needs and we recognize the value and importance of screening for such needs. **With respect to the first measure, we appreciate the flexibility proposed by C**MS. Hospitals could use the screening tool of their choice and use data from administrative claims, EHRs, patient assessments, or patient-reported surveys. Similar to the proposed Hospital Commitment to Health Equity measure, this proposed measure has not yet been endorsed by NQF, and we urge the agency to quickly submit this measure for review.

With respect to the second measure, CHA recommends CMS postpone its inclusion in the IQR program. We have several concerns. CMS believes the use of this measure could help promote linkages with relevant community-based services that would address those needs and support improvements in health outcomes following hospitalization. The link between performance on this measure to better health outcomes is unclear, as noted during review of these measures by the Measure Applications Partnership (MAP) Hospital Workgroup. The screen-positive rates will be extremely difficult to interpret since their denominators will not be specific to the HRSN in the numerator for which a rate is being calculated. It is unclear how this information by itself will promote connection with services in the community. While many of our members are using screening tools and have partnerships with community service providers, establishing these relationships can be different and vary by area. Because this measure would provide information about needs in the community, not about care provided by the hospital, we have concerns about publicly reporting the results. It could be misused as a way to compare hospitals on factors outside of their control. Should CMS decide to adopt this measure, we strongly urge that the voluntary reporting period be extended and that CMS work with hospitals to monitor its implementation and whether it has had a positive effect on efforts to engage community partners.

CHA reiterates our strong belief that the concepts and intentions of these measures are of great importance to holistic, patient-centered care delivery by hospitals and health systems, including our members. We agree that screening for social needs, when done in an appropriate manner and part of a larger community-wide system to provide the services needed is a valuable goal that should be encouraged and supported. Many of our members are leaders in this work. While we appreciate CMS' desire to take steps to encourage social needs screening, it is essential that this be done in a way that furthers screening and does not discourage providers or patients from participating. Screening must be done in a culturally sensitive and appropriate manner and in a way that minimizes burdens on caregivers. Identifying needs without a means to address them is demoralizing for both the caregiver and the patient and could erode the patient's trust. CMS should work with stakeholders to develop technical support and education on the most effective way to both screen for social needs and work with community and other organizations to meet those needs. We support continued work on the proposed measures to produce data that will be

interpretable, meaningful, actionable, and reliably scored and will not impose excessive burden compared to the benefits of the information collection.

Cesarean Birth electronic clinical quality measure (eCQM) and Severe Obstetric Complications electronic clinical quality measure (eCQM)

CMS proposes to add the *Cesarean Birth* and the *Severe Obstetric Complications* eCQMs to the HIQR measure set. Both measures would be available for self-selected reporting for the CY 2023 EHR reporting period, and reporting for both would become mandatory beginning with the CY 2024 period.

Reducing maternal morbidity, ending disparities in maternal health outcomes and improving the health of mothers and infants is a top priority for CHA. Providing compassionate care for mothers and babies has long been an integral part of the founding ministries of Catholic health care, and we strongly support the development of measures to improve the quality of maternal health care. **However, while we fully agree with CMS that more must be done to protect health and lives of mothers and infants, we have some concerns about these two measures as proposed.**

A chart-abstracted version of the Cesarean Birth measure has been continuously endorsed by the NQF since 2008. During Measure Applications Partnership (MAP) review of the eCQM version, reservations were expressed whether sufficient feasibility testing of measure reporting had been completed. We note that additional testing was done subsequently, and the eCQM is under review by the NQF. CHA does not object to the measure *per se*, but we would prefer that CMS defer adopting this measure into the HIQR Program until NQF review is completed and endorsement awarded.

More extensive reservations were raised during MAP review of the Severe Obstetric Complications eCQM related to feasibility, reliability, and validity, and potential discouragement of medically necessary maternal blood transfusions. The measure has a complex, multifactorial risk-adjustment structure about which the MAP also voiced concerns. CHA does not object to this measure *per se*, but we would strongly prefer NQF endorsement be awarded prior to measure adoption by CMS. We would not want much needed efforts to improve maternal health care to be confounded by premature adoption of a flawed measure.

CHA recommends modification of the proposed timeline for reporting of these two eCQMs. We support their addition to the HIQR and the Medicare Promoting Interoperability (PIP) programs for the CY 2023 EHR reporting period for optional reporting as self-selected measures, if NQF endorsement has been received. However, we do not agree with transition to mandatory reporting beginning with the CY 2024 EHR reporting period. First, adding the two measures would substantially increase the number of specified mandatory measures from four to six in a single year. Our members continue to experience challenges with reporting the currently required

eCQMs and we note that new eCQM implementation is very costly and time consuming for hospitals. Second, given the concerns already voiced about insufficient testing of these measures for reporting feasibility across a range of EHR products and statistical reliability questions, CHA recommends that CMS limit these measures to self-selected reporting until enough experience has been gained in the field to confirm feasibility and reliability. We also recommend that these measures not be considered for addition to other CMS quality or P4P programs until satisfactory real-world experience with them has been documented.

Hospital-Level Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Patient-Reported Outcome Performance Measure (PRO-PM)

CMS proposes to adopt the Hospital-Level, Risk Standardized THA/TKA PRO-PM measure into the HIQR Program. This patient-reported outcome measure includes standardized functional status data collection preoperatively and for 1 year postoperatively. CMS proposes to begin with two sets of voluntary collection and submission periods followed by mandatory reporting. Measure results would affect payment determinations starting in FY 2028.

CHA is generally supportive PRO-PMs for clinical conditions when reliable outcome tools are available for patient completion, as is true for this measure. We believe that the long-term (12-month) patient-reported follow-up included in this NQF-endorsed measure has considerable potential value for hospital and surgeon quality improvement initiatives and for beneficiary decision-making. We note that hospitals participating in the Comprehensive Care for Joint Replacement (CJR) bundled payment model have had the option of reporting this measure since the model began in 2016. Unfortunately, CMS has not yet publicly released any performance results or other information about experience with this measure by CJR participant hospitals. CHA is aware that reporting this measure has proven extremely challenging and quite burdensome for hospitals and measure completion rates have been low**. Therefore, CHA recommends that CMS defer adoption of this measure into the HIQR Program until data about its usage in the CJR model are released publicly and independently analyzed.**

Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty

CMS proposes to return a revised version of the THA/TKA Complications measure to the HIQR Program beginning with the FY 2024 payment determination. The original measure version was removed from the Program as part of burden reduction efforts during FY 2018 IPPS rulemaking and has since undergone comprehensive review. The proposed revised measure version differs from its predecessor by the addition of 26 ICD-10 diagnostic codes for mechanical joint prosthetic complications to the numerator (outcome) specifications. CMS plans to replace the predecessor original measure version that currently remains in the HVBP Program with the revised measure if finalized, once the statutory requirement for public display of the revised measure's results in the HIQR Program for a year has been met.

CHA supports the adoption of the proposed revised version of the THA/TKA Complications measure into the HIQR Program. Complication rates are highly valuable for provider self-improvement and beneficiary decision making. We are concerned, however, that for a period of at least one year, two slightly different versions of this claims-based measure will be applied to hospital performances and yield differing results, one set for the HIQR Program measure (revised version) and a second set for the HVBP Program measure (original version). This could make accurate interpretation of their performance results difficult for hospitals and easily confuse consumers when publicly reported. CHA asks CMS to share its plan to mitigate adverse effects of this version mismatch. We would prefer that the revised measure version be NQF-endorsed, but it was supported by the MAP for rulemaking and we understand that CMS plans to submit the measure to NQF in the near future. Finally, we reiterate our prior objection to simultaneous use of this measure in the HIQR and HVBP programs, effectively creating a double-jeopardy scenario for hospitals. We advise CMS to consider avoiding that scenario by planning to remove the revised measure from the HIQR Program when it is adopted onto the HVBP Program as a replacement for the original measure version.

Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty

CMS proposes to adopt a refined version of the current THA/TKA Episode Payment measure beginning with the FY 2024 payment determination. The measure numerator would be revised to include the same 26 additional ICD-10 diagnostic codes for THA/TKA complications that are also being proposed for addition to the THA/TKA Complications measure. The proposed update was developed as a result of routine measure maintenance review. Prior to refinement, this measure was NQF-endorsed and CMS plans to submit the refined measure to NQF in the near future.

CHA would prefer the refined measure to be NQF-endorsed and we encourage CMS to expeditiously seek NQF review or to consider delaying measure adoption. We do believe the refined measure to be an improvement over the current version, as CMS indicates it would capture complications being missed by the current measure version. However, we are concerned about overlap between this episode payment measure and the MSPB-Hospital measure that CMS is also proposing to reintroduce to the HIQR Program for FY 2024.

Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)

CMS proposes to refine the AMI EDAC measure by increasing the minimum case count from 25 to 50 cases. This change is designed to address reliability concerns identified during routine measure maintenance review.

CHA supports this change to increase measure reliability. However, we do not support continued inclusion of the AMI EDAC measure in the HIQR Program. The proposed revision does not

address the problem of lumping readmissions, observation stays and ED visits into a single category. Combining these very different care settings and approaches to patient care yields a number of days that is difficult to interpret and not actionable. We also note that this measure was added on the assumption that then-new readmission measures would increase use of observation stays and ED visits, but evidence to support that assumption has not emerged.

Hospital-Harm—Opioid-Related Adverse Events eCQM

CMS proposes adding an outcome measure designed to measure adverse effects of opioid administration to hospital inpatients as defined by use of naloxone for opioid reversal outside of an Operating Room setting. This measure has had a lengthy development history involving multiple refinements.

CHA supports efforts led by CMS to address our nation's opioid epidemic, but we are uncertain that adoption of this measure will be impactful. We do not object to the proposed measure itself, which appears to better capture true "rescue event" uses of naloxone than prior versions. However, we note that the overall number of inpatient naloxone rescue events is small. More generally, we are concerned about the substantial cost and time burden faced by hospitals when adopting new eCQMs. If CMS proceeds to finalize adopting this measure into the HIQR Program, CHA recommends to CMS that it remain for the foreseeable future in the optional, self-selected for reporting category.

- **Actions to Improve the Quality and Safety of Maternal Care**

Reducing maternal morbidity, ending disparities in maternal health outcomes and improving the health of mothers and infants is a top priority for CHA. Providing compassionate care for mothers and babies has long been an integral part of the founding ministries of Catholic health care, and we strongly support the development of measures to improve the quality of maternal health care. We fully agree with CMS that more must be done to protect health and lives of mothers and infants.

Establishing the Maternal Care Designation

CMS proposes to establish a hospital designation reflecting the quality and safety of maternal care. Hospital designation would be publicly displayed on a public-facing CMS website beginning later this year. CMS further proposes to award designation initially to those hospitals that report "Yes" to both questions embedded in the Maternal Morbidity Structural Measure of the Hospital IQR Program. Additionally, CMS intends to expand the requirements for designation, possibly adding the proposed Cesarean Birth and Severe Obstetric Complications measures, if finalized, as a next step.

CHA agrees with CMS that more must be done now to protect health and lives of mothers and infants. Delivering compassionate care for mothers and babies remains an integral part of Catholic health care. **We support the proposed designation program and other initiatives designed to improve the quality of maternal health care.** We support beginning with the current Maternal Morbidity measure but urge CMS to move quickly beyond attestation to outcome measures. Adding the proposed Cesarean Birth and Severe Obstetric Complications eCQMs is a reasonable next step if feasibility questions about them are resolved and they achieve NQF endorsement. Patient-reported measures and experience-of-care surveys could add significant value.

Request for Information (RFI): Additional Activities to Advance Maternal Health Equity

CMS asks if and how changes in the hospital Conditions of Participation (CoP) could be used to leverage improved (QI) maternity care and address maternal outcome disparities.

While we fully support the necessity of timely initiatives to improve maternity care in general and to resolve maternity care disparities, CHA urges caution in using the CoP for these purposes. The conditions are often structured in a manner that sharply limits approaches that are acceptable for meeting the conditions. That structure is designed to be appropriate for requirements that rise to the level of potential loss of Medicare certification but is inappropriate as an approach to foster the innovation and flexibility that will best advance maternal health care quality and equity. Unintended adverse consequences are also a serious risk of inappropriate application of the CoP. The penalty for noncompliance with the conditions, exclusion from the Medicare program, is draconian and is most likely to threaten facilities with greater resource challenges, such as rural, low-volume, and safety-net hospitals. Access to maternity care could be seriously reduced as those facilities respond to the threat by eliminating labor and delivery services. Similarly, using the CoP as a lever is highly likely to discourage facilities to newly engage in maternity care. The risk of Medicare exclusion adds significantly to the downside of initiating labor and delivery service provision, including costs for specialized equipment and personnel. Rather than CoP changes, CHA encourages CMS to explore ways to incent improvement and expansion of maternity care.

CMS asks about challenges to collecting maternal health risk data stratified by demographics to be used in quality improvement efforts. CHA members have considerable experience in collecting a broad range of social risk factor and demographic data from all of our patients, including those receiving maternity care. Challenges encountered include the following:

- Need for standardized definitions of social risk factors and demographic concepts (e.g., ethnicity, gender identity);
- Engendering confidence in patients that their self-reported, sensitive personal information (e.g., marital status, interpersonal violence) will be protected from unauthorized release, including to governmental and judicial system entities; and

- Finding a quiet and unpressured time in which to collect sensitive information, separate from the urgency of admission for a woman in labor and from the flurry of discharge planning for mother and infant.

CHA recommends that CMS first focus on the standardization, use and sharing of data that is already being collected by hospitals. Many of our members already collect numerous social risk factor and demographic variables while caring for mothers and babies. Effective staff training programs to support culturally competent and compassionate interactions during data collection are essential, and CMS should facilitate sharing of curricula and best practices among hospitals. CHA recommends that arbitrary requirements for the timing of data collection be avoided (e.g., during the admission process), as very few social risk or demographic variables will change importantly from admission to discharge.

- **Medicare Promoting Interoperability Program**

Policy Revision: Increasing eCQM Reporting Requirements for the HIQR Program and the Promoting Interoperability Program

CMS proposes to modify the current eCQM reporting requirements by increasing eCQM reporting from a total of four required eCQMs (one mandatory and three self-selected) to six required eCQMs (three mandatory and three self-selected) beginning with the CY 2024 reporting period/FY 2026 payment determination. To maintain the alignment of reporting requirements between the HIQR Program and the PIP, CMS would make this proposal applicable to both programs.

CHA appreciates efforts made by CMS to align eCQM reporting requirements for the HIQR Program and the PIP. Alignment partially mitigates the cost and time burdens of eCQM implementation and maintenance incurred by our members. **However, expanding the eCQM reporting requirement of specified mandatory measures from four to six in a single year represents a substantial change in a short timeframe.** CHA recommends a delayed and phased implementation of this policy change over several years, particularly since CMS has indicated actively working to move from eCQMs to digital quality measures (dQMs) by 2025. CMS also has stated that revising eCQMs to dQMs will be an early step in the agency's plan for transitioning to digital quality measurement. CHA recommends that CMS coordinate its strategies to expand eCQMs in its quality and PIP programs with its plan for revising those same measures to dQMs to avoid unnecessary and costly overlap and conflicts.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2023 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments

or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Lisa A. Smith
Vice President
Public Policy and Advocacy