AMERICA'S ESSENTIAL HOSPITALS

June 28, 2021

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

Ref: CMS-1752-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Reporting 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:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high-quality health care across the care continuum and to close the existing health equity gap. We commend the agency's regulatory flexibility to date as hospitals respond to the unprecedented COVID-19 public health emergency (PHE). As the agency finalizes Medicare inpatient payment policies, we ask that it consider the following comments on reducing burden and providing flexibility to hospitals that will be critical in light of the ongoing COVID-19 PHE.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care (UC), and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.[1] These

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed June 6, 2021.

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narrow operating margins result in minimal reserves and low cash on hand, circumstances which have been exacerbated by the financial pressures of COVID-19.

Throughout the COVID-19 pandemic, essential hospitals have been on the front lines screening, testing, and treating COVID-19 patients in their communities. Essential hospitals continue to make substantial investments to maintain capacity for treatment of COVID-19 patients and to lead vaccination efforts in their communities. They were some of the first providers involved in vaccinating health care workers and the general public. As the pandemic continues and hospitals dedicate additional resources to vaccination efforts, essential hospitals face an uncertain financial future.

Compounding these challenges are essential hospitals' complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospitals' patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. In communities served by essential hospitals, approximately 10 million people struggle with food insecurity and nearly 22.3 million live below the poverty line.[2] To address the needs of these populations, members of America's Essential Hospitals constantly engage in robust quality improvement initiatives and have created programs to break down language barriers, address social determinants, and engage patients and families to improve quality of care and equity.

As the nation continues to confront the unprecedented COVID-19 pandemic, we urge the agency to finalize proposals in the quality reporting programs that address the impact of COVID-19 on quality measurement and health outcomes. CMS' flexibility on Medicare inpatient payment policies through this rulemaking will be imperative for the duration of the COVID-19 PHE and beyond. Hospitals will rely on this flexibility as they help their communities recover, provide care to the large number of patients who avoided seeking care during the pandemic and will be sicker and costlier to treat, and prepare for future outbreaks.[3] As proposed, steep reimbursement cuts in the form of Medicare disproportionate share hospital (DSH) payment reductions will devastate hospitals facing an uncertain financial future. To ensure our members have sufficient resources to continue responding to COVID-19 and are not unfairly disadvantaged for providing comprehensive care to complex patients, CMS should consider the following recommendations when finalizing the above-mentioned proposed rule.

1. **CMS should ensure data used to implement the Affordable Care Act's (ACA's) Medicare DSH payment methodology accurately capture the full range of UC costs hospitals sustain when caring for disadvantaged patients.**

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[2] Ibid.

[3] Up to 41 percent of adults avoided or delayed seeking care during the pandemic, resulting in higher morbidity and mortality from chronic and acute conditions. Czeisler M, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. *Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention. September 11, 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm. Accessed June 11, 2021; Gonzalez D, et al. Delayed and Forgone Health care for Nonelderly Adults during the COVID-19 Pandemic. Urban Institute. February 2021. https://www.urban.org/sites/default/files/publication/103651/delayed-and-forgone-health-care-for-nonelderly-adults-during-the-covid-19-pandemic_0.pdf. Accessed June 11, 2021.

The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC. In 2019, our members provided $6.9 billion in UC, representing 16 percent of all UC nationwide.[4]

As mandated by Section 3133 of the ACA, the majority of DSH payments is distributed based on a hospital's UC level relative to all other Medicare DSH hospitals (factor 3). While DSH hospitals continue to receive 25 percent of their otherwise payable DSH payments, the remaining 75 percent is decreased to reflect the change in the national uninsured rate and distributed based on UC burden (referred to as UC-based DSH payments). This change incorporates UC costs into the DSH formula to better target dollars to hospitals with the greatest need.

While we welcome the targeting of DSH funds to hospitals serving the greatest numbers of uninsured and low-income patients, we are concerned about the reductions to DSH payments that have occurred because of the implementation of the ACA's DSH methodology. After multiple years of substantial decreases and two years of slight increases, hospitals in fiscal year (FY) 2021 again saw a decrease in UC-based DSH payments from the previous year. Based on CMS' estimates, hospitals will see an even steeper cut to UC-based DSH payments in FY 2022—an estimated $660 million reduction, to $7.6 billion. Total DSH payments, including the estimated empirically justified amount, are estimated to be $11.1 billion—nearly $1 billion lower than total DSH payments in FY 2021. For essential hospitals, which bear the burden of treating disproportionate numbers of uninsured and underinsured patients, these cuts are unsustainable. Essential hospitals will feel the impact profoundly in FY 2022, as they continue to recover from substantial financial losses related to COVID-19.

Although the ACA has increased access to coverage nationally, essential hospitals still provide high levels of UC as part of their mission. Hospitals in states that have not expanded Medicaid are not experiencing the drop in UC that hospitals in expansion states have seen. Even in expansion states, essential hospitals continue to provide large amounts of UC in different forms, such as treating underinsured patients and increased Medicaid shortfalls. Targeting DSH payments based on a hospital's UC levels might mitigate the effect of the lack of Medicaid expansion, but the overall magnitude of cuts to the UC pool often outweighs any redistributive benefit. As a result, steep cuts to DSH payments are detrimental and unjustifiable for essential hospitals.

We urge the agency to consider how changes in DSH policy will affect essential hospitals and the communities they serve. In particular, the agency should consider how to accurately capture changes in the uninsured rate, which in turn plays a role in determining aggregate DSH payments. CMS also should consider how to define UC for allocating UC-based DSH payments among eligible hospitals and continue efforts to accurately capture all UC costs as data sources evolve and coverage patterns change. In addition, clarifying the Medicare cost report and other guidance would ensure DSH payments are targeted toward hospitals that need them most. In accounting for these considerations, CMS can ensure essential hospitals receive adequate DSH payments to provide vital care to underrepresented populations.

[4] Ibid.

a. CMS should exclude FY 2020 data from the calculation of factor 1 for FY 2022 and be transparent about the other assumptions it uses in estimating factor 1.

As noted previously, CMS' estimate of total UC-based payments in FY 2022 is $660 million lower than the aggregate UC-based payments it finalized for FY 2021. This drastic reduction is driven largely by methodological choices and assumptions CMS makes in estimating the total amount of DSH payments it would have paid hospitals using the pre-ACA methodology. **CMS can address this issue by omitting FYs 2020 and 2021 data in calculating factor 1 and publishing a detailed methodology explaining how it estimated factor 1.**

To calculate the overall pool of UC-based DSH payments in a year, CMS first estimates what hospitals would have been paid in the aggregate using the pre-ACA methodology and reduces that amount by 25 percent to yield factor 1. CMS then reduces factor 1 by the change in the uninsured rate (factor 2), to produce the aggregate UC-based amount to distribute across all Inpatient Prospective Payment System (IPPS) hospitals receiving DSH payments. Because factor 1 determines the size of the UC pool before the adjustment for the change in uninsured rate is applied, CMS' estimates must be accurate and its methodology transparent; stakeholders must be able to replicate the data to verify the accuracy of the figures CMS uses to derive its factor 1.

From implementation of the ACA's DSH methodology in FY 2014 until FY 2020, CMS' estimate of factor 1 increased annually, which is expected given the elements the agency uses to trend forward previous years' pre-ACA DSH estimates. In FY 2022, for the second year in a row, factor 1 in the proposed rule is inexplicably lower than the previous year's factor 1. In FY 2022, CMS estimates pre-ACA DSH payments at $14.1 billion—$1.1 billion lower than the amount used in FY 2021 and $2.5 billion lower than the amount used in FY 2020.

YEARLY FACTOR 1 AMOUNTS FROM IPPS FINAL RULES (IN BILLIONS)

	FY 2014 FR	FY 2015 FR	FY 2016 FR	FY 2017 FR	FY 2018 FR	FY 2019 FR	FY 2020 FR	FY 2021 FR	FY 2022 NPRM
Estimated Pre-ACA DSH Amount	$12.77	$13.38	$13.41	$14.40	$15.53	$16.34	$16.58	$15.17	$14.10
Finalized Factor 1	$9.58	$10.04	$10.06	$10.80	$11.65	$12.25	$12.44	$11.38	$10.57

To estimate how much DSH funding the agency would have distributed in the absence of the ACA's DSH methodology, CMS uses the latest available year of complete DSH payment data (FY 2018) and trends it forward using four factors: the annual payment update, estimated changes in discharges, estimated changes in case-mix, and an "other" category. The "other" category includes the effect of Medicaid expansion on DSH payments and other payment updates not captured in the annual update category. While the payment update factor is determined in each year's rulemaking,

CMS has to estimate the three other factors using incomplete data (due to a data lag in the availability of full discharge information, for example) and various assumptions.

In the rule, CMS revises downward the discharges factor for 2020 and 2021 based on updated data about the effect of COVID-19 on Medicare discharges. As anticipated, during the peak of the COVID-19 pandemic, Medicare discharges dropped significantly—a trend in line with the general drop in utilization during the pandemic, caused in large part by postponed or canceled procedures. The decline in discharges in FYs 2020 and 2021 was significant, causing a large decrease in CMS' estimate of pre-ACA DSH payments. **CMS should exclude data from these two years because they represented an anomaly and a stark departure from usual trends in Medicare discharges, sharply skewing the estimate of pre-ACA DSH payments.** Including data from these two years results in a substantial reduction in DSH payments at a particularly inopportune time, as hospitals are still grappling with the effects of the pandemic.

Omitting data from these years would be consistent with CMS' authority in the Medicare statute and with other policies that CMS proposes in the rule to control for the effects of the pandemic. The paragraph of the Medicare statute that dictates how CMS is to calculate factor 1 notes that the estimate of DSH payments that would have been made in the absence of the ACA is to be "estimated by the Secretary," thus affording CMS significant discretion over how to calculate factor 1.[5] In various other parts of the rule, CMS alludes to the detrimental effect using 2020 data could have on setting rates in FY 2022. For example, CMS proposes to use FY 2019 claims data instead of FY 2020 data in setting payment rates, noting that in 2020, the "utilization of inpatient services was generally markedly different for certain types of services in FY 2020 than would have been expected in the absence of the [PHE]." Further, in calculating each hospital's per discharge UC-based payment amount, CMS proposes to exclude FY 2020 discharges due to the decrease during the pandemic. CMS should apply this logic consistently by excluding the affected years of data from the estimate of pre-ACA DSH payments, as well.

In addition to omitting 2020 and 2021 data, CMS should be transparent about the other assumptions it uses in its factor 1 estimate. In the rule, CMS also revises downward the "other" factor for FYs 2019 through 2021. CMS should clarify what additional data and assumptions led the agency to adjust these factors downward. Because the "other" category is driven by many assumptions, CMS should describe the reasons for the drop in the "other" factor, as well as the case-mix factor. **CMS should be transparent and detailed in explaining its methodology so stakeholders can replicate this information, which directly relates to the aggregate amount of DSH payments paid in a given year.**

[5] Social Security Act §1886(r)(2)(A).

b. CMS should include Medicaid Section 1115 waiver days associated with premium assistance programs and UC pools in its calculation of the Medicaid fraction.

To determine if a hospital is eligible to receive DSH payments, CMS uses a hospital's disproportionate patient percentage (DPP), consisting of a Medicare fraction and a Medicaid fraction. CMS then uses the DPP to calculate a DSH adjustment percentage, which determines the amount of empirically justified DSH payments a hospital will receive. The Medicaid fraction is calculated using the hospital's number of patient days for patients who were eligible for Medicaid (but not entitled to Medicare Part A benefits) divided by the hospital's total patient days. **Consistent with the text of the Medicare statute and recent federal court decisions, CMS should include patient days for patients receiving premium assistance through Section 1115 waivers, as well as patient days for patients whose care was reimbursed through a waiver-based UC pool.**

The portion of the Medicare statute that governs the calculation of the DPP says that in calculating the Medicaid fraction, CMS "may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI."[6] This reference to demonstration projects is to those approved through Section 1115 waivers. In the rule, CMS proposes to include patient days associated with Section 1115 demonstrations in the Medicaid fraction only when the patient directly receives inpatient hospital insurance coverage through the demonstration project. In other words, CMS specifically proposes to exclude patient days paid for through a waiver-based UC pool, as well as patient days for patients who receive premium assistance to purchase private insurance, arguing that these arrangements do not provide individuals with inpatient hospital insurance coverage. CMS' policy since 2004 has been to exclude these types of waivers but several federal court decisions from 2018 to 2020 invalidated CMS' interpretation of the Medicare statute.[7] In response to those federal court decisions, CMS is attempting to re-write the regulations again, to preclude hospitals from counting UC pool and premium assistance waiver days in their Medicaid fractions.

CMS should withdraw this proposal and include these types of Section 1115 waiver days in the Medicaid fraction. Many states expand coverage to individuals through premium assistance programs, while others use UC pools to cover the cost of a variety of services (including inpatient hospital services) for uninsured and underinsured individuals. CMS' proposed language would potentially exclude from the Medicaid fraction days associated with all types of premium assistance waivers, including in states that expand coverage to the newly eligible Medicaid-expansion population through premium assistance programs. Excluding these types of waiver days from the Medicaid fraction would effectively penalize hospitals in states that have chosen different types of arrangements to extend coverage or reimburse for health care services through Section 1115 waivers.

[6] Social Security Act § 1886(d)(5)(F)(vi).
[7] See *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020).

CMS' proposal to distinguish between different types of waiver days is contrary to the Medicare statute. As noted by the U.S. Court of Appeals for the Fifth Circuit, "If patients underlying a given day were Medicaid-eligible or 'receive[d] benefits under a demonstration project,' then that day goes into the numerator. Period." That is, even patients who do not directly receive coverage but "are capable of receiving a demonstration project's helpful or useful effects," such as patients covered by UC pools, are to be included in the Medicaid fraction.[8]

c. CMS should ensure its estimates of the uninsured rate are current and account for regulatory and legislative changes, as well as other timely external factors.

CMS should ensure its estimates of the uninsured rate are up to date and incorporate the effects of regulatory or legislative changes that could drive up uninsured rates. CMS also should account for other external factors, such as economic shifts, that could change the uninsured rate. The ACA directs CMS to reduce the total funds available for the UC-based DSH payment by a factor based on the estimated decline in the national uninsured rate (factor 2). Until FY 2017, CMS used estimates from the Congressional Budget Office, as required by statute. Since FY 2018, CMS has used estimates of the uninsured rate from the National Health Expenditure Accounts (NHEA), produced by CMS' Office of the Actuary. COVID-19 and its impact on the economy and the uninsured rate demonstrate the importance of transparency and accuracy in CMS' calculation of factor 2. While CMS' FY 2021 proposed factor 2 did not incorporate the effects of the COVID-19 pandemic, CMS reversed course in the final rule. CMS indicates that NHEA estimates for FY 2022 also incorporate the effects of COVID-19 on the uninsured rate. **Going forward, we urge CMS to be transparent in providing the assumptions behind its calculations of the uninsured rate, and to ensure its data source for factor 2 is the most accurate source publicly available.**

d. CMS should continue its work to accurately capture hospital UC costs in its calculation of Medicare DSH allocations.

Given the importance of UC to the Medicare DSH program, we urge CMS to continue to refine its methodology to accurately capture these costs. This should include providing clear and consistent guidance to auditors and contractors tasked with reviewing hospital-reported UC costs. Under the ACA's DSH methodology, CMS determines a hospital's qualifying UC burden by estimating its percentage of the total UC costs incurred by all DSH hospitals. Hospitals report their UC costs and other indigent patient care costs on worksheet S-10 of the Medicare hospital cost report form. For FY 2022, CMS proposes to continue the policy of using one year of data—in this case, from the audited FY 2018 S-10. As CMS relies solely on the S-10 for calculating UC costs, the accuracy and equity of S-10 data will be increasingly important to ensure consistency across the field. We urge the agency to incorporate the below recommendations to ensure a more accurate representation of each hospital's total UC costs.

[8] *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)

i. CMS should mitigate the effect of anomalies in FYs 2020 and 2021 cost report data that will have an adverse impact on UC-based DSH payments in future years.

During the COVID-19 PHE, hospitals—at the prompting of federal guidance and state orders—suspended their regular operations, including by postponing non-emergent and elective procedures. In addition to these actions by hospitals, patients were reluctant to seek care, whether in the emergency department or in outpatient clinics, even for severe conditions such as heart attack or stroke. One survey showed that nearly half of Americans put off seeking care because of COVID-19.[9] This disrupted hospitals' day-to-day operations and changed the types of patients and cases they normally see. For some, this meant a focus primarily on COVID-19 patients, with other cases being delayed and many shifted to telehealth. Other hospitals in cities with fewer COVID-19 cases might not have seen the same surge in COVID-19 patients but nonetheless were required to postpone their non-emergent cases in preparation for a possible surge. Therefore, hospitals saw substantial changes in their usual payer mix during the pandemic. Hospitals with predominantly uninsured and public-payer patients likely experienced a drop in the number of these patients seeking care, as well. The drop in volume could affect the amount of UC many hospitals provided in 2020 and 2021, compared with what they typically provide. These changes in UC will vary by geographic region and differences in the severity of COVID-19 in these locations.

While it is too early to know the exact variation in UC provided by each hospital, CMS should begin to consider policies that will mitigate any atypical drops in UC that some hospitals likely will experience. Cost report data from FY 2020 that coincide with COVID-19 likely will be used for FY 2024 rulemaking, while cost report data from FY 2021 will be used for FY 2025 rulemaking. **CMS should begin considering steps to dampen the effect of large downward swings in UC attributable to COVID-19 that will have large redistributive effects on UC-based payments.**

ii. CMS should provide clear guidelines on its audit protocols and ensure S-10 reviews impose minimal burden and are equitable and uniform across all hospitals.

CMS has yet to make public its audit protocols; it is imperative that the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. Hospitals and other stakeholders audited or involved in audits of FY 2015 data underscored the need for this transparency. **We urge the agency to disclose the criteria it uses to identify hospitals for audits.** Given the relative and redistributive nature of DSH payments, it is important to ensure audits are conducted consistently and equitably. Under the methodology of CMS' DSH calculation, a change in even one hospital's reported UC costs will alter its factor 3 and, in turn, affect all other hospitals' factor 3 values. As a hospital's factor 3 changes, so does the amount of UC-based DSH payments it receives (as this is the product of factor

[9] Lawrence E. Nearly Half Of Americans Delayed Medical Care Due To Pandemic. *Kaiser Health News*. May 27, 2020. https://khn.org/news/nearly-half-of-americans-delayed-medical-care-due-to-pandemic/. Accessed June 8, 2021.

3 and total UC-based payments). Thus, any inaccurate audits or audits conducted selectively for some hospitals but not others will skew DSH payments across the board. Further, CMS must minimize burden associated with audit documentation requests and conduct the audits well in advance of the use of the data for payment purposes so hospitals have the opportunity to address adverse findings.

For its audits thus far, CMS and Medicare Administrative Contractors (MACs) worked with external auditing firms to review data for a subset of all hospitals receiving DSH payments nationwide. These audits include extremely burdensome documentation requests by MACs, requiring hospitals to compile and turn over large amounts of information not already available in their financial recordkeeping systems. The audits, particularly in FY 2015, were conducted in a haphazard manner, with hospitals informed of last-minute unjustified reductions in their UC costs due to arbitrary decisions made by MACs or subcontractors.

CMS can avoid these issues in the future by providing more transparency on its audit protocols. Publishing the audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address any findings. Because of the relative nature of UC-based payments, CMS also must select hospitals for audits in an equitable and systematic way. CMS should review audit findings to ensure MACs and subcontractors consistently apply audit protocols across hospitals nationwide. Finally, CMS should complete audits well in advance of its rulemaking for a given year to ensure the cost report data used are accurate and final. The accuracy and uniformity of audits across DSH hospitals is critical to ensure the data CMS uses to calculate UC-based payments are accurate and do not unfairly disadvantage audited hospitals at the expense of hospitals that were not audited.

iii. CMS should not adjust hospital UC costs or cost-to-charge ratios (CCRs) of hospitals reporting accurate values.

Because some hospitals report what CMS refers to as anomalous UC costs, the agency proposes to continue its policy of adjusting UC values of hospitals with "extremely high" ratios of UC costs to total operating costs on the cost report year used for calculating DSH payments. If a hospital cannot justify high UC costs to its MAC, CMS would scale those costs. The agency would base this scaling factor on the ratio of UC costs to total costs from the next year's cost report—for FY 2022 DSH payments, that would mean the FY 2019 cost report if CMS finalizes its proposal to use FY 2018 UC costs. We agree with the need for data integrity and accurate reporting of UC costs. However, CMS should quickly discern erroneous data from legitimate instances in which a hospital might incur very high UC costs. Essential hospitals serve as the primary health care safety net in their communities, especially in heavily populated metropolitan areas, and have very high volumes of uninsured and low-income patients that drive up their UC costs. **We are encouraged that CMS continues to state that the UC cost adjustment will not apply to hospitals for which FY 2018 UC values have been audited and found in compliance. We call on CMS to finalize this policy and continue to work with its MACs to distinguish inaccurate UC values from legitimately high values.**

iv. CMS should include all patient care costs when using the S-10 to determine UC costs.

The S-10 does not account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues using the S-10 as the data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs—including those for teaching—into the CCR. In particular, CMS should:

- use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component; and
- use worksheet C, column 8, line 200, as the charge component.

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently in the S-10.

CMS should include GME costs when calculating a hospital's CCR. Excluding these costs will disproportionately affect teaching hospitals by reducing their share of the UC pool in relation to other hospitals. The costs associated with direct GME constitute a significant portion of overall costs at essential hospitals. Leaving out these costs in the CCR understates teaching hospitals' UC costs when it converts those hospitals' UC costs to charges. Incorporating GME costs into the CCR would reflect the full range of costs incurred by teaching hospitals. By excluding these costs, CMS' proposed CCR for determining UC costs will penalize teaching hospitals, such as academic medical centers, which tend to provide high levels of UC. **We strongly urge CMS to include teaching costs when converting charges to ensure accurate distribution of UC pool funds to hospitals with the highest levels of UC.**

CMS also should include the cost of providing physician and other professional services when calculating UC. In addition to employing physicians and paying community specialists directly for patient care, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other UC, CMS should recognize them when determining UC. **By refining the S-10 to reflect these issues, CMS will accurately measure the UC costs hospitals incur to serve low-income and uninsured patients.**

v. CMS should issue clarifying guidance as soon as possible to improve the consistency and accuracy of S-10 data and, in particular, the accuracy of UC amounts on the S-10.

A review of S-10 data indicates an inconsistency in how hospitals categorize and report charity care versus bad debt. While CMS can overcome this data limitation using the sum of charity care and bad debt, the agency still should issue clarifying guidance so there is consistency across the field in how hospitals report these costs.

CMS should treat the unreimbursed portion of state or local indigent care programs as charity care. Many state or local indigent care programs are not formal insurance products, but rather local coverage programs that help reduce hospitals' overall UC costs through de minimis reimbursement for services. These programs typically support the same populations that qualify for hospital charity care policies. Just as the unreimbursed costs for charity care patients are recognized in the S-10, the worksheet also should reflect the unreimbursed portion (i.e., the shortfall) of state or local indigent care programs.

Moreover, the agency must revise the S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. CMS to date has not used Medicaid shortfalls from the S-10 in the calculation of UC costs. We agree that Medicaid shortfalls, as currently reported on the S-10, should not be included in the calculation of UC. All information produced on the S-10, including data not used in CMS' DSH calculations, should be an accurate representation of a hospital's UC and other costs. Data on Medicaid shortfalls increasingly will be useful for informational purposes as previously uninsured low-income individuals gain access to health coverage through Medicaid. Further, data on the unreimbursed costs of providing care to Medicaid patients (many of whom formerly were uninsured) will provide information on Medicaid underpayment and, thus, should be accurate.

Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs is an inaccurate way to measure shortfall. Second, the S-10 should consistently allow hospitals to reduce their Medicaid revenues by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are used to finance the nonfederal share of Medicaid and are critical to a state's ability to fund the program at adequate levels.

Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. **Because of this discrepancy in the instructions and the different types of permissible financing arrangements used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.**

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients. The agency should allow hospitals to include coinsurance and deductibles on the S-10 without multiplying these amounts by the CCR. CMS' revised cost report instructions and guidance dictate hospitals do not have to multiply nonreimbursed Medicare bad debt by the CCR, because coinsurance and deductibles are actual amounts expected from the patient (as opposed to charges, which are not the actual amounts a patient is expected

to pay). However, CMS' September 2017 transmittal states that hospitals still should multiply their non-Medicare bad debt by the CCR.

The different treatment of nonreimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients other than Medicare fee-for-service (FFS) patients, such as those with Medicare Advantage, are actual amounts the hospital expects the patients to pay. Therefore, hospitals should list unpaid coinsurance and deductible amounts as bad debt in their entirety and CMS should not reduce those amounts by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts that patients do not have the ability to pay—do not have to be reduced by the CCR. **CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR.**

vi. CMS should clearly communicate S-10 changes to stakeholders.

CMS should provide ample opportunities for stakeholder feedback and education before issuing substantive revisions to the S-10. We urge the agency to clearly communicate to stakeholders any revisions, as well as information about extended submission deadlines.

CMS should conduct additional educational outreach to hospitals as the agency transitions to using S-10 data. The S-10 has assumed increased importance as it becomes the sole basis for UC-based DSH payments; as such, it is critical that CMS provide necessary guidance to hospital staff tasked with completing Medicare cost reports. Hospitals report the S-10 and its corresponding instructions are ambiguous in certain respects, including directions on how hospitals should report non-Medicare bad debt. CMS should provide educational resources to hospitals in the form of agency conference calls, webinars, FAQs, and examples illustrating how to report values on the S-10. Because the data entered on the S-10 will significantly affect hospital reimbursement, CMS should work with hospitals to ensure they have appropriate and thorough direction when completing the worksheet.

2. **CMS should finalize its proposal to repeal its collection of market-based payment rate information on hospital cost reports.**

In an effort to develop a market-based approach to payment under Medicare FFS, CMS last year finalized a policy to require hospitals to report certain market-based payment rate information on their Medicare cost report for periods ending on or after January 1, 2021. Specifically, CMS was requiring hospitals to report median payer-specific negotiated inpatient services charges for Medicare Advantage (MA) organizations by Medicare severity diagnosis-related group (MS-DRG). CMS also finalized a policy to begin using these MA data to set market-based FFS payment rates and MS-DRG relative weights beginning in FY 2024. CMS now proposes to repeal both the data collection and rate-setting policies. **America's Essential Hospitals applauds**

CMS for its decision to respond to stakeholder feedback by repealing these policies, and we urge the agency to finalize its plan.

3. **CMS should adopt policies that will encourage the training of health professionals in underserved areas.**

CMS proposes policies implementing the GME provisions in the Consolidated Appropriations Act (CAA) of 2021, including adding 1,000 new teaching slots beginning in FY 2023 and further defining the types of hospitals that should receive priority for these slots. Essential hospitals are committed to training the next generation of health professionals and equipping them with the necessary skills to provide culturally and linguistically competent care. In 2019, the average member hospital trained 240 physicians, more than three times as many as other U.S. teaching hospitals.[10] Further, our members trained an average of 59 physicians above their GME funding cap, versus 17 at other teaching hospitals.[11] **CMS should implement policies that will promote residency training in underserved areas and encourage the retention of talent in these areas.**

a. CMS should allow hospitals to receive up to 10 residency slots in a year and 25 slots over five years.

CMS proposes to distribute 200 total slots per year over a five-year period and to limit the number of additional residency positions a hospital can acquire in any year to one full-time equivalent (FTE). This annual per-hospital maximum allotment, which equates to a maximum of five FTEs over the five-year period, is lower than the 25 slot per hospital maximum contained in the legislation. **We urge CMS to raise the maximum number of FTEs to allow hospitals to receive up to 10 slots in any given year and a total of 25 slots over five years.**

As noted above, the average essential hospital trains 240 residents, 59 of which are above their funding cap. These hospitals could use immediate federal funding support to incentivize the creation of new programs or the expansion of existing programs. While we recognize CMS' desire to allow distribution of the slots to as many hospitals as possible, it is imperative that these slots be reserved for those hospitals most in need. A hospital with a large teaching program would see minimal benefit under CMS' proposal capping the number of FTEs to one per hospital per year, especially when compared with the investment required to recruit and train residents. The nuances of GME funding, which require the establishment of a new cap over five years, also make it more beneficial for hospitals to receive addition slots up-front and then build or adjust their cap over the five-year window. **If CMS does not increase the maximum slots a hospital can receive, it should at least allow hospitals to apply for all of their slots up front—that is, a hospital could receive all five of its slots in the first year, thus allowing it to begin its cap-building window.**

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[10] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey.* America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed June 6, 2021.
[11] Ibid.

b. CMS should finalize proposals that will encourage the creation and expansion of rural training track (RTT) programs.

In the rule, CMS proposed policies implementing provisions of the CAA related to RTT programs, which are partnerships between urban and rural hospitals (or rural nonhospital sites) to train residents. Under current rules, when an urban hospital rotates its residents in an accredited RTT with a rural hospital, and if those residents spend more than half of their time training at the rural hospital, the urban hospital may be reimbursed for these residents above its traditional training cap, while rural hospitals may receive additional slots only in limited instances. CMS proposes multiple changes to RTT programs, including:

- allowing both urban and rural hospitals to increase their caps when participating in a new RTT;
- allowing urban and rural hospitals to increase their caps when the urban hospital expands an existing RTT to a new rural hospital training site;
- permitting the creation of RTT programs in any specialty (previously limited to family medicine);
- no longer requiring an RTT receive separate accreditation, provided the entire program is accredited by the Accreditation Council for Graduate Medical Education and more than half of residents' training time is in a rural area; and
- exempting RTTs from the three-year rolling average during the five-year rural track limitation window.

RTT programs often are leveraged by teaching hospitals to expand training opportunities and address workforce shortages in rural areas. The policies CMS proposes would spur the creation of RTT programs and encourage urban and rural hospitals to enter into these agreements. **America's Essential Hospitals urges CMS to finalize its proposals for RTT programs.**

4. **CMS should withdraw its proposal to change the calculation of reimbursable organ acquisition costs at transplant centers.**

CMS proposes changes to its decades-old policy on how transplant centers are reimbursed for the cost of organ acquisition. Medicare's long-standing policy is to reimburse transplant centers and organ procurement organizations (OPOs) for the cost of excising donor organs under the assumption that most excised organs will eventually be transplanted into a Medicare beneficiary. CMS proposes to change the calculation of the Medicare share of excised organs to permit transplant centers only to claim the costs of organs that are excised and that actually are transplanted into a Medicare beneficiary. By limiting transplant centers' Medicare share of allowable organ acquisition costs to only those organs that end up being transplanted into a Medicare beneficiary, CMS is reversing longstanding policy and undermining the organ donation program and the viability of transplant centers.

If this proposed policy were to take effect, it would be extremely burdensome to implement and would undermine transplant centers and the organ donation system. Transplant centers would be responsible for tracking an organ from its donor to its

recipient to determine which organs are eventually transplanted into a Medicare beneficiary, which is not administratively feasible. When a transplant center excises an organ that is not transplanted into a patient at the same transplant center, it sends the organ to another transplant center directly or to an OPO, which identifies a recipient transplant center and sends the organ to that center. The OPO, not the hospital, is responsible for identifying a recipient. Transplant centers would have to work with OPOs to determine the insurance status of the recipient of each organ that was excised at the transplant center. This would be an extremely cumbersome process that also raises patient privacy implications. Medicare is proposing to reduce reimbursement for these organs under the assumption that other payers will assume the costs of organ acquisition. This is a bold assumption that is very unlikely to actually materialize in reality. Transplant centers would need to negotiate contracts with other payers and determine a reimbursement model for the acquisition of these organs—a process which will require substantial time.

The reduced reimbursement and burden associated with this policy would cause many transplant centers to cease or limit operations and would decrease the number of organs excised for donation, thus undermining the organ donation program and potential organ recipients. Moreover, the reduction in available organs would result in higher costs to Medicare in the form of more costly treatment—for example, fewer available kidneys might result in more treatment and dialysis for patients with end stage renal disease. **Given the potential adverse consequences, CMS should withdraw this policy until the agency has evaluated the full impact and has worked with stakeholders to consider alternative approaches.**

5. **CMS should implement policies that reduce administrative burden on hospitals in the Medicare Promoting Interoperability Program (PIP) and allow hospitals to dedicate their resources to providing patient-centered care.**

CMS proposes changes to the Medicare PIP in calendar year (CY) 2022 and beyond, including a 90-day reporting period in CY 2023 and a 180-day reporting period beginning in CY 2024. Eligible hospitals still face obstacles to the meaningful use of health information technology (IT). In looking to develop future policies, CMS should take additional steps to reduce provider burden and enable hospitals to deliver high-quality, patient-centered care. The recommendations below will ensure providers have sufficient time and flexibility to attain true interoperability and extend the benefits of electronic health records (EHRs) to their patients.

a. <u>CMS should finalize a 90-day reporting period for CYs 2023 and 2024.</u>

CMS should finalize a 90-day PIP reporting period for CYs 2023 and 2024, which will offer much-needed relief as providers continue to work toward interoperability. CMS previously reduced the CYs 2019 through 2022 reporting periods to 90 days, and in this year's rule, again proposes a 90-day reporting period for CY 2023. However, CMS proposes a 180-day reporting period in CY 2024. We urge CMS to finalize its proposal for CY 2023 and to shorten the proposed reporting period in CY 2024 to 90 days. America's Essential Hospitals strongly supports a 90-day reporting period, which gives providers flexibility to develop their reporting

infrastructure and make necessary updates to their EHRs to comply with evolving PIP requirements. As CMS makes changes to the measures and scoring methodology of the PIP hospitals will benefit from additional preparation time resulting from a shorter reporting period. The shorter reporting period will give hospitals time to adjust to these changes and make system changes necessitated by revised measures. **Accordingly, CMS should finalize a 90-day reporting period for CYs 2023 and 2024.**

b. CMS should keep the prescription drug monitoring program (PDMP) measure voluntary until the agency has adequate standards and specifications.

CMS should keep the PDMP measure voluntary until there is uniformity across states in the adoption of these practices, as well as adequate standards and certification criteria. Essential hospitals are on the front lines of treating patients most affected by the opioid crisis and have implemented innovative strategies to reduce opioid dependence. As leaders in population health, essential hospitals continue to develop programs that prevent opioid misuse among vulnerable populations. They partner with pharmacies, public health departments, law enforcement, emergency medical services, and other community providers to combat the crisis. As key stakeholders in combating the opioid epidemic, essential hospitals stand ready to implement practices that have proved effective in reducing opioid dependence. While the intent of using EHRs to fight the opioid crisis is commendable, there are significant barriers to the use of IT to report the PDMP measure CMS includes in the PIPs.

The PDMP measure requires eligible hospitals and critical access hospitals to use data from certified EHR technology to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. After initially proposing to require this measure in 2019, CMS reversed course and kept it voluntary. CMS again proposes to keep the measure voluntary in 2022 and we applaud the agency for this decision. While the measure is voluntary, we urge CMS to work with stakeholders toward PDMP integration.

The PDMP measure is not ready for inclusion in the PIPs because it lacks uniformity of adoption across states and providers. PDMPs are state-level databases that can increase provider awareness of at-risk patients and thus reduce prescription drug misuse, but they are unevenly used across the country due to varying state requirements. Not all states require the use of PDMPs and one—Missouri—only recently passed legislation to implement a PDMP. Additionally, platforms differ by state, creating a lack of uniformity in accessing PDMP data and difficulty in establishing standards for the use of EHRs to access such data. There are no standards or certification criteria for the use of PDMPs or their integration into EHRs. **CMS should work with other agencies to rectify this lack of uniform governance before requiring the use of these databases as part of the PIP.**

In addition to the lack of standards and certification criteria, the use of PDMPs can cause workflow disruptions when practitioners check a patient's opioid medication history. Our members have indicated to us that accessing PDMPs can be an arduous process that requires the provider to close the EHR and provide credentials to log on to

a state PDMP website. In other words, a provider cannot always seamlessly access PDMP information from within the EHR when electronically prescribing a medication. **Until CMS can confirm PDMP integration and workflow issues are resolved, it should keep the PDMP measure voluntary.**

6. **CMS should finalize its policy to extend the New COVID-19 Treatments Add-on Payment (NCTAP).**

Medicare pays hospitals an add-on payment for certain high-cost cases involving the use of new technologies. In response to the COVID-19 PHE, CMS established the NCTAP under the IPPS for COVID-19 cases that meet certain criteria. The purpose of the NCTAP is to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments during the PHE and is effective for discharges occurring on or after November 2, 2020, until the end of the COVID-19 PHE.

CMS anticipates there might be inpatient cases of COVID-19 beyond the end of the PHE for which payment might not adequately reflect the additional cost of new COVID-19 treatments. Therefore, the agency proposes to extend the NCTAP for certain eligible products through the end of the fiscal year in which the PHE ends. **We appreciate CMS acknowledging the need to provide certain innovative, high-cost COVID-19 treatments beyond the end of the PHE, and we urge CMS to finalize its extension of the NCTAP.**

7. **CMS should address the impact of the COVID-19 PHE on quality measures across its programs and work with stakeholders to adopt a permanent suppression policy for use in future pandemics.**

The COVID-19 PHE has had, and continues to have, significant and ongoing effects on care delivery nationwide. Challenges over the course of the COVID-19 PHE have included: shortages of personal protective equipment; issues relating to hospitalizations and transfers; increasing community food insecurity; staffing and supply shortages; and funding scarcity. Further, because COVID-19 prevalence is not consistent across the country, hospitals in different areas have been affected differently at various times throughout the pandemic.

Due to the likelihood there will be significant distortions to quality measurement, CMS proposes to adopt a suppression policy to provide short-term relief to hospitals. The cross-program measure suppression policy would be adopted in the Hospital Readmission Reduction Program (HRRP), the Hospital Value-Based Purchasing (VBP) Program, and the Hospital-Acquired Condition (HAC) Reduction Program. We appreciate CMS' recognition that hospitals in the quality programs should not be negatively affected when their quality performance suffers due to external factors rather than actual care provided.

The proposed measure suppression factors are:

- significant deviation (better or worse) in national performance on the measure during the PHE, compared with historical performance during the immediately preceding program years;
- clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE;
- rapid or unprecedented changes in:
    - (i) clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
    - (ii) the generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin; and
- significant national shortages or rapid or unprecedented changes in:
    - (i) health care personnel;
    - (ii) medical supplies, equipment, or diagnostic tools or materials; or
    - (iii) patient case volumes or facility-level case mix.

We agree with the factors developed and used by CMS to guide its determination of whether to propose measure suppression for one or more program years that overlap with the COVID-19 PHE. However, we are concerned about the long-term impacts of COVID-19 diagnosis (i.e., "long haulers") and encourage CMS to explicitly include flexibility in the suppression factors to address changes in our understanding of the disease course that occur over a longer period of time. For example, along with pneumonia, blood clots, and other serious health concerns caused by SARS-CoV-2, the virus that causes COVID-19, recent studies have identified a connection to diabetes after an acute COVID-19 infection.[12]

Additionally, we encourage CMS to engage stakeholders in developing a permanent suppression policy that could be used for future PHEs and that integrates lessons learned from COVID-19.

8. **CMS should adopt a suppression policy in the HRRP that accounts for the impacts—direct and indirect—of COVID-19 on patient outcomes.**

After conducting analyses on the six current HRRP measures, CMS concluded that COVID-19 has severely impacted the validity of one measure—the hospital 30-day, all-cause, risk-standardized readmission rate following pneumonia hospitalization measure—such that the agency cannot fairly assess the measure. The FY 2022 applicable period for the pneumonia readmission measure is July 1, 2017, through June 30, 2020. However, in CMS' September 2020 interim final rule, the agency noted it would not use first or second quarter 2020 claims data to assess performance for the applicable fiscal years. CMS has determined it is unnecessary to suppress this measure for the FY 2022 program year. However, given the ongoing status of the PHE and the impact of COVID-19 on this measure data, CMS proposes to temporarily suppress this measure for FY 2023. **We urge CMS to finalize its proposal to suppress the**

[12] Collins F. How COVID-19 Can Lead to Diabetes. NIH Director's Blog. June 8, 2021. https://directorsblog.nih.gov/2021/06/08/how-covid-19-can-lead-to-diabetes/. Accessed June 8, 2021.

pneumonia measure data for FY 2023 in light of the clear impact COVID-19 has had on the validity of this condition-specific readmission measure.

CMS does not propose to suppress the five remaining condition-specific measures for FY 2022. The agency reasons that while COVID-19 has impacted these five measures, the impact is "less severe overall." However, the agency does propose to modify these five measures to exclude COVID-19 patients from the measure denominators. **We support this technical measure specification update to exclude COVID-19 patients from the denominator.**

Additionally, we know that hospitals nationwide were forced to delay or cancel procedures to control infection, reduce virus transmission and respond to surge. Patients also might have avoided care due to stay-at-home orders. The full impact of the pandemic on chronic conditions—often experienced most by patients of essential hospitals—has yet to be determined. From a risk adjustment perspective, this will result in a need to account for potentially higher acuity in patients. **We urge CMS to examine its clinical risk adjustment models to ensure accuracy in measure calculations and mitigate the impact of COVID-19.**

9. **CMS should adopt its suppression policy for the HAC Program and continue to monitor the impact of COVID-19 on quality measures on future program years.**

CMS proposes to adopt a policy to suppress several measures from the FYs 2022 and 2023 total HAC score calculations to account for regional and temporal differences in COVID-19 prevalence rates that do not reflect differences in care quality provided by hospitals. Specifically, CMS proposes to suppress third and fourth quarters of CY 2020 (i.e., July 1–Sept. 30, 2020, and Oct. 1–Dec. 31, 2020) Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network health care–associated infection and CMS PSI 90 data from the FYs 2022 and 2023 performance calculations. **We support this measure suppression proposal for the HAC Program** and thank CMS for acknowledging concerns about the national comparability of these data due to geographic differences of COVID-19, as well as a decrease in volume across all infection measures, especially those related to elective procedures.

We continue to believe there are potential implications of exempting quarters of data from reporting, such as measure reliability and accuracy in future public reporting. It is important to closely examine performance measures or policies in Medicare that are tied to payment. CMS must ensure accuracy and completeness of data submitted. **We urge CMS to continue its measure reliability analyses using shortened performance periods to ensure it has sufficient data to calculate performance accurately, and to make public the results of any such analysis.**

10. **CMS should adopt a suppression policy for the VBP Program that results in a neutral payment adjustment for all hospitals in FY 2022, and the agency should evaluate the need for continued flexibility in subsequent program years.**

As noted by CMS, the COVID-19 pandemic has impeded effective quality measurement in many ways. Changes to clinical practices to accommodate safety protocols for health care personnel and patients, as well as unpredicted changes in capacity and facility-level case mixes, have affected the data used in quality measurement and the resulting quality scores.

CMS proposes to apply a special rule for FY 2022 to account for the impact of COVID-19 on quality measures such that the agency will suppress all of the measures in the person and community engagement, safety, and efficiency and cost reduction domains for the FY 2022 program year. CMS would assign each hospital a value-based incentive payment percentage that results in a value-based incentive payment amount that matches the 2 percent reduction to the base operating diagnosis-related group (DRG) payment amount (i.e., net result would be a neutral payment adjustment). We thank CMS for recognizing that COVID-19, particularly for essential hospitals, has significantly impacted quality measures and **we support this proposal to prevent skewed payment incentives and inequitable payments**.

Additionally, **we support CMS' proposal to suppress the 30-day pneumonia mortality measure beginning in FY 2023**. We encourage CMS to continue to monitor the claims that form the basis for all VBP Program measure calculations to evaluate the effect of ongoing PHE circumstances on quality measurement and to determine appropriate policies in the future.

11. **CMS should continue to refine the hospital Inpatient Quality Reporting (IQR) Program measure set so it contains only reliable, valid measures that provide an accurate representation of care quality, including health equity.**

CMS should continue to tailor the IQR Program measure set so it helps hospitals improve care quality and benefits the public by accurately reflecting hospital care. America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. However, CMS must verify the measures are properly constructed and do not lead to unintended consequences. Further, when a conceptual and empirical basis exists, quality measures should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure the measures reflect quality of care, rather than factors outside of hospitals' control.

We support CMS' efforts to address gaps in quality measurement, such as in maternal health, and urge the agency to ensure quality measurement and reporting have a clear tie to improving patient safety and advancing CMS' quality priorities. Through focus, consistency, and organization, measures can help drive overall effectiveness in improving health system performance and patient outcomes.

a. <u>CMS should seek National Quality Forum (NQF) endorsement of the COVID-19 vaccination among health care personnel (HCP) measure, refrain from publicly reporting the measure, and streamline vaccination-related reporting by hospitals.</u>

CMS proposes a new measure to track vaccination among HCP in acute care facilities. The COVID-19 vaccination coverage among HCP measure would assess the proportion of a hospital's health care workforce that has been vaccinated against COVID-19. CMS proposes an initial shortened reporting period from October 2021 through December 2021, followed by quarterly reporting for calendar year (CY) 2022 and subsequent years.

Hospitals would collect data for the COVID-19 HCP vaccination measure for at least one self-selected week during each month of the reporting quarter and submit the data to CDC NHSN Healthcare Personnel Safety Component. CMS proposes that each quarter, CDC would calculate a single COVID-19 HCP vaccination coverage rate for each hospital, which would be calculated by taking the average of the data from the three weekly rates submitted by the hospital for that quarter. If finalized, CMS would publicly report this rate each quarter.

This measure is not NQF-endorsed and has not been submitted to NQF for endorsement consideration. The Measures Application Partnership (MAP) Hospital Workgroup noted several factors with the measure that need to be addressed, including well-documented evidence, finalized specifications, testing, and NQF endorsement before implementation.[13] **We urge CMS to seek NQF endorsement of the COVID-19 vaccination coverage among HCP measure.**

America's Essential Hospitals firmly believes vaccination is a critical part of the nation's strategy to combat COVID-19 and our essential hospital members continue to promote widespread vaccination within their organizations and in the communities they serve. However, it is unclear whether CMS plans to address factors that might contribute to variation among hospitals' reported vaccination rates and the potential for confusion among consumers if publicly reported. For example, some hospitals have implemented a vaccination requirement policy for all employees, while others have limited requiring vaccination to those with certain job functions, and still others are awaiting full approval of the vaccines by the Food and Drug Administration before making such decisions. Most recently, the Department of Labor's Occupational Safety and Health Administration (OSHA) issued a COVID-19 emergency temporary standard that encourages vaccination by requiring employers to provide reasonable time and paid leave for employee vaccinations and any side effects.[14] **Given this potential variation in hospital policies, we urge CMS to refrain from publicly reporting this data.**

Additionally, hospitals voluntarily report to HHS the number of COVID-19 vaccination doses administered to health care personnel and patients. This reporting is weekly and entered through HHS' outside vendor, Teletracking. Alternatively, hospitals may submit data to their state (if properly certified) and the state reports on the hospital's

[13] Measure Applications Partnership. MAP Preliminary Recommendations 2020–2021. http://www.qualityforum.org/Project_Pages/MAP_ Hospital_Workgroup.aspx. Accessed June 7, 2021.
[14] Subpart U—COVID-19 Emergency. U.S. Department of Labor Occupational Safety and Health Administration. June 10, 2021 (pending publication in the *Federal Register*). https://www.osha.gov/sites/default/files/covid-19-healthcare-ets-preamble.pdf. Accessed June 11, 2021.

behalf to the federal government.[15] **We urge CMS to issue clear guidance to hospitals on the various reporting requirements to HHS, CDC, and states to minimize duplication of efforts and confusion.**

b. CMS should ensure maternal health measures in the IQR Program are valid and meaningful, improve outcomes, and eliminate health disparities.

From the very beginning of their lives, many Americans have a relationship with our member hospitals—one in 10 U.S. residents are born at an essential hospital. Further, between 1999 and 2019, our member hospitals served counties in which maternal mortality rates can reach 45 maternal deaths per 100,000 live births, compared with 16 deaths per 100,000 nationally.[16] To beat these staggering odds, essential hospitals invest in programs to help pregnant women, new mothers, and their babies at this critical time in their lives. This requires special attention to the unique circumstances faced by new mothers, particularly those who might experience additional socioeconomic risk factors. America's Essential Hospitals supports the development of meaningful quality measures to improve maternal health outcomes and eliminate health disparities, while not adding administrative burden to essential hospitals.

CMS proposes to adopt a maternal morbidity structural measure to address the U.S. maternal health crisis. The measure would determine hospital participation in a state or national perinatal quality improvement (QI) collaborative and whether hospitals are implementing the patient safety practices or bundles included as part of these QI initiatives. CMS defines a state or national perinatal QI collaborative as "a statewide or a multistate network working to improve women's health and maternal health outcomes by addressing the quality and safety of maternity care." These collaboratives employ clinical practices and processes to address gaps in care, as well as collect and review performance data.

We applaud CMS in prioritizing maternal health and addressing the lack of quality measures that to address maternal morbidity. Essential hospitals across the country initiate and sustain programs to help reduce maternal morbidity and mortality. For example, an essential hospital in Massachusetts launched a partnership with a local insurer aimed at improving maternal health and birth outcomes. The results from this effort will be used to establish a standard of care for all of New England. In New York, an essential hospital offers a comprehensive approach through its new maternal medical home program, which provides specialty care, mental health, and wraparound services to high-risk obstetric patients.

The NQF MAP Coordinating Committee supported the proposed structural measure, with the condition that the measure go through the NQF endorsement process and

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[15] COVID-19 Guidance for Hospital Reporting and FAQs For Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting. May 27, 2021. https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf. Accessed June 7, 2021.

[16] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialhospitals.org/wp-content/uploads/2021/05/EssentialData2021_Web.pdf. Accessed June 7, 2021.

receive endorsement. **We urge CMS to seek NQF endorsement before including this measure in the IQR Program.**

Additionally, maternal health measures should advance patient safety in a meaningful way, including eliminating gaps in health equity among certain populations. Racial and ethnic disparities are closely linked to the high pregnancy-related mortality rates in the United States. Black women die from pregnancy-related causes at a rate three to four times higher than white women.[17] This quality gap is growing among non-Hispanic Black women, which had the fastest rate of increase in maternal deaths between 2007 and 2014 and maternal death rates up to 12 times higher in some cities than non-Hispanic white women.[18]

The unconscionable racial disparities in maternal health outcomes are a glaring example of the health inequities experienced by minority populations. As noted by NQF in its report on maternal morbidity and mortality, "racial disparities within maternal care and the impact on birth outcomes are a significant public health concern."[19] **We encourage CMS to further examine factors such as language access, structural racism, mental health, and implicit bias that can potentially influence maternal health outcomes.**

c. CMS should continue to examine ways to appropriately risk adjust quality measures across its programs to account for factors outside the control of hospitals that impact health outcomes.

Outcomes measures do not accurately reflect hospitals' performance if they do not account for sociodemographic factors that can complicate care. Patients who do not have a reliable support structure at discharge are more likely to be readmitted to a hospital or other institutional setting. CMS should not include in the IQR Program outcome measures sensitive to sociodemographic factors—e.g., readmissions, mortality, episode payments—until the measures have been risk adjusted.

We urge CMS to include factors related to a patient's background—such as sociodemographic status, language, and post-discharge support structure—in measure development and risk-adjustment methodology.

12. **Future measures for the IQR Program should be developed with broad stakeholder input to ensure an accurate representation of care quality, including health equity and the impact of COVID-19 on health outcomes.**

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[17] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016. *Morbidity Mortality Weekly Report*. 2019;68(35):762–765.
[18] Howell EA. Reducing Disparities in Severe Maternal Morbidity and Mortality: Clinical Obstetrics and Gynecology. January 2018:1.
[19] Maternal Morbidity and Mortality Environmental Scan. Final Report. November 2, 2020. https://www.qualityforum.org/Publications/2020/11/Maternal_Morbidity_and_Mortality_Environmental_Scan.aspx. Accessed June 7, 2021.

a. CMS should allow flexibility in the priority domains for a measure of organizational commitment to health equity to ensure the measure is actionable and meaningful to consumers.

CMS seeks to use quality measurement to support health care organizations in building a culture of equity. The agency believes hospital leaders play an important role in setting specific, measurable, and relevant goals to assess progress toward achieving equity priorities.

The proposed attestation-based structural measure, to be developed, would assess organizational commitment to health equity, including: the degree to which the hospital organization regularly examines existing algorithms for the presence of bias, and regularly shares these findings with the hospital organization's leadership and board of directors; the presence of a hospital organizational disparities impact statement; the presence of an updated language access plan; and degree to which the hospital conducts staff training on collection of demographic information.

For essential hospitals, the journey to eliminate health care disparities is ongoing and began long before the COVID-19 pandemic. However, the pandemic shined a light on the reality faced by our members every day—that the communities they serve are plagued by social and economic disparities rooted in a history of structural racism. These inequities manifest as chronic stress and chronic medical conditions, traumatic injuries, substance use disorders, and other profound challenges for marginalized people.

Community health needs and hospital structures vary, which might lead to differing priority domains for health equity. For example, an essential hospital in North Carolina identified a health disparity in its service area—access to care—due to the limited number of physicians working with Medicare, Medicaid, and underserved populations. To address this challenge, the hospital provided initial funding to assist the county's federally qualified health center in expanding into new areas and developed new access points through community partnerships with civic, educational, and religious organizations. In South Carolina, leaders at an essential hospital committed to investing in community health care in the form of rebuilding housing around its main campus; this partnership seeks to improve health outcomes in an area plagued with high rates of obesity, cancer, and heart disease, along with high crime. **We urge the agency to seek input from essential hospitals and the broader stakeholder community to ensure existing efforts are incorporated into a health equity measure.**

While the work to eliminate disparities is not new to essential hospitals, this type of structural measure is novel. CMS acknowledges that collection of this measure might impose administrative and reporting requirements for hospitals. **We urge CMS to begin with voluntary reporting so hospitals can become familiar with this type of measure** and to provide confidential hospital-specific reports before any public reporting.

b. CMS should seek stakeholder input on the development of an all-cause mortality measure for COVID-19 and consider the use of stratification to

account for social risk factors impacting health outcomes, as well as geographic location, prevalence or burden of disease, and scarcity of resources.

CMS seeks input on the development of a hospital-level 30-day, all-cause mortality measure for patients admitted with COVID-19 infection for future inclusion in the IQR Program. The outcome would be mortality within 30 days from admission with a primary diagnosis—or in select cases, secondary diagnosis—of COVID-19. The measure would use administrative claims data (not including the Jan. 1–June 30, 2020 data excluded in the blanket emergency circumstances exception [ECE] issued in response to the COVID-19 PHE). CMS does not expect public reporting of a COVID-19 mortality measure to be feasible until at least FY 2024, due to the time required for measure development, testing, and required notice-and-comment rulemaking.

The COVID-19 pandemic hit the patients and communities served by essential hospitals particularly hard—especially racial and ethnic minorities. Further, sociodemographic factors greatly influence patient health status, making our member hospitals' patients most at risk, as COVID-19 continues to be detrimental for those with underlying health conditions. **We urge CMS to consider stratifying a COVID-19 outcome measure by social risk factors**.

Further, the sensitivity and specificity of clinical and laboratory tests used to diagnose COVID-19, as well as availability of diagnostic tests and reagents required to run the tests, might impact data used to calculate a COVID-19 mortality measure. In addition to social risk factors, **CMS should consider stratification by geographic location, prevalence or burden of disease, and scarcity of resources (including supplies and workforce)**.

Additionally, other hospital-level mortality measures, such as the heart failure or pneumonia 30-day mortality measures, were first introduced in the IQR Program and later adopted for the Hospital VBP Program. **We strongly urge CMS to be thoughtful in its development of a COVID-19 outcome measure and to avoid its use in pay-for-performance programs, such as the Hospital VBP Program.** We encourage a phased approach to measure development and implementation that includes extensive stakeholder input, followed by a dry run of the measure and confidential hospital-specific reports, before considering public reporting.

c. CMS should address barriers to collection of patient-reported outcomes (PRO) data for total hip and/or total knee arthroplasty (THA/TKA) and the potential impact the migration of services from the inpatient to outpatient setting will have on these measures.

America's Essential Hospitals supports patient empowerment and quality measures that capture the full spectrum of care. Collection of patient-reported outcome (PRO) data is a method of assessing pre-, peri- and post-operative care quality and functional improvement for procedures, such as elective THA/TKA. In November 2020, the NQF endorsed the THA/TKA PRO performance measure (PRO-PM). CMS proposes future inclusion of the THA/TKA PRO-PM, first allowing hospitals to submit their data voluntarily before it would become mandatory in the IQR Program.

There are barriers to PRO data collection, including administration in underserved populations, low literacy and health literacy, and language and cultural differences. Patient populations served by essential hospitals include those with lower education or income, as well as racial and ethnic minorities. In addition to overall survey fatigue, limited health literacy might be more prevalent in these groups and could impact understanding or interpretation of the questions in a PRO measure, resulting in lower response rates for essential hospitals. An unintended consequence might be that hospitals become increasingly selective in the patients they treat, and beneficiaries who might have benefitted—i.e., racial and ethnic minorities and those dually eligible for Medicare and Medicare—could be denied the opportunity to undergo these procedures, ultimately widening the disparity gap.[20] **We urge CMS to further examine the impact these barriers might have on PRO measurements among vulnerable populations, including people with limited health literacy, before including in CMS programs**.

Additionally, clinical services are increasingly moving from inpatient to ambulatory settings. Most recently, in the CY 2021 Outpatient Prospective Payment System rule, CMS finalized the elimination of the inpatient only (IPO) list (approximately 1,700 services) over a three-year transitional period. THA/TKA procedures were among the procedures removed from the IPO list. This shift has implications for measures in both settings relative to how they are specified as well as their use in pay-for-performance programs. For example, the increasing shift toward outpatient and ambulatory services could jeopardize certain minimum case thresholds over time as the inpatient volume decreases. We support measuring care services provided within the inpatient setting. However, **we encourage CMS to be sensitive to changes in health care delivery and the migration of services to the ambulatory setting**.

13. **Closing the Health Equity Gap in CMS Hospital Quality Programs—Request for Information**

As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify gaps in care quality that exist and to eliminate disparities as a matter of public health. It is critical that health equity is integrated and aligned across CMS programs. We applaud the new administration's emphasis on health equity and CMS' stated ongoing effort across the agency to evaluate appropriate initiatives to reduce health disparities, including the request for information (RFI) about closing the health equity gap in CMS quality programs. America's Essential Hospitals and its members are committed to tackling these important topics and look forward to additional opportunities for stakeholder engagement.

a. <u>CMS should promote culturally appropriate collection of patient race, ethnicity, and language (REL) data and information on other social risk factors in a</u>

[20] Thirukumaran CP, Kim Y, Cai X, et al. Association of the Comprehensive Care for Joint Replacement Model With Disparities in the Use of Total Hip and Total Knee Replacement. *JAMA Network Open*. 2021;4(5). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780437. Accessed June 8, 2021.

standardized and useful way to help identify disparities and target improvement activities to achieve equity.

America's Essential Hospitals encourages the collection of patient demographic data in a culturally sensitive and linguistically appropriate manner. Limited documentation of REL and social determinants of health (SDOH) data hinders our capacity to understand and adequately address social barriers to positive health outcomes.

Essential hospitals' commitment to caring for all people, including the vulnerable, has made them providers of choice for patients of virtually every ethnicity and language. In 2019, more than half of discharges at essential hospitals were racial and ethnic minorities.[21] America's Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. By involving the patient as an active participant in their care, hospitals can better assist patients in identifying care choices, as well as clinical and social needs that might improve health outcomes.

America's Essential Hospitals supports CMS' efforts to gather accurate, standardized information on patient demographic data. In 2011, the association partnered with other industry leaders in the National Call to Action to Eliminate Health Care Disparities, which promotes the culturally appropriate collection of patient REL information. We believe the collection of REL data supports hospitals' efforts to identify preferences and needs and to tailor a care plan to specific patient characteristics. For example, collecting preferred language helps identify appropriate interpreter services, as necessary. The ability to monitor and stratify data also helps front-line staff identify problems and standardize efforts across hospitals. As noted by CMS, "[c]omprehensive patient data on race, ethnicity, language, and disability status are key to identifying disparities in quality of care and targeting quality improvement interventions to achieve equity."[22] One essential hospital in South Carolina gave patients the ability to add or edit sensitive information, such as gender self-description, through their secure online patient portal. **CMS should encourage efforts to collect demographic data in a culturally appropriate and standardized way.**

The unconscionable rates of COVID-19 infections and deaths among Black, Latino, and other minority populations have emphasized the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language of patients. Further, the COVID-19 pandemic has shown that pervasive disparities only deepen during times of crisis. A CDC study of characteristics associated with hospitalization among patients with COVID-19 found a higher rate of COVID-19 hospitalizations among Black people. The agency noted that these higher rates "might indicate that Black persons are less likely to be identified in the outpatient setting, potentially reflecting differences in health care access or utilization or other factors not identified through medical record

[21] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. www.essentialdata.info/. Accessed June 8, 2021.
[22] Centers for Medicare & Medicaid Services. Inventory of Resources for Standardized Demographic and Language Data Collection. March 2020. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Collection-Resources.pdf. Accessed June 17, 2020.

review."[23] Data are critical to understanding the unique challenges and disparities patients face. While some of the data collection efforts included in COVID-19 legislative packages sought to deepen our understanding of these disparities and their root causes, it is clear that more can and should be done to ensure all Americans have equitable access to high-quality care.

America's Essential Hospitals also supports efforts to improve the collection of SDOH information to better understand how these factors impact outcomes; this work is important in identifying the needs of our nation's underrepresented patients. **We support a consensus-building approach that brings interested stakeholders together to determine relevant social factors and how to capture them in a standardized, culturally sensitive way.** However, there are challenges to collecting SDOH data, including the sensitive nature of these conversations, a lack of alignment across screening tools, and a need to link data from medical and nonmedical sources (i.e., community services).

Since 2015, providers have been able to use Z codes—a subset of ICD-10 codes—to capture social determinant information for Medicare FFS beneficiaries. An analysis from CMS found less than 2 percent of Medicare FFS beneficiaries in 2017 had a Z code associated with a claim.[24] By encouraging the collection of these data in a standardized manner, CMS can help ensure essential hospitals have the resources necessary to address the adverse impact social barriers have on health. For example, in the FY 2020 IPPS rule, CMS recommended changing the severity level designation of the ICD-10 code for homelessness (Z59) from a noncomorbid condition to a comorbid condition. CMS cited data suggesting when the Z59 diagnosis code is reported as a secondary diagnosis, the resources involved in caring for the patient justify increasing the severity level. CMS chose not to finalize this policy. We encourage the agency to further examine these types of coding and payment adjustments available through existing mechanisms.

When equipped with proper data, essential hospitals can innovate and collaborate with community partners to mitigate health disparities, improve outcomes, and reduce health care costs. For example, essential hospitals in Pennsylvania teamed up with schools and community organizations to form the North Philadelphia Health Enterprise Zone (HEZ). The initiative, launched in 2016, focuses on four key factors: health, community, education, and technology. Hospitals in the region struggled to share data across different EHR platforms. Hospitals supporting the HEZ now participate in the regional health information exchange, HealthShare Exchange, which allows real-time information sharing among care providers, reducing unnecessary or repeat procedures and driving down hospital costs. In fact, Pennsylvania recently made a financial investment in this collaborative to support HEZ efforts on

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[23] Killerby ME, Link-Gelles R, Haight SC, et al. Characteristics Associated with Hospitalization Among Patients with COVID-19—Metropolitan Atlanta, Georgia, March–April 2020. *Morbidity and Mortality Weekly Report*. June 17, 2020. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6925e1.htm?s_cid=mm6925e1_w. Accessed June 8, 2021.

[24] Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017. CMS Office of Minority Health. January 2020. https://www.cms.gov/files/document/cms-omh-january2020-zcode-datahighlightpdf.pdf. Accessed June 8, 2021.

employment and housing protections—activities that can help mitigate barriers to care and reduce disparities.[25] **We urge CMS to support existing best practices in data collection and sharing of meaningful data as a critical step in eliminating health disparities.**

b. CMS should seek extensive input from stakeholders, including essential hospitals, before developing a Hospital Equity Score, to ensure any potential measure of hospital equity is actionable, meaningful to consumers, and reflective of the needs of the community served by a particular hospital.

CDC defines health equity as "when all members of society enjoy a fair and just opportunity to be as healthy as possible." Further, the agency states "[p]ublic health policies and programs centered around the specific needs of communities can promote health equity."[26] Essential hospitals understand that factors driving heath equity go well beyond the delivery of hospital care and are highly dependent on the characteristics and needs of a hospital's patient population and the community it serves.

Our members recognize the effect of upstream social factors and are working to mitigate social determinants of poor health by screening patients for food insecurity, housing instability, and other social needs and referring these patients to community resources. By identifying the needs of their patient population, essential hospitals work tirelessly, and with limited resources, to eliminate disparities and provide cutting-edge care to all, regardless of income or insurance status. For example, during the COVID-19 PHE, an essential hospital in New York designed an SDOH screening tool tailored to the needs of its patients at four of the health system's ambulatory care clinics. The tool surveyed patients about COVID-19 symptoms, living situations, chronic conditions, medication needs, food security, economic needs, and child care requirements. Medical students conducting the survey then referred patients to resources based on their responses—e.g., unemployment and job search resources; the Supplemental Nutrition Assistance Program; and access to free Wi-Fi, diapers, and formula.[27] **We encourage CMS to work with stakeholders to ensure any measure of hospital equity accurately reflects the ongoing efforts by essential hospitals to address the specific needs of their patient population.**

CMS indicates that creation of a hospital equity score would provide easily interpreted information about disparities and "an overall indicator of equity." However, a single, summary score might fail to capture a hospital's efforts, informed by the community, to address their specific needs, such as transportation, food, or housing. An equity

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[25] George J. State invests $4 million in North Philadelphia's Health Enterprise Zone. *Philadelphia Business Journal*. October 18, 2019. https://www.bizjournals.com/philadelphia/news/2019/10/18/state-invests-4- million-in-north-philadelphia-s.html. Accessed June 8, 2021.
[26] *Health Equity Considerations and Racial and Ethnic Minority Groups*. Centers for Disease Control and Prevention. April 19, 2021. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html. Accessed June 8, 2021.
[27] Schweich E. Students Step Up: Integrating Social Determinants Screening into Medical Education amid COVID-19. America's Essential Hospitals. November 17, 2020. https://essentialhospitals.org/students-step-integrating-social-determinants-screening-medical-education-amid-covid-19/. Accessed June 8, 2021.

measure should also account for the differences among hospitals and the resources necessary to support evidence-based quality improvement strategies that extend beyond the hospital walls and into the community. Further, a hospital equity measure should account for circumstances outside a hospital's control, such as a lack of nonhealth, community-based services in a particular geographic area that might limit a hospital's ability to meet the needs of a patient.

Essential hospitals often serve as community anchors, with deep ties to the residents; this leads to a clear understanding of the nonclinical influences on patients and population health. However, significant challenges still exist for essential hospitals in developing partnerships, building needed infrastructure, engaging patients, measuring progress, and creating sustainable funding models. The Healthcare Anchor Network (HAN) is an example of a collaboration that seeks to bring together health systems to share best practices and scale strategies that ultimately improve community health and well-being. HAN members have identified priority areas for the work they are advancing, including addressing upstream SDOH; inclusive, local hiring and internal workforce development; and local purchasing. **We encourage CMS to examine the role of essential hospitals as anchor institutions when developing a hospital equity measure**.

c. CMS should continue to refine its disparity methods reports to include social risk factors beyond dual-eligibility and race and ethnicity, and refrain from publicly reporting results that use indirect estimation for race and ethnicity.

The CMS disparity methods reports provide hospital-level confidential results stratified by dual eligibility (i.e., patients eligible for both Medicaid and Medicare) for the six condition-specific readmission measures currently in the HRRP. CMS proposes to expand the disparity methods to include stratified results by dual eligibility and race and ethnicity. CMS currently does not consistently collect self-reported race and ethnicity for the Medicare program. As such, the agency plans to use indirect estimation of race and ethnicity to overcome the current limitations of demographic information.

Indirect estimation of race and ethnicity often uses a combination of other data sources predictive of self-identified race and ethnicity, such as language preference, administrative records, first and last names matched to validated lists of names correlated to specific national origin groups, and the racial and ethnic composition of the surrounding neighborhood.

America's Essential Hospitals appreciates CMS' work to ensure transparency on disparities in health care and improve care for patients with social risk factors. However, we are concerned with the proposed use of indirectly estimated race and ethnicity data in reporting disparity methods results and the unintended consequences if this information is publicly reported—for instance, the statistical uncertainty of this approach and the risk that consumers will rely on inaccurate results when making important care decisions. **We also encourage CMS to examine social risk factors beyond dual eligibility and race and ethnicity in order to inform hospital efforts to identify disparities.**

i. CMS should refrain from publicly reporting disparity methods results that use indirectly estimated race and ethnicity data.

Essential hospitals are committed to transparency and accuracy in quality measurement. Our members understand the importance of quality improvement reporting, especially with increasing demands for accountability, movement toward value-based purchasing, and growing consumer engagement. Our members also know the importance of sound data to reduce disparities in care, and they lead efforts to close gaps in quality for racial and ethnic minorities.

CMS notes that indirect estimation of race and ethnicity is "an intermediate step, filling the pressing need for more accurate demographic information" and that "self-reported race and ethnicity date are the gold standard for classifying an individual according to race or ethnicity." Further, the agency acknowledges the limitations of using indirect estimation, including inaccuracies in certain geographies or populations.

In November 2020, the Urban Institute held a virtual workshop on the ethics of using imputation and related methods to fill missing race and ethnicity data for various datasets. Among the ethical risk areas raised during the workshop was the power dynamic between individuals whose data are collected and organizations collecting and using the data, such that communities of color are prevented from exercising ownership over their own data. The workshop participants also highlighted the degree of statistical uncertainty that comes from using imputation and related methods and the risk of "misinformed policy choices that harm [Black, Indigenous, and other people of color]." In particular, the level of variability is higher for smaller race and ethnicity subgroups because fewer observations are imputed.[28] **CMS should further examine the unintended consequences of using indirect estimation of race and ethnicity data and seek stakeholder feedback on mechanisms that promote self-reported data among hospitals.**

Hospitals should be armed with as much meaningful information as possible to inform their decision-making and quality improvement efforts. The CMS disparity methods reports enable hospitals to internally examine their efforts to address disparities in the context of other hospitals in their region. Essential hospital leaders deeply understand the characteristics of the populations their hospitals treat and the challenges they face and are the best audience to view and interpret these reports. Publicly posting results using a method with potential variability and inaccuracy could lead to consumer confusion and would be a misrepresentation of care quality. **We strongly urge CMS to refrain from publicly posting disparity methods results that use indirect estimation of race and ethnicity.**

ii. CMS should examine social risk factors, beyond dual eligibility and race and ethnicity, to capture the full array of variables that might impact quality of care.

[28] Randall M, Stern A, Su Y. Five Ethical Risks to Consider before Filling Missing Race and Ethnicity Data, Workshop Findings on the Ethics of Data Imputation and Related Methods. Urban Institute. March 2021. https://www.urban.org/sites/default/files/publication/103830/five-ethical-risks-to-consider-before-filling-missing-race-and-ethnicity-data-workshop-findings_0.pdf. Accessed June 9, 2021.

America's Essential Hospitals previously expressed concern that the HRRP and other CMS programs unduly penalize hospitals that serve the nation's underrepresented populations because they fail to account for external factors that explain higher readmission rates. We are pleased the HRRP now includes peer grouping based on a hospital's proportion of dually eligible patients. However, as we have noted, this is only the first step toward true risk adjustment for hospitals treating patients facing social and economic challenges.

While we appreciate the conceptual basis for expanding the disparity methods by stratifying results by race and ethnicity, in addition to dual eligibility, this risk factor is limited in scope and flawed in approach. CMS should consider additional factors, such as the importance of screening for health literacy and communicating with at-risk patients and their caregivers, as well as integrating community and health care resources in care coordination after discharge. However, the disparity methodology fails to incorporate factors beyond dual-eligible status and race and ethnicity. Identifying which social risk factors might drive outcomes and how best to measure and incorporate those factors into payment systems is a complex task, but doing so is necessary to ensure better outcomes, healthier populations, lower costs, and transparency. **We urge CMS to further examine data sources and methods to capture social risk factors in a uniform way that can be used in future reporting of disparities.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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