



AMERICA'S ESSENTIAL HOSPITALS

September 13, 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-1751-P: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates the Centers for Medicare & Medicaid Services' (CMS') proposals recognizing the importance of telehealth to expand health care access and encouraging the continuation of flexibility that benefits marginalized populations. We also support the agency's work to encourage improved care delivery across the industry. However, we are concerned by the timeframe for adoption of new clinician pathways within Quality Payment Program (QPP). We also are deeply troubled by the continued cuts to Medicare payments for off-campus provider-based departments (PBDs) under the Bipartisan Budget Act of 2015 (BBA); these cuts undermine efforts by essential hospitals to mitigate health disparities. Further, these changes come as essential hospitals struggle to respond to challenges and uncertainty caused by the COVID-19 public health emergency (PHE) and continue efforts to serve many of the communities hit hardest by the pandemic.

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, 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 a 2.9 percent margin, on average, compared with 8.8 percent for all hospitals nationwide.¹

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 August 23, 2021.

Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in essential hospital communities have limited access to healthy food, and more than 22 million live below the federal poverty line.² Essential hospitals are uniquely situated to target these social determinants of health and are committed to serving these marginalized patients. But these circumstances compound challenges and strain resources, requiring flexibility to ensure essential hospitals are not unfairly disadvantaged for serving people who face financial and social hardships and can continue to provide vital services in their communities.

We are pleased by the proposed extension of the CMS Web Interface as a reporting method for Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs). However, we are concerned about the transition to ACOs reporting data via the new APM Performance Pathway (APP) at a time when hospitals are continuing to respond to COVID-19—particularly amid case surges related to the delta variant. In addition, many ACOs still are adapting to the agency's overhaul of the MSSP, which created new participation tracks in 2019.

We support CMS' work to identify measures and activities that appropriately assess performance, promote quality of care, and improve outcomes through the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs) under the QPP. We urge CMS to be thoughtful in its approach and timeframe for shifting to the new MIPS Value Pathways (MVPs) and sunsetting traditional MIPS. To ensure alignment across Medicare programs and allow all providers flexibility to be efficient and successful under the QPP, CMS should consider our recommendations before finalizing calendar year (CY) 2022 updates to the program.

Improving care coordination and quality while staying true to a mission of helping those in need can bring extra challenges to essential hospitals. To ensure our members have sufficient resources to advance their mission and are not unfairly disadvantaged for providing comprehensive care to complex patients, we urge CMS to consider the following recommendations when finalizing the abovementioned proposed rule.

- 1. Communities served by essential hospitals face unique health and social challenges; CMS should account for these challenges and preserve adequate reimbursement rates for essential hospitals' excepted and non-excepted PBDs.**

As mandated by Section 603 of the BBA, CMS on January 1, 2017, discontinued paying certain off-campus PBDs under the Outpatient Prospective Payment System (OPPS). The BBA instructed CMS to pay these non-excepted PBDs under a Part B "applicable payment system" other than the OPPS; CMS determined the Physician Fee Schedule (PFS) to be such a system. **America's Essential Hospitals urges CMS to reimburse non-excepted PBDs of essential hospitals at no lower than 75 percent of the OPPS payment rate.** Doing so would ensure essential hospital PBDs can continue to cover the costs associated with providing comprehensive,

² Ibid.

coordinated care to complex patient populations in underserved areas and advance the administration's health equity goals.

Since 2018, CMS has established an interim payment rate under the PFS for non-excepted items and services provided at non-excepted off-campus PBDs that is equivalent to 40 percent of the OPPS payment rate. To public knowledge, CMS has not analyzed how reduced reimbursement would affect patient access to care in PBDs or the differences between the patients treated at PBDs and physician-owned offices. Reduced payments to off-campus PBDs have been impeding the ability of essential hospitals to provide care to vulnerable patients in these facilities. **We urge CMS to ensure essential hospitals are adequately reimbursed for complex services provided in their PBDs.**

In the aggregate, members of America's Essential Hospitals operate on margins one-third that of other hospitals nationally.³ For hospitals serving a safety net role that operate on narrow (often negative) margins, this reduced payment rate is unsustainable and disproportionately impacts low-income and marginalized communities. Essential hospitals often are the only providers willing to take the financial risk of opening a clinic in a community with many clinically complex and low-income patients. Inadequate payment rates affect patient access by limiting the ability of essential hospitals to bring health care into these communities of need. CMS' implementation of Section 603—especially the inadequate payment rate—already has caused essential hospitals to re-evaluate plans to expand their provider networks into underserved areas.

CMS' application of Section 603 has played an undeniable role in limiting health care access for the country's most disadvantaged patients and will only further exacerbate health disparities. Essential hospitals are committed to advancing the Biden administration's goal of advancing racial equity, including by addressing health disparities.⁴ Off-campus clinics are a critical part of our members' efforts to bring care nearer to where their under-resourced patients live. Patients seeking care at essential hospitals' off-campus PBDs typically are low-income and people of color. A significantly higher proportion of patients treated at essential hospital PBDs are dually eligible for Medicare and Medicaid—a key indicator of patient complexity. Dual-eligible beneficiaries tend to have poorer health status and are more likely to be disabled and costlier to treat compared with other Medicare beneficiaries.⁵ In fact, CMS uses a hospital's proportion of dual-eligible beneficiaries as a proxy for adjusting the hospital readmission measures to recognize differences in sociodemographic factors. Essential hospital clinics often fill a void by providing the only source of primary and specialty care to these patients in their communities. Because of their integrated health systems, essential hospitals can help drive down overall health care costs, including for the Medicare program, by efficiently providing coordinated care through ambulatory networks.

³ Ibid.

⁴ Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. January 20, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>. Accessed August 23, 2021.

⁵ Medicare Payment Advisory Commission. Data Book: Health Care Spending and The Medicare Program. July 2020. http://www.medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0. Accessed August 23, 2021.

It is worth noting that PBDs must comply with provider-based regulations, which include requirements pertaining to billing, medical records, and staffing. For example, an outpatient department must be clinically and financially integrated with the main provider and have full access to services at the main hospital to qualify as a provider-based facility and receive Medicare reimbursement. The department also must integrate its medical records into the main provider's system. These and other requirements impose additional compliance costs on hospitals that freestanding physician offices do not bear.

CMS has acknowledged it cannot directly compare payment to hospital PBDs and freestanding clinics because payment under the OPSS accounts for the cost of packaging ancillary services to a greater extent than payment under the PFS. For many services paid under the OPSS, including comprehensive ambulatory payment classifications, CMS makes a single payment for the main service and related packaged services. Comparing payment under the OPSS and PFS without accounting for the higher level of packaging that occurs under the OPSS understates the costs of services in hospital PBDs.

The Medicare Payment Advisory Commission (MedPAC) in a June 2013 report discussed equalizing payment across settings. MedPAC noted that adjustment in payment rates to hospital PBDs should account for the higher level of packaging in the hospital setting by paying the hospital department at a higher rate than the physician freestanding office.⁶ **To adjust for the higher level of packaging in the OPSS, as well as higher costs incurred by essential hospital PBDs compared with freestanding offices, CMS should revise its payment rate for non-excepted items and services of essential hospital PBDs to at least 75 percent of the OPSS payment rate.**

By paying non-excepted PBDs at 40 percent of the OPSS rate, CMS grossly undercompensates hospitals for services they provide to complex patients. **We urge CMS to increase the payment rate for non-excepted PBDs of essential hospitals to adequately account for the higher acuity of patients they treat compared with physician offices and promote access to care in the nation's most marginalized communities.** Payment rates also should reflect the requisite resources, staff, and capabilities necessary for PBDs to both comply with other CMS regulations and provide high-quality care to all patients. Essential hospital PBDs offer culturally and linguistically competent care tailored to the disadvantaged patients in their communities. Whether due to the clinical complexity of their patients or the additional resources needed to provide translators and wraparound services, essential hospitals incur higher costs than other facilities. By considering the recommendations above, CMS can lessen the negative effect of Section 603 on disadvantaged patients' access to care.

⁶ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2013. http://www.medpac.gov/docs/default-source/reports/jun13_entirereport.pdf. Accessed August 23, 2021.

2. CMS should expand disadvantaged populations' access to lifesaving services by broadening the scope of telehealth reimbursement and lifting barriers to Medicare reimbursement for these services.

During the COVID-19 PHE, CMS has expanded flexibility by adding to the list of reimbursable telehealth services; waiving geographic and site-of-service restrictions on the originating site; and allowing hospitals to bill an originating-site fee. Continuing such flexibility will be indispensable as essential hospitals respond to the latest surge in COVID-19 cases resulting from the delta variant and prepare for future outbreaks. This pandemic has demonstrated the effectiveness of telehealth in providing high-quality, cost-effective care while protecting patients and health care personnel from unnecessary exposure to illness.

The key role technology can play in linking patients to access and high-quality care has become increasingly evident amid COVID-19. Telehealth expands the reach of specialists and other providers, allowing hospitals to efficiently connect patients to care and improve population health. Essential hospitals, which are on the front lines of responding to the pandemic, use technology to connect their providers with patients in a variety of settings. The use of telehealth has been critical not only in screening potential COVID-19 patients, but also in allowing other patients to maintain continuity of care with their primary and specialty care providers while respecting physical distancing mandates. At essential hospitals, no-show rates among low-income patients are significantly lower for telehealth visits compared with in-person visits. The ability to virtually access care helps low-income populations overcome some common barriers to care. The importance of telehealth will expand well past the current PHE, to include responding to future outbreaks and ensuring continuity of care for patients with acute and chronic conditions.

In the rule, CMS proposes changes to Medicare reimbursement for telehealth, including extending the period for which it will reimburse temporarily added services and implementing legislative provisions requiring payment for mental health services. We are encouraged by these proposals but, as we note below, the agency should assess additional ways it can promote telehealth to ensure health care access for beneficiaries.

a. CMS should permanently add a broad variety of services to the list of Medicare reimbursable telehealth services.

Through previous rulemaking, CMS added more than 160 new services to the list of reimbursable Medicare telehealth services but only for the duration of the COVID-19 PHE. The categories of services added include physical and occupational therapy, behavioral health, audio-only evaluation and management (E/M), emergency department (ED) care, and critical care. The addition of these services has been crucial to essential hospitals' pandemic response, enabling them not only to assess potential COVID-19 patients, but also to continue monitoring and treating patients with acute and chronic conditions unrelated to COVID-19.

In last year's PFS rule, CMS added nearly 60 of these more than 160 codes to the list of category-three services and finalized a policy to reimburse them as telehealth services until the end of the calendar year in which the COVID-19 PHE ends. The list includes levels one to three ED visit codes, as well as codes for psychological and neuropsychological testing. CMS now proposes to cover these category-three services

until the end of CY 2023. **We support extending the time period these 60 services are reimbursable but urge CMS to permanently cover these category-three services, as well as the broader list of more than 160 services temporarily added during the COVID-19 PHE.**

Provider and patient experiences with telehealth encounters during the pandemic make clear the value of this technology to the provider-patient relationship. The ability to continue primary and specialty care visits remotely will be important as essential hospitals and their communities rebound from COVID-19. **To ensure continued access to lifesaving services, particularly for marginalized populations facing barriers to care, CMS should permanently include those services added during the COVID-19 PHE to the list of Medicare reimbursable telehealth services.**

- b. CMS should provide additional flexibility on the provision of telehealth services for the diagnosis, treatment, or evaluation of mental health disorders.

CMS proposes to implement a provision of the Consolidated Appropriations Act (CAA) of 2021, which requires that Medicare permanently waive the geographic restrictions imposed on telehealth services for the diagnosis, treatment, or evaluation of mental health disorders. This provision allows a practitioner to treat a beneficiary via telehealth, even if the beneficiary is located in their home or in an urban area at the time of treatment. However, CMS imposes a condition that the beneficiary must have received an in-person visit from the practitioner within the six months preceding the telehealth visit. **We urge CMS to lift this unnecessary barrier to access by lengthening the time period from six months to a year.** Requiring beneficiaries to receive in-person visits before a telehealth visit runs counter to the CAA's intended purpose of expanding access to mental health services. Particularly for underserved populations facing social risk factors, such as lack of transportation, the in-person requirement is unnecessarily restrictive and jeopardizes access to vital mental health services.

Additionally, CMS seeks comment on whether it should allow the in-person requirement to be satisfied when a patient is seen in-person by another physician or practitioner of the same specialty and subspecialty within the same group as the physician or practitioner who furnishes the telehealth services. **CMS should allow this practice to satisfy the in-person requirement, which will provide needed flexibility, particularly for patients seen by large practices with multiple practitioners.**

- c. CMS should reimburse for a broader variety of audio-only services.

Through other rulemaking, CMS allowed certain services to be provided using audio-only technology during the COVID-19 PHE. These codes include audio-only E/M services, as well as various codes for behavioral health assessments and evaluations. CMS also increased the reimbursement rate for audio-only E/M codes to equal payment for in-person E/M visits. In last year's PFS rule, CMS on an interim basis added payment for an extended virtual check-in (HCPCS code G2252), which can be performed using audio-only communications or other synchronous means. CMS now proposes to permanently pay for this virtual check-in service. **We urge CMS to**

adopt its proposal to permanently pay for extended virtual check-ins using audio-only communications or other similar means.

Additionally, CMS proposes to redefine the term “interactive communications technology” to include audio-only communications when a telehealth service is provided to a beneficiary in their home at the time of the service and is for the diagnosis, evaluation, or treatment of a mental health disorder. However, CMS states it will pay for audio-only mental health services *only* if the beneficiary receives an in-person visit from the practitioner within six months of the audio-only visit. **CMS should finalize the proposal to allow audio-only communications for mental health telehealth services but remove the requirement for an in-person visit within six months of the telehealth visit, which will hinder access to mental health services.**

In addition to finalizing, with modification, the two proposals above related to audio-only services, CMS should permanently adopt payment for the other audio-only services it reimburses for during the COVID-19 PHE. Essential hospitals and their patients have benefited from this flexibility during the pandemic. The use of audio-only capabilities is beneficial for vulnerable patients who do not have access to computers or phones with video capabilities, and those who have limited access to broadband that can support synchronous video visits. When the provider can deliver care and assess the patient without seeing the patient, it is entirely appropriate to offer these services through audio-only means. **We urge CMS to continue to reimburse a subset of services, and ensure parity for these services, conducted through audio-only technology.**

- d. CMS should facilitate the provision of communication technology-based services by allowing such services for both new and established patients.

Separate from Medicare telehealth services, Medicare pays for communication technology-based services, which are services that do not have in-person equivalents—these include remote patient monitoring (RPM), virtual check-ins, and e-visits. Typically, these services are reimbursable by Medicare when they are provided to established patients of a provider or a patient of another provider in a practice. During the COVID-19 PHE, CMS has permitted providers to offer these services to new and established patients. For RPM services, during the COVID-19 PHE, CMS has allowed practitioners to monitor new and established patients for both acute and chronic conditions, as well as patients with only one disease. For example, RPM can be used to observe a patient’s oxygen levels through pulse oximetry. Before the COVID-19 PHE, practitioners could only use RPM for patients with multiple conditions. The benefits of communication technology-based services are equally applicable to new and established patients; this was demonstrated during the COVID-19 pandemic, when new patients sought to avoid exposure to health care facilities. This type of flexibility will be critical through the duration of the COVID-19 PHE, as well as during new outbreaks of COVID-19 and other public health crises. **CMS should continue to reimburse these services for new and established patients, and in the case of RPM, to reimburse for more types of conditions and for patients with only one condition.**

- e. CMS should remove restrictions on telehealth and continue to push for expanded access to high-quality care via telehealth services.

During the pandemic, CMS has used its amended Section 1135 authority to waive geographic and site-of-service restrictions on originating sites, allowing Medicare patients to receive telehealth services in a wide variety of settings, including their own home. In addition, CMS has allowed hospitals to bill an originating-site facility fee when the patient receives the service at their home. These changes have been transformative in paving the way for increased access to telehealth services, both for providers in the early stages of adoption and those with established telehealth footprints. It is imperative these providers reach patients facing barriers to care.

CMS should work with Congress to permanently eliminate the geographic and site-of-service restrictions on Medicare telehealth services. In practice, lack of transportation and other barriers to access prohibit more than just rural patients from timely access to care. Large populations in many urban areas are in health care deserts and are classified as medically underserved. Drawing a distinction between rural and urban underserved populations artificially restricts access to health care for those who need it most. Even if these patients live in heavily populated urban areas, receiving a timely telehealth service from a physician can result in the early diagnosis of a life-threatening condition and play an important role in providing cost-effective follow-up care. Outside the context of COVID-19, CMS allows originating-site flexibility in limited circumstances, such as for telestroke services and ACOs. CMS can encourage the continued push toward coordinated care and improved care access by working with Congress to remove geographic and site-of-service restrictions to care.

CMS should appropriately reimburse hospitals for the costs associated with maintaining technology, staff, and overhead expenses related to health information technology (IT) infrastructure capable of supporting telehealth services. When a Medicare service is provided in-person, hospitals typically are reimbursed for the facility fee under the OPSS to cover the costs of personnel, equipment, supplies, and other overhead. Though furnishing telehealth services to patients doesn't require the patient's physical presence within the walls of a hospital, these services nonetheless require significant hospital and staff resources. Hospitals incur substantial costs investing in telehealth technology and maintaining staff and equipment to ensure operation of their platforms. CMS recognized this by allowing hospitals to bill an originating-site facility fee for services provided through telehealth as long as the patient is a registered outpatient of the hospital, even if the patient receives the service from their home. **We encourage CMS to work with Congress to ensure adequate hospital reimbursement for costs associated with providing Medicare telehealth services.**

3. **CMS should finalize its proposal to delay the penalty phase of its new appropriate use criteria for advanced diagnostic imaging.**

To allow providers sufficient time to update systems, train staff, and revise workflows, CMS should delay the start date of penalties related to the new appropriate use criteria (AUC). CMS proposes to delay the penalty phase of the new AUC for advanced diagnostic imaging services to the later of January 1, 2023, or the January 1 following the end of the COVID-19 PHE. Pursuant to the Protecting Access to Medicare Act, CMS previously finalized a policy requiring practitioners to

consult AUC using a clinical decision support mechanism (CDSM) when ordering applicable imaging services, with penalties for failing to do so effective January 1, 2021. Last year, due to the COVID-19 PHE, CMS delayed the effective date of penalties for noncompliance to CY 2022. CMS now proposes another delay of the penalty phase to allow the agency and providers additional time to prepare for the AUC requirements.

America's Essential Hospitals supports the delay of the AUC penalty phase. Some hospitals experienced delays in implementing the CDSM necessary for the AUC requirements. For some providers, this was because they were undergoing electronic health record (EHR) vendor transitions, and their old EHR system did not have an integrated CDSM. Others have implemented CDSM modules but require additional time to gain experience, conduct testing, and train staff to comply with the new AUC requirements. Delaying the penalty phase will allow providers to implement and adopt CDSM modules and ensure their staff are prepared for the requirements before CMS imposes penalties. **Therefore, CMS should finalize its proposal to finalize the penalty phase of the AUC requirement.**

4. CMS should reimburse providers for complex medication management services when performed by clinical pharmacists incident to a physician or nonphysician practitioner.

In interim final rulemaking last year, CMS stated physicians and nonphysician practitioners (NPPs) can bill for medication management services provided by pharmacists incident to a physician or NPP service. This occurs when the physician or NPP performs the initial service and remains actively involved in the course of treatment, including providing direct supervision to the pharmacist or other staff. Subsequently, in the CY 2021 PFS final rule, CMS clarified physicians and NPPs can only bill for the lowest-level E/M visit, corresponding to current procedural terminology (CPT) code 99211, when billing on behalf of pharmacists providing a service. Medicare reimbursement increases for higher code levels, which indicate increased complexity and higher costs associated with a service. The final rule prevents physicians and NPPs from billing for more complex services provided by pharmacists that would normally be billed under CPT codes 99212–99215. **We urge CMS to revisit this policy and allow physicians and NPPs to bill for the full range of E/M codes to capture the complexity of medication management services offered by pharmacists.**

Clinical pharmacists are integral parts of health system clinical care teams, providing important services, such as medication management therapy, in collaboration with physicians and NPPs. Inclusion of clinical pharmacists in these care teams can reduce workload on physicians and NPPs while improving patient outcomes, reducing readmissions, and improving transitions of care.⁷ The time and resources involved in

⁷ Budlong H, et al. Impact of Comprehensive Medication Management on Hospital Readmission Rates. *Population Health Management* 2018. 21(5): 395–400; Ni W, et al. Budget Impact Analysis of a Pharmacist Provided Transition of Care Program. *Journal of Managed Care & Specialty Pharmacy*. Feb 2018; McFarland MS, et al. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. *Journal of the American College of Clinical Pharmacy*. 2020;3:494–500; Funk K, et al. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. *Journal of American Board of Family Medicine*. 2019; 32(4):462–473.

providing these services depend on the specific patient and level of care required. CMS' policy of only reimbursing for the lowest-level E/M code does not account for the time and resources invested in the care of patients. **To ensure adequate coverage for these services, CMS should permit physicians and NPPs to bill for the full range of E/M codes, 99211–99215, when a service is provided by a pharmacist incident to the physician or NPP service.**

- 5. CMS should continue to refine the QPP by delaying mandatory reporting under the new MIPS Value Pathways (MVPs) to allow adequate time to test MVPs and ensure there will be MVP options for all participants. The agency also should delay sunseting traditional MIPS until a transition plan for participants is clearly outlined.**

Implementation of the QPP in CY 2017 consolidated three existing physician quality programs into the MIPS. CMS previously finalized a methodology for assessing the total performance of each MIPS-eligible clinician through a composite score based on four categories: quality, cost, clinical practice improvement activities, and promoting interoperability.

MVPs are being developed as an option to motivate clinicians to move away from reporting self-selected activities and measures; they encourage clinicians instead to report on an aligned set of measure options designed to be more relevant to a clinician's scope of practice, a specific condition, or an episode of care. CMS intended to begin transitioning to MVPs in the 2021 MIPS performance year; however, due to the COVID-19 PHE, CMS in the CY 2021 PFS final rule shifted its timeline such that initial MVPs were delayed until at least the 2022 performance year.

CMS proposes seven voluntary MVPs for the CY 2023 MIPS performance period. From CYs 2024–2027, CMS intends to gradually add newly developed MVPs. CMS proposes that traditional MIPS would sunset by the end of the CY 2027 MIPS performance period, and MVP reporting would become mandatory beginning in the CY 2028 MIPS performance period. **We urge the agency to thoughtfully approach the development and implementation of the MVPs, as well as the transition away from traditional MIPS.**

CMS should seek feedback from stakeholders on specific MVP proposals to ensure their approach is responsive to clinician needs. To ensure success in adoption of MVPs, clinicians and other stakeholders will need adequate time to review and respond to specific proposals and prepare for participation in this new pathway. Further, it is unclear whether there will be MVP options for all MIPS-eligible participants before the CY 2027 sunseting of traditional MIPS. For example, the limited availability of relevant cost measures for all specialties and subspecialties could be a potential barrier to MVP implementation.

Participants need more time to become familiar with the proposed options within the MVP framework, as well as MVPs yet to be developed. **We support further development of these new pathways for clinicians and urge the agency to refrain from mandatory participation until there is adequate testing of the MVPs and assurance there will be MVP options for all MIPS-eligible clinicians.**

Additionally, we encourage CMS to consider the populations served by essential hospitals—those with complex medical and social needs—as part of the MVP development process. The mission to integrate health equity into care delivery and develop initiatives that target social determinants of health is embedded in the fabric of essential hospitals. Our members reach beyond their walls to understand what promotes or hinders health in their communities and to partner with local organizations to deliver community-integrated health care. **We urge the agency to examine the unique role clinicians at essential hospitals play in reducing disparities and implementing improvement activities to promote health equity.**

6. CMS should continue to refine the complex patient bonus in the MIPS, examine alternative approaches to target the bonus to clinicians with higher caseloads of complex patients, and increase the bonus cap.

For the 2020 and 2021 MIPS payment years, CMS finalized a policy that accounts for MIPS-eligible clinicians who care for complex patients by adding a complex patient bonus of up to five points to their final score. The bonus is based on a combination of the average Hierarchical Condition Category (HCC) risk score of the beneficiaries treated and the proportion of dually eligible patients treated. **We continue to urge the agency to create a complex patient bonus for the MIPS that accounts for social risk factors—in addition to HCC and dual-eligible status—when determining patient complexity.**

In the CY 2021 PFS final rule, CMS increased to 10 points the cap for the complex patient bonus for the 2020 performance period (2022 MIPS payment year) due to the anticipated increase in patient complexity resulting from the COVID-19 PHE. We appreciate CMS' acknowledgement that the pandemic has impacted patients served by essential hospitals—those already at high health risk due to social factors beyond the control of the clinician and who are disproportionately likely to be severely affected by COVID-19. The rationale for increasing the cap for the complex patient bonus extends beyond the PHE.

In looking at the first year of the MIPS, researchers found an association between patient social risk and physician performance. Namely, clinicians with the highest proportion of socially disadvantaged patients (based on dual eligibility) had significantly lower MIPS scores.⁸ Further, CMS references updated analyses using actual 2018 MIPS scored data which found “clinicians with a higher caseload of complex patients have lower final scores, by more than 10 points on average, prior to the assignment of the complex patient bonus.” America's Essential Hospitals supports policies that advance equity within the MIPS scoring system for clinicians treating medically and socially complex patients. Differences in final MIPS scores, influenced by factors outside the control of the clinician and unrelated to the care provided, create an unfair system in which clinicians at essential hospitals are disproportionately penalized for providing care to the most disadvantaged patients. **We urge the agency to consider further increasing to 20 points the maximum bonus available for clinicians with a higher caseload of complex patients.**

⁸ Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. *JAMA*. 2020;324(10):975–983.

7. CMS should continue to refine the methodology to establish ACO quality performance under the MSSP. The agency also should seek further input from stakeholders on the APP measure set to ensure reliability and fairness and to prevent unintended consequences.

In the CY 2021 PFS final rule, CMS finalized the APP, which was designed to provide a predictable and consistent MIPS reporting option. For performance year 2021 and subsequent years, ACOs are required to report quality data via the newly adopted APP. Under this new approach, ACOs report a smaller set (six versus 23) of quality metrics that would satisfy the reporting requirements under both MIPS and the MSSP.

We understand CMS' desire to align the MSSP quality performance standard with the proposed APP under the QPP, such that participants in the MSSP also would report quality via the APP. While we support greater alignment and reduced burden, **we urge CMS to be thoughtful in its approach for adoption of the APP at a time when ACOs face ongoing concerns related to COVID-19.**

CMS notes the APP was designed for all MIPS APMs. However, the agency believes the APP measure set also would be appropriate for ACOs participating in the MSSP. The APP contains a narrower measure set than previously used in MSSP quality measurement—six measures versus the current 23 scored measures. The measures used in the APP are related to patient experience, diabetes, depression screening, blood pressure control, all-cause unplanned readmissions, and all-cause unplanned admissions for multiple chronic conditions.

We applaud CMS' intent to move the quality measure set used in the MSSP toward more outcome-based, primary care measures. However, **we do not feel the current proposed APP measure set achieves this goal.** As quality reporting programs focus more on outcomes and move away from process measures, CMS must ensure that measures chosen for these programs accurately reflect quality of care and account for factors beyond a hospital's control. **The agency should ensure the measure set includes metrics that are valid and reliable; aligned with other existing measures; and risk adjusted for sociodemographic factors.** CMS should not include measures in ACO quality performance standards until they have been appropriately risk adjusted for sociodemographic factors, including socioeconomic status. Without appropriate risk adjustment for outcome measures, such as the readmission measure, the APP measure set creates an inaccurate picture of care quality at essential hospitals.

Quality metrics should focus on high-impact, high-value measures that are meaningful to patients and that promote improved outcomes while minimizing costs. A set of "core measures" should be identified using agreed-on principles for measure selection. CMS' Meaningful Measures Initiative has introduced a set of priority areas with the potential to focus quality improvement efforts. But more work is needed to effectively apply this framework to all levels of quality measure development, reporting, and assessment. **CMS should seek further input on the appropriateness of the APP's one-size-fits-all approach to quality measurement.**

We urge CMS to take time to gather more stakeholder input, such as through a request for information and listening sessions. Further, CMS

should seek endorsement by organizations with measurement expertise, such as the National Quality Forum (NQF) and its Measure Applications Partnership (MAP). Through NQF processes, measures are fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders. Measures should undergo review and obtain NQF endorsement before inclusion in the APP.

8. CMS should provide additional time before removing the CMS Web Interface as a reporting option for ACOs and should further assist ACOs in transitioning to the new APP.

The CMS Web Interface is an internet-based data submission mechanism for ACOs and groups (or virtual groups) of 25 or more clinicians to report quality data to the QPP. CMS originally proposed to discontinue use of the Web Interface submission method for performance year 2021 as the agency transitioned to electronic clinical quality measures (eCQMs) which require submission of all-payer quality data under the APP. However, in light of concerns raised during the public comment period for the CY 2021 PFS proposed rule, CMS in the CY 2021 PFS final rule decided to extend the use of the CMS Web Interface for ACOs as a collection type under the APP for performance year 2021. CMS proposes to further extend use of the CMS Web Interface for CYs 2022 and 2023.

We are pleased CMS recognizes the obstacles ACOs face in transitioning away from the CMS Web Interface. **We believe there are key issues to address before removal of the CMS Web Interface**—namely, a lack of standard data fields and interoperability. Removing the CMS Web Interface and pivoting to an alternative reporting method requires time and resources to change workflows, pay for registries, and adapt EHRs to comply with eCQMs. ACOs and their participants, as well as health IT vendors and developers, need additional time to prepare for reporting all-payer eCQM/MIPS measures. Further, the move to ACO-level eCQM reporting comes with technical challenges, such as the inability to de-duplicate patients across participant tax identification numbers. **We urge CMS to work with vendors to solve these issues and extend the CMS Web Interface collection type for longer than the two years proposed.**

9. CMS should consider changes to the MSSP to improve participation by ACOs serving complex patients who are impacted by social risk factors that influence outcomes.

In the proposed rule, CMS seeks comments on how to encourage health care providers serving marginalized populations to participate in ACOs. We applaud the Biden administration and CMS leadership for engaging stakeholders in combating health inequities that have long plagued communities served by essential hospitals. Our members deeply understand the coordination required to effectively lower costs and improve care quality for patients with comorbidities and chronic conditions, combined with social risk factors—those outside the control of the hospital, such as lack of transportation for follow-up care or limited access to nutritious food. However, barriers often impede essential hospitals from more robust participation in ACOs and other value-based care initiatives.

Quality measures in Medicare’s pay-for-performance programs and those chosen for value-based care models continue to lack appropriate risk adjustment for factors outside a hospital’s control. As such, essential hospitals in these programs and models are disproportionately disadvantaged based on the quality metrics used to evaluate performance and calculate shared savings or reconciliation payments. CMS should recognize the safety net mission in quality and outcomes measures used to evaluate performance in ACOs and other value-based initiatives.

We support the use of dual eligibility in the Hospital Readmissions Reduction Program (HRRP) as a first step that should be applied across CMS programs. However, dual eligibility is an insufficient proxy for poverty and social risk. **We strongly support the inclusion of factors related to a patient’s background—including sociodemographic status, language, and post-discharge support structure—in risk-adjustment methodology for the MSSP and other value-based care initiatives.**

Essential hospitals, which operate on margins lower than other hospitals, strike a delicate balance between improving care coordination and quality while maintaining a mission to serve the most disadvantaged people. Our members need the predictability of stable and sufficient payment streams, including upfront funding investment to support and sustain models that address acute social needs. **CMS should align incentives across the health care delivery and payment system to promote equity of care and eliminate disparities.** Further, there should be program flexibility to allow ACOs to use a tailored approach to address identified community-based needs.

10. Request for Information—Closing the Health Equity Gap in CMS Clinician Quality Programs

As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify gaps in care quality 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 Biden administration’s emphasis on health equity and CMS’ stated ongoing effort across 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 opportunities for ongoing stakeholder engagement.

- a. CMS should promote culturally appropriate collection of patient race, ethnicity, and language (REL) data and information on social risk factors in a 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 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 people of color.⁹ 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."¹⁰ Essential hospitals are leading this work; for example, 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 and Latino populations and other people of color emphasize the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language of patients. Further, the pandemic has shown 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 review."¹¹ Data are critical to understanding the unique challenges and disparities patients face. While some of the data collection efforts in COVID-19 legislative packages sought to deepen our understanding of these disparities and their root causes, it is clear 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

⁹ 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.

¹⁰ 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.

¹¹ 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.

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 used Z codes—a subset of ICD-10 codes—to capture social determinant information for Medicare fee-for-service (FFS) beneficiaries. A CMS analysis found less than 2 percent of Medicare FFS beneficiaries in 2017 had a Z code associated with a claim.¹² By encouraging 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 Inpatient Prospective Payment System 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 previously struggled to share data across different EHR platforms; hospitals in the HEZ now participate in the regional health information exchange, which allows real-time information sharing, 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 employment and housing protections—activities that can help mitigate barriers to care and reduce disparities.¹³ **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 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 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 does not consistently

¹² 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.

¹³ 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.

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 to 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 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 people of color.

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 data 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.¹⁴ **CMS should further examine**

¹⁴ 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_o.pdf. Accessed June 9, 2021.

the unintended consequences of using indirect estimation of race and ethnicity data and seek stakeholder feedback on mechanisms that promote self-reported data.

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 mitigate disparities in the context of other hospitals in their region. Essential hospital leaders deeply understand the characteristics and challenges of the populations their hospitals treat 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 care quality.

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 noted, this is only the first step toward true risk adjustment for patients with 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 screening for health literacy, communicating with at-risk patients and their caregivers, and 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,

Bruce Siegel, MD, MPH
President and CEO