



A Passionate Voice for Compassionate Care

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-1752-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year (FY) 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program

Dear Administrator 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, 2021. (86 Federal Register 25070). 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.

- **Market-Based Medicare-Severity Diagnosis-Related Group (MS-DRG) Relative Weights**

In the FY 2021 IPPS final rule CMS finalized a requirement for hospitals to report the median MA payer-specific negotiated charge by MS-DRG on their Medicare cost report effective for cost reporting periods ending on or after January 1, 2021. CMS also finalized a policy to use the median MA payer-specific negotiated charge in the MS-DRG relative weight methodology beginning with FY 2024.

Public comments on the change to the Medicare cost report made as part of the Paperwork Reduction Act process raised questions about the usefulness of this data. CMS also further considered the many contract arrangements hospitals use to negotiate rates with MA plans. For these reasons, **CHA supports the proposal to repeal the reporting requirement and its plan**

to use payer-specific MA negotiated rates in the MS-DRG relative weight methodology for FY 2024 and subsequent fiscal years.

- **FY 2022 Outlier Threshold**

CMS proposes an FY 2022 outlier threshold of \$30,967, a 6.5 percent increase over the FY 2021 outlier threshold of \$29,064. Normally, CMS would calculate the outlier threshold based on the latest claims and cost report data. For FY 2022, the latest year of claims data would be from FY 2020 and the latest cost report data would be from 2019 and 2020. However, CMS provides an analysis showing that the latest available data, which is from the 2020 period of the COVID-19 public health emergency (PHE), are atypical and will impact the outlier threshold.

These data are atypical because of the suspension of elective admissions and the high number of COVID-19 respiratory cases during the early months of the pandemic. If CMS continued to use the latest available data, its analysis shows that the FY 2022 threshold would be \$36,483 or \$5,516 higher than threshold proposed. **CHA supports CMS' proposal to continue using claims data and cost report data from prior to the pandemic to set the FY 2022 outlier threshold.**

- **MS-DRG Relative Weights**

CMS revises the MS-DRG groups and weights annually to reflect changes in technology, medical practice and other factors. Ordinarily, CMS uses the latest available claims data (FY 2020 claims for FY 2022 MS-DRG relative weights) and Medicare cost reports (FY 2019 cost reports for FY 2022 rate-setting) to determine the MS-DRG relative weights. However, similar to the policy CMS proposed for setting the outlier threshold, CMS proposes to use claims data and Medicare cost report data preceding the pandemic to determine the FY 2022 MS-DRG relative weights because the data CMS ordinarily uses will span the period of the pandemic and is atypical and will impact rate-setting.

CMS presents a complex analysis for why the FY 2020 claims data and FY 2019 Medicare cost report is atypical and will affect the calculation of the MS-DRG relative weights. **CHA agrees with CMS' analysis and supports its proposal to use older pre-pandemic data to set the FY 2022 MS-DRG relative weights.** Nevertheless, CHA does urge CMS to further consider the following points:

FY 2021 Claims Data and FY 2020 Cost Reports for Setting FY 2022 MS-DRG Relative Weights: The COVID-19 pandemic began in March of 2020 in the U.S. and extended well into FY 2021. While the suspension of doing elective procedures may have ended by the beginning of FY 2021, there was still significant spread of COVID-19, including many cases being treated on an inpatient basis, in the first two quarters of FY 2021. The presence of COVID-19 cases in hospitals may have made patients in need of other hospital services reluctant to seek inpatient

treatment. CMS will need to consider whether it needs an analogous policy for the FY 2023 IPPS rule that it proposed for FY 2022.

- **MS-DRGs**

In the FY 2020 IPPS proposed rule, CMS proposed changes to the severity level designations—either a major complication and comorbidity (MCC), a non-major complication and comorbidity (CC) or neither—for 1,492 ICD-10-CM diagnosis codes. Many commenters expressed concern with CMS’ proposal and recommended that CMS conduct further analysis. In the FY 2020 final rule, CMS postponed adoption of the proposed comprehensive changes in the severity level designations to allow further opportunity to provide additional information to the public on the methodology utilized and clinical rationale for its proposals

CMS indicates that it plans to continue a comprehensive MCC and CC analyses using a combination of the prior mathematical analysis of claims data in combination with nine guiding principles that are listed in the rule. As interim step before proceeding with changes to MCC and CC designations, CMS is proposing to demote 3,490 codes that are classified as MCCs and CCs identified as “unspecified” to non-MCCs or CCs when there are other codes available in that code subcategory that further specify the anatomic site. The proposed rule indicates a concern that use of “unspecified” diagnosis codes may contribute to less reliable data for researching clinical outcomes.

CHA urges CMS to use caution in proceeding as we believe there is insufficient analysis in the proposed rule to justify finalizing the proposed policy at this time. If the costs of patients with an “unspecified” diagnosis mandates higher payment as an MCC or CC case, it would be unfair to demote these cases to a non-CC DRG and pay them less.

- **Changes to the Wage Index**

Continuing a Transition on Reductions to the Wage Index

In FY 2021, CMS made significant changes to labor market areas based on Office of Management and Budget 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 FY 2021 final rule, CMS adopted a policy that limited reductions in the hospital wage indexes to 5 percent. CMS is now seeking comment on whether, in light of the public health emergency, to continue to limit the decrease in a hospital’s wage index resulting from use of the new OMB CBSA delineations. Such an extended transition could potentially take the form of continuing the FY 2021 wage index for those hospitals experiencing a continuing reduction in the wage index in FY 2022 from the adoption of the new CBSAs.

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CHA agrees that CMS should continue to limit reductions in a hospital's wage index from year-to-year and should do so in a budget neutral way. However, we do not believe the limitation on the reductions should be limited only to those result from adoption of new OMB CBSA delineations. **CHA recommends that CMS adopt a limitation on reductions in the wage index that occur for any reason.**

Changes to Urban to Rural Cancellation Requirements

In the FY 2020 IPPS/LTCH PPS final rule, CMS noted concerns about relatively low wage hospitals timing an urban to rural reclassification to become effective after the wage index has been set for the following year to avoid reducing their state's rural wage index. These hospitals then cancel their rural reclassifications effective for the next fiscal year and then reapply to become rural again after the wage index is set for the subsequent fiscal year. CMS says that at least twenty-one hospitals in one state and five hospitals in another state engaged in this practice for FY 2020. CMS proposed two policies to address possible misuse of urban to rural classification.

While CHA understands CMS' concerns in this area, we also believe any new policy should not interfere with the ability of hospitals to reclassify or cancel a rural reclassification for legitimate policy reasons such as becoming a Medicare Dependent Hospital or obtaining a higher cap on residents for graduate medical education payments. **For this reason, CHA urges CMS to ensure the proposed policies do not limit the flexibility of hospitals to cancel an urban to rural reclassification for reasons other than to effect a change in the rural wage index.**

- **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 (ACA). 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 \$8.3 billion in FY 2021 to \$7.6 billion in FY 2022, a decrease of 8 percent or \$662 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.

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To determine Factor 1, CMS begins with an estimate of what Medicare DSH payments would have been in the absence of the ACA and applies several adjustments to that amount to reflect inflation, changes in discharges and case-mix, and an “other” category which includes changes in Medicaid enrollment.

The proposed rule indicates a 7 percent decrease in Factor 1 for FY 2022 compared to FY 2021 largely driven by a decrease in discharges and the “other” category. As CMS is using data for the Factor 1 estimate for FY 2022 from September of 2020 and March of 2020 it is critically important that these data be updated to reflect the latest discharge information for FY 2022 to ensure that hospitals are accurately paid for their uncompensated care costs. **CHA urges CMS to update the data used to forecast Factor 1 for FY 2022 in the IPPS final rule.**

It is not clear from the proposed rule what factors account for the difference between the increase in Medicaid enrollment and the other factor. Of those mentioned, the 2-midnight rule is not likely to explain the difference as that policy has been in effect for many years. The 20 percent add-on for COVID-19 discharges would contribute to an increase, not a decrease in the “other” factor. The only other factor mentioned that could account for this difference is the adjustment between for the difference between total inpatient hospital discharges and IPPS hospital discharges. **CHA requests that CMS explain how the difference between total inpatient discharges and IPPS hospital discharges affects the determination of the “other” factor.**

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2021 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 2018 (85 FR 32751).

In selecting use of the NHEA to determine Factor 2, OACT states:

Timeliness and continuity are important considerations because of our need to be able to update this estimate annually. Accuracy is also a very important consideration and, all things being equal, we would choose the most accurate data source that sufficiently meets our other criteria.” (86 FR 25448)

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.” (86 FR 25449) **CHS urges OACT to update Factor 2 with more timely and accurate data to reflect the increase in FY 2021 and FY 2022 in uninsured patients.**

Distributing Uncompensated Care Payments

For FY 2022, CMS proposes to use one year of audited Worksheet S-10 data from FY 2018 for distributing uncompensated care payments. In the past, CHA has commented that CMS should

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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 audited Worksheet S-10 data in the uncompensated care distribution.

In the past, CMS used three years of data to distribute uncompensated care payments. Using three years of data lessens instability and mitigates wide swings in hospital payments from year to year. CMS proposes to use only one year of data stating that using multiple years of data would potentially dilute the effect of revisions to the cost reporting instructions that were effective on October 1, 2017 (FY 2018 cost reports) while introducing unnecessary variability into the uncompensated care determinations.

CHA disagrees that using multiple years of data will introduce unnecessary instability into the determination of a hospital's uncompensated care payment. Rather, CHA believes using multiple years of data will improve stability in the determination of these payments. While CMS is correct that FY 2018 and FY 2017 cost reports were submitted under different Worksheet S-10 instructions, both years of cost reports have been audited. For this reason, **CHA requests that CMS base the uncompensated care distribution on two years of audited Worksheet S-10 data in FY 2022 (FY 2017 and FY 2018 cost reports) and three years of audited Worksheet S-10 data in FY 2023 (FY 2017, FY 2018 and FY 2019 cost reports) and going forward to mitigate large year-to-year changes in a hospital's uncompensated care payments.**

Definition of Uncompensated Care

CMS does not propose any changes to its definition of uncompensated care from prior years. Under this definition, CMS would recognize non-Medicare bad debt and charity care. However, CMS would not recognize payment shortfalls from public health programs like Medicaid, the Children's Health Insurance Program and state and local indigent care programs. **CHA believes that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, the Children's Health Insurance Program and state and local indigent care programs.** This approach would be a fairer way to allocate uncompensated care to hospitals, especially given that analyses we have reviewed suggest that hospitals located in states that opted out of Medicaid expansion do significantly better under the CMS proposed approach than hospitals located in states that have expanded Medicaid. Broadening the definition to include Medicaid shortfalls and other forms of unreimbursed costs of other public health care programs would help make the allocation more equitable.

Puerto Rico, Tribal and Indian Health Service Hospitals

For Puerto Rico, Tribal and Indian Health Service (IHS) hospitals, CMS is not using Worksheet S-10 to determine their uncompensated care payments. Rather, because of special reporting issues that make Worksheet S-10 inaccurate for these hospitals, CMS proposes to continue to

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using low-income patient days as a proxy for uncompensated care in FY 2022 for these hospitals. **CHA supports this proposal.**

In the FY 2021 IPPS rule, CMS discussed potentially removing Tribal and IHS hospitals from the uncompensated care distribution beginning FY 2022 (85 FR 58824). Given the unique nature of IHS and Tribal hospitals serving a vulnerable Native American community with special health care needs, Medicare would pay Tribal and IHS hospitals 100 percent of Medicare DSH instead of 25 percent of Medicare DSH and uncompensated care. CMS does not mention this proposal in the FY 2022 IPPS proposed rule. **CHA supported CMS adopting this idea beginning in FY 2022 and asks that CMS explain why it did not propose and appears to no longer be considering this idea.**

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

The Consolidated Appropriations Act, 2021 (CAA), division CC, contained 3 provisions affecting Medicare DGME and IME payments to teaching hospitals.

New Residency Positions:

Section 126 of the CAA makes available 1,000 new Medicare-funded GME positions (but not more than 200 new positions for a fiscal year) to be distributed beginning in FY 2023, with priority given to hospitals in four statutorily-specified categories.

1. Hospitals located in rural areas or treated as rural for IPPS purposes;
2. Hospitals that are training more residents than their FTE cap;
3. Hospitals in states with new medical schools or additional locations and branches of existing medical schools; and
4. Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs).

As CMS is limited by statute in the number of additional resident slots it may award and it expects hospitals will qualify for more residents than the limit, CMS is proposing to limit any qualifying hospital to 1.0 per hospital per year. CMS would further prioritize among hospitals based on residency programs that provide services to medically underserved populations using health professional shortage area scores as a measure of the severity of a primary care or mental health shortage.

Alternatively, CMS considered prioritizing hospitals that qualify in more than one of the four statutory eligibility categories. Hospitals that qualify under all four categories would receive top priority, hospitals that qualify under any three of the four categories would receive the next highest priority, then any two of the four categories, and finally hospitals that qualify under only one category.

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The CAA allows hospitals to receive up to 25 additional positions over the course of five years. We believe the proposed limitation of 1.0 slot per hospital is too limiting and could even deter programs from applying for additional slots. While we appreciate the desire to maximize the number of hospitals that benefit, CMS should instead take an approach that gives flexibility to distribute slots to hospitals most in need and makes operational sense for hospitals. **CHA urges CMS not to finalize the proposed 1.0 limit on annual hospital slots.** If CMS decides to finalize a number smaller than that allowed by the statute, it should allow no fewer than 5.0 slots per hospital per year and should revisit the cap after CMS and hospitals have gained experience with the new process.

CHA supports in principle prioritizing allocation of new resident slots among those areas that are primary care and mental health shortage areas. We ask, however, that CMS clarify that shortage areas can be rural or urban and that CMS continue to seek input from stakeholders on how best to maximize the effectiveness of the new slots

Rural Training Tracks (RTT):

Section 127 of the CAA makes statutory changes relating to the determination of both an urban and rural hospital's FTE resident limit for direct graduate medical education (DGME) and indirect medical education (IME) payment purposes. These changes address shortcomings of the prior statute that generally only provided exemption from FTE caps to urban hospitals participating in RTTs and not the rural hospitals that provided training sites.

CMS is proposing that each time an urban hospital establishes a relationship with a new rural hospital for an RTT, both the urban and rural hospital would receive a 5-year exemption for the new program from the DGME and IME FTE caps to allow the program to grow to full capacity. **CHA supports this proposal.**

CMS further proposes technical changes consistent with the CAA that would allow for RTT programs in any specialty—not just family practice as long as 50 percent or more of the training occurs in a rural area, CMS would allow the program to qualify as an RTT for the 5-year exemption to the DGME and IME FTE cap. **CHA supports this proposal.**

Resident Caps and Per Resident Amount for Hospitals that Hosted a Small Number of Residents for a Short Duration:

Section 131 of the CAA makes statutory changes to the determination of DGME per resident amounts (PRA) and DGME and IME FTE resident limits of hospitals that hosted a small number of residents for a short duration. This provision allows particular hospitals that may have inadvertently established a low PRA or an FTE cap based on small number of residents rotating in from another hospital's residency program to have their PRA and FTE caps reset.

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The threshold for resetting the PRA and FTE cap differs based on whether the hospital's cap was less than 1.0 FTEs (for cost reporting periods beginning before October 1997) or 3.0 FTEs (for cost reporting periods beginning on or after October 1, 1997 and before December 20, 2020 consistent with the statute. CMS proposes that the cap and PRA can be reset for hospitals that meet the requisite thresholds that are training residents between the December 27, 2020 enactment of the CAA and December 26, 2025 (5 years from enactment). A hospital can qualify for a reset FTE cap or PRA regardless of whether the residency program is new or existing.

CHA supports this proposal.

- **Medicare Bad Debt Policy**

Medicare bad debt is uncollectible deductible and coinsurance amounts owed but not paid by Medicare beneficiaries. Under specific circumstances, Medicare bad debt can be partially reimbursed to hospitals. In the case of dual eligible Medicare/Medicaid beneficiaries, hospitals are obligated to bill the beneficiary's state Medicaid plan to determine whether the state is responsible for paying Medicare deductibles and coinsurance. The state Medicaid plan would then be obligated to provide remittance advice indicating whether it is responsible for beneficiary cost-sharing.

In the FY 2021 IPPS rule, CMS reported that state plans do not always fulfill their obligation to provide remittance advice (85 FR 59001). The lack of remittance advice from the relevant state agency means the hospital cannot claim the unreimbursed amounts as bad debt. In the FY 2022 IPPS proposed rule, CMS proposes a state Medicaid agency would be required to allow enrollment of all Medicare-enrolled providers and suppliers for purposes of processing claims to determine Medicare cost-sharing if the providers or suppliers meet all Medicaid enrollment requirements, even if the Medicare-enrolled provider or supplier is of a type not recognized by the state Medicaid agency. **CHA supports this proposal.**

- **Cross-Program Measure Suppression Policy: Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing Program (HVBP), and Hospital-Acquired Condition Reduction Program (HAC RP)**

CHA appreciates that CMS realizes the many and significant ways, largely outside the control of hospitals, that the COVID-19 public health emergency (PHE) has impacted the Medicare program's quality data collection, reporting, and results for hospitals. We further appreciate that CMS has broadly applied its discretionary authority during the PHE to support continuous delivery of patient-centered care by hospitals and their personnel through granting policy waivers and adopting regulatory flexibilities. We also share the particular concern expressed by CMS that, absent policy interventions, the payments and penalties of its pay-for-performance (P4P) programs could be inequitable, especially for hospitals treating large numbers of COVID-19 patients. **We are grateful to CMS for their proposals regarding cross-program and**

individual program measure suppression as the net outcomes generally will support our members in continuing their mission to serve vulnerable patients.

CHA supports the purpose of the cross-program measure suppression policy proposed by CMS for application to the inpatient hospital pay-for-performance (P4P) programs, namely, preservation of equitable payments across hospitals under these three programs. Our understanding is that the policy would permit CMS to suppress the use of data from one or more measures in a P4P program when the agency judges that PHE-related circumstances have significantly compromised measure data and resulting performance scores. Coincident with data suppression, CMS would design performance scoring and payment calculation modifications for each program to preserve payment equity across hospitals required to participate.

CMS proposes a set of Measure Suppression Factors to guide its determination of when to apply the cross-program measure suppression policy. We support the proposed set of factors to be comprehensive and rational decision-making guides. CMS further proposes that the policy would begin in FY 2022 and apply for the duration of the PHE. CMS also proposes to report performance results to hospitals calculated using available data and to continue public results reporting as provided for in previously established P4P individual program policies. The agency states that publicly reported information would be accompanied by an explanation of the source data limitations due to the COVID-19 PHE.

We have several comments and questions for CMS:

- What is meant by policy adoption “for the duration of the COVID-19 PHE? Does this automatically correspond to the expiration date of the most recently issued renewal of the declared PHE or will an end date for the purpose of this policy be explicitly stated? CHA strongly recommends that CMS allow for the as yet incompletely known future needs of chronically ill COVID-19 survivors (“long haulers”).
- We ask CMS to clarify when and through what process the agency would expand the set of factors if as yet undetected PHE effects on measures or scoring were to be identified.
- The COVID-19 PHE could extend beyond FY 2022, particularly if booster vaccination doses are required or more aggressive viral variants emerge. In the interests of clarity, transparency, and collaboration, CHA urges CMS to choose rulemaking as the mechanism for most updates to the cross-program policy.
- We support the confidential reporting to hospitals of results of all available data even for suppressed measures and of unadjusted performance scores. This information may retain value by helping help hospitals candidly assess the strengths and weaknesses of their responses to the PHE.
- CHA does not support public reporting of the results from P4P programs in which measures have been suppressed. 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.

In regards to the agency's questions about cross-program measure suppression policy development for future PHEs, we note the following:

- CHA agrees that CMS should have discretion outside of rulemaking to establish and use measure suppression factors to determine whether measures and performance scores have been significantly and adversely by a future PHE.
- Should CMS identify compromised data and results, CHA would have serious concerns about empowering the agency to move forward with implementing scoring adjustments and related payment changes to the hospital P4P programs outside of rulemaking.
- CHA believes that the propriety of regional or partial measure suppression can only be validly considered in the context of a specific PHE event.

- **Hospital Readmissions Reduction Program (HRRP)**

CHA supports the agency's proposal to suppress the pneumonia readmission measure for FY 2023,¹ and not to use an excess readmission ratio based on this measure for calculating payment reductions for hospitals. We also agree with the exclusion of cases with COVID-19 diagnoses from calculations for payment reductions to hospitals under the HRRP. CMS poses questions about expanding HRRP results reporting from stratification only by dual eligibility to include race and ethnicity and we address these topics below in our response to the separate, broader RFI about closing the equity gap through changes to CMS quality programs.

As CMS continues to evaluate 2020 performance for the PY2023 payment year, we would encourage CMS to consider additional suppression policies to address the impacts of COVID-19 on the other readmissions measures, beyond just excluding patients who have been diagnosed with COVID-19.

- **Hospital Value-Based Purchasing Program (HVBP)**

CHA strongly supports measure suppression and the special scoring policy as proposed for the HVBP for FY 2022. We greatly appreciate the stability provided by what is essentially a budget-neutral solution for hospitals. We also support continued suppression of the pneumonia mortality measure for FY 2023 along with technical updates of the other HVBP Clinical Outcomes domain measures to exclude cases with COVID-19 diagnoses from calculations. **We support the proposed removal of the persistently controversial CMS PSI 90 measure from the HVBP measure set beginning with the FY 2023 payment year.**

¹ Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506)

- **Hospital-Acquired Condition Reduction Program (HAC RP)**

CHA continues to have ongoing concerns about a program that imposes a substantial penalty on a fixed number of hospitals each year, regardless of whether quality improvement has occurred. That said, **we fully support the proposed suppression of Q3 and Q4 CY 2020 data and scoring for multiple HAC RP measures**, including all of the National Health Safety Network (NHSN) Hospital Associated Infection (HAI) measures that are reported to the Center for Disease Control and Prevention (CDC). Some hospitals would still be required by their states to report the NHSN measures to CDC for other purposes. CMS advises these hospitals to apply for individual extraordinary circumstance exceptions (ECEs) so that such reported data would be excluded from all total HAC score calculations. We strongly urge CMS to create a streamlined subregulatory process for such hospitals self-identify to CMS and thereby be automatically granted the necessary ECEs.

- **Request for Information: Closing the Health Equity Gap in CMS Hospital Quality Programs (Equity RFI)**

General Considerations

CHA enthusiastically joins CMS in its commitment to achieving equity in the provision and quality of health services. As a Catholic health ministry, our mission is rooted in our respect for the dignity of each and every human person, created in the image of God. Access to health care is essential to promote and protect the inherent and inalienable worth and dignity of every individual. Our vision for health care calls for a system that achieves health equity by delivering the same level and quality of care to everyone in our nation without exception. Every day our members provide needed health care to all in their community regardless of age, gender, race, ethnicity, sexual orientation or sociodemographic characteristics. They have considerable experience with the delivery of culturally competent care and meeting 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.

This commitment motivated the Catholic health ministry's imitative *We Are Called: Confronting Racism by Achieving Health Equity*. CHA members have committed to working for health 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 policies to end systemic racism and health inequity.

We firmly concur with CMS that more can be done to use performance measurement systems to identify, understand, and eliminate health disparities. We appreciate the opportunity to respond to the Equity RFI, which poses numerous questions with a focus on three areas for potential future actions by the agency: stratifying quality measures by social risk factors, improving

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demographic data collection, and creating a Hospital Equity Score that incorporates multiple social risk factors.

As an introduction to our comments, we suggest the following as essential characteristics of measures focused on issues of health:

- Data-driven: Developed based upon well-documented outcome disparities with clear associations to well-defined social risk factors.
- Actionable: 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: Constructed for timely performance scoring and prompt provider feedback.
- Feasible: Based on considerations of provider burden and CMS operational capabilities.
- Aligned: Standardized and aligned within CMS programs, across agencies and among stakeholders.

Stratified Results Reporting by Race and Ethnicity

CHA echoes our previous support for the use of performance measure stratification as a valuable tool to identify and reduce health disparities, and for use in tandem with risk adjustment for social risk factors where appropriate. Differences in performance measure outcomes due to actual variation in the quality of care provided to subgroups of patients should not be tolerated. Outcomes variation independent of quality of care, however, must be explored and reflected appropriately in measure development and risk adjustment. The choice of social risk factors for stratification should reflect their distribution within a given quality program's patient population. **CHA agrees that race and ethnicity are reasonable choices for stratification for several CMS quality programs using the CMS Disparity Methods, including the Hospital Readmissions Reduction Program (HRRP), in which reporting stratified by dual eligibility status is already underway.** Future stratification factors for consideration should include language preference and disability status; consideration should also be given to applying stratification to results of resource use measures such as the Medicare Spending per Beneficiary.

CHA notes that stratification for race and ethnicity would depend upon having standardized definitions of race and ethnicity and accurate and reproducible race and ethnicity information for all beneficiaries. We favor the practicality of the Office of Management and Budget's standard minimum set of five racial and one ethnicity categories over the added precision of the 900 race and ethnicity concepts of the CDC's code system. To address the known gaps in race and ethnicity data CMS proposes to use a method of indirect estimation. We urge CMS to proceed cautiously. While we share with CMS the desire to move forward expeditiously using the data it has, we are concerned with the high risk of data inaccuracy and measurement bias. Patient self-reporting is widely acknowledged to be the best way to gather accurate sociodemographic data.

We would prefer CMS to focus on efforts to improve access to directly collected self-reported race and ethnicity data.

CHA agrees with CMS that measure results stratified by race and ethnicity must first be confidentially reported to hospitals. Public reporting should not be pursued until sufficient time has elapsed for establishing processes for review and correction and for data validation, demonstrating that the imputed data and results based upon them are highly reliable and reproducible, allowing for emergence and identification of unintended consequences. Prior to public reporting, we recommend strongly that CMS undertake focus groups to test messaging and understanding of the data, so that the results reported are clear and actionable for patients, families, and caregivers. A broad outreach program to educate beneficiaries about stratified results should also be considered.

CHA wants to emphasize the unassailable importance of privacy safeguards for all uses of sensitive personal information such as race, ethnicity, and other social risk factors. A starting point would be to treat these variables as protected health information along with using industry best practices for data protection from cyberattack.

Improving Data Collection

CHA firmly agrees with CMS that improved data collection would allow better measurement of performance and outcomes with respect to individuals with social risk factors. Many of our members already deploy EHR capabilities that facilitate improved collection and routinely collect race, ethnicity, and language preference data; they are also already expanding their efforts to link their data to quality measurement. Our hospitals already have effective programs for training staff members to interact with patients and families in ways that are culturally competent and respectful when collecting sensitive information.

We note that most social risk factors will not undergo change during a hospitalization and that data collection near the time of discharge intended to optimize discharge planning is likely to be more productive than attempts at data collection during the often hurried admissions process. CHA appreciates the value of collecting a standardized set of social, psychological, and behavioral data along with race and ethnicity for each patient to be shared with multiple users for a variety of purposes. We are, however, extremely concerned by the privacy, burden, and cost implications, much of which would be borne by hospitals. Before considering additional data collection requirements we urge CMS to consult with stakeholders and focus on the standardizing, use and sharing of data that is already being collected by hospitals.

Hospital Equity Score

CMS seeks input about a summary score aggregating hospital performance data across multiple quality measures and social risk factors as a means of enhancing the utility of stratified data

reporting. The Hospital Equity Score (HES) would be modeled on the recently developed Health Equity Summary Score (HESS) for stratified reporting by MA plans on quality and patient experience measures by race, ethnicity, and dual eligibility. A period of undefined duration during which confidential results would be shared with hospitals would precede any public reporting.

CHA commends CMS for forward thinking about a key end-user of hospital quality performance results -- the beneficiary -- and agrees generally that an HESS-type score could resonate well with patients and their families. **However, consideration of a hospital equity score is quite premature.** The HESS has only been described publicly to date in proof-of-concept terms; no actual implementation experience appears to be available. We note that in the proof-of-concept HESS simulation study, HESS scores for both CAHPS and HEDIS measures were calculable for only 44 percent of 398 MA plans analyzed using a combination of self-reported and indirectly estimated race and ethnicity data for stratification. We are also not convinced that a hospital level equity score would provide useful information for patients or hospitals. For example, an overall positive score could mask poor performance on particular measures and/or among certain subpopulations. While an appropriate sense of urgency should inform our work toward the goal of ending health inequity, the obligation to improve the health of our patients and communities demands that we ensure our tactics are well-tailored to achieving that goal.

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

Proposed Measures

Maternal Morbidity Structural Measure: CMS proposes to adopt one new structural measure to determine whether hospitals are participating in a state or national perinatal quality improvement collaborative and whether participating hospitals are implementing safety practices or bundles related to complications and maternal morbidity. 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. **We support the development of measures to improve the quality of maternal health care. While we do not object to the proposed measure, we generally prefer that measures receive NQF endorsement before being included in the IQR measure set and this measure has not yet been endorsed. But we agree that more must be done to protect health and lives of mothers and infants and we urge CMS to encourage the development and adoption of performance and outcome measures that will more directly assess the quality of maternal health care.** We also note that additional guidance and clarification is necessary before the proposed measure is adopted, concerning which state and national programs would qualify and how to address variation across state programs.

COVID-19 Vaccination among Health Care Personnel (HCP) Measure: CMS proposes to add a new process measure to the IQR Program beginning with FY 2023 to track the percentage of health care personnel who receive a complete COVID-19 vaccination course. CMS proposes an initial data submission period of October 1 through December 31, 2021, for use in the FY 2023 IQR Program, with data reported for at least one week of every month in the reporting period. For FY 2024 and subsequent years, CMS proposes a full calendar year reporting period. CMS proposes to publicly report the CDC's quarterly summary of the COVID-19 health care personnel vaccination measure. CHA and its members are working actively to promote equitable COVID-19 vaccination for employees, patients and everyone in our communities. However, we do not support the adoption of a mandatory health care personnel vaccination measure at this time. We are concerned about the unintended consequences it could have on vaccination rates, given the unique circumstances of the COVID-19 pandemic. While we believe the three vaccines in use are safe and effective, they are still operating under the Food and Drug Administration's emergency use authorization. We also note that much is still unknown about the need for booster shots or annual shots, and that measure specification revisions may be required in the short-term based on availability of new vaccines. **Given these considerations, and that the measure has not yet received NQF endorsement, we recommend CMS delay implementation of this measure.**

Hybrid Hospital-wide All-cause Mortality Measure: CMS is proposing the addition of a new, NQF-endorsed, hybrid measure: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure with Claims and Electronic Health Record Data to begin voluntary reporting July 1, 2022 followed by mandatory reporting beginning July 1, 2023. CHA believes that refining risk adjustment using EHR information has potential to improve the value of this measure in distinguishing hospital mortality performances and we support the testing of this and similar measures. **However, we do not support the automatic transition to a mandatory measure as proposed. Transition should occur only when sufficient experience and analysis are available to confirm the benefit of the added effort of hybrid measure reporting.**

Glycemic Control eCQMs: CMS is proposing to add two new eCQMs addressing adverse events from failure of glycemic control: Hospital Harm – Severe Hypoglycemia Electronic Clinical Quality Measure and the companion Hospital Harm – Severe Hyperglycemia Electronic Clinical Quality measure. Both are NQF-endorsed and are also being proposed in this rule for adoption into the hospital Promoting Interoperability program (PIP) by CMS. **CHA appreciates the ongoing commitment by CMS to align the hospital IQR Program eCQMs with those of the PIP. We support adding these NQF-endorsed measures to the IQR program.**

Measures for Removal

CMS is proposing to remove five measures from the program, none of which would be retained for use in the hospital inpatient P4P programs; two would be replaced by new measures. CHA

supports removal of these measures and appreciates ongoing attention by CMS to burden reduction through removal of measures that are no longer clinically relevant.

Future Measure Considerations

30-Day Mortality Rate for Patients Admitted with COVID-19 Infections: CMS asks for input into development of a hospital all-cause 30-day mortality measure for patients admitted with COVID-19 infections: The measure would be structured similarly to the existing hospital IQR mortality measures. We acknowledge such a claims-based measure could provide potentially valuable information. **However, we do not support its adoption at this time.** We have concerns about whether appropriate risk adjustment methodologies and performance standards could be set for mortality rates related to a previously unknown infection that had different impacts across regions and hospitals as the pandemic progressed. We would not want this measure to be adopted for performance scoring or public reporting for the foreseeable future.

Patient-Reported Functional Outcome Measure Following Elective Total Knee or Total Hip Arthroplasty: CMS is considering future IQR program adoption of the patient-reported functional outcome measure following elective total knee or total hip arthroplasty that is currently available for voluntary reporting by hospitals participating in the Comprehensive Care for Joint Replacement (CJR) model. The long-term (12-month) patient-reported follow-up that is part of this measure has considerable future potential value for beneficiary decision-making if and when results are publicly reported. **We are aware, however, that reporting this measure has proven extremely challenging and quite burdensome for CJR participant hospitals and would advise CMS to defer adoption of this measure** into other CMS quality programs until the CJR model ends and all of its data have been independently evaluated and until total joint arthroplasty procedure volumes and practice patterns return to pre-COVID-19 PHE levels.

CEHRT Edition Update

Beginning with the CY 2023 reporting period/FY 2025 payment determination, CMS is proposing to require hospitals to use only certified EHR technology (CEHRT) that has been updated consistent with the 2015 Edition Cures Update to submit data to the IQR program. Similarly, all available electronic clinical quality measures (eCQMs) and hybrid measures (EHR + electronic combination) would need to be reported using 2015 Edition Cures Update CEHRT. CHA appreciates the effort by CMS to maintain alignment of the CEHRT Edition requirements across the IQR and PIP measures. **We support a gradual transition to the 2015 Edition Cures Update version and ask that CMS exercise flexibility when hospitals are delayed in their transitions by vendor issues beyond their control.**

- **Medicare and Medicaid Promoting Interoperability Program (PIP)**

Changes to the Electronic Health Record (EHR) Reporting Period and PIP Scoring Threshold

CHA supports maintaining FY 2023 EHR reporting period as any continuous 90-day interval within the year, but we object to the proposed FY 2024 increase 180 days. The increased flexibility offered by a 90-day period is helpful to those hospitals undergoing an EHR vendor transition or major upgrade during the year, which event happens with some frequency as the requirements of certified EHR technology (CEHRT) continue to evolve. CMS should consider creating an exceptions process for hospitals undergoing transitions to have a 90-day requirement. We agree with the proposed 10-point increase in the PIP's minimum performance scoring threshold but request a delay until the endpoint of the COVID-19 PHE has been identified.

Modified PIP Measures and Objectives

CHA strongly recommends that applicability of proposed modifications to the Provide Patients Electronic Access to Their Health Information Measure be delayed at least one year beyond CY 2022. Many of our members will need additional time to ramp up to be able to maintain all patients' access their information indefinitely, beginning with health care encounters dating back to January 1, 2016. We appreciate the potential value to patients of the concomitant requirement that they be able to access their information via an application of the patient's choice whose configuration meets the technical specifications of the Application Programming Interface (API) in the hospital's CEHRT. However, CHA continues to have serious concerns about safeguarding privacy in a process that allows large-scale vendor access to our systems and the protected health information for which we are held accountable.

CMS proposes a package of changes to the Public Health and Clinical Data Exchange Objective beginning with the CY 2022 EHR reporting period that includes increasing required reporting to four specified measures rather than two (of six) measures of the hospital's choice. CHA strongly supports the intent of the package— to strengthen early warning, fast public health response, and effective and efficient vaccine uptake during future PHEs. **We equally strongly urge CMS to be mindful of added hospital burden, and to adopt the revisions incrementally and only after real-world testing has shown that all states are prepared to receive and process the data as reported by hospitals, which is currently not the case.**

CHA fully supports the burden reduction and added clarity offered by the streamlining of the attestation statements associated with prevention of information blocking from three to one, as proposed. We also support proposals for changes to the electronic clinical quality measure (eCQM) inventory: adding two National Quality Forum endorsed measures and removing four. The latter would be replaced by measures better reflecting current practice. Further, we support retaining the Query Prescription Drug Monitoring Program measure as optional with a proposed increase from five to 10 bonus points.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2022 IPPS rule. We look forward to working with you on these and other issues that continue to

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June 28, 2021
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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,

A handwritten signature in black ink, appearing to read "Lisa Smith". The signature is fluid and cursive, with the first name "Lisa" written in a larger, more prominent script than the last name "Smith".

Lisa A. Smith
Vice President Public Policy and Advocacy