June 17, 2022

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 Ave. SW
Washington, DC 20201

Ref: CMS-1771-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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment 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. As the agency finalizes Medicare inpatient payment policies, we ask that it consider the following comments on supporting the unique role essential hospitals play in promoting health equity by crafting policies that protect these hospitals from payment cuts and ensure their continued stability.

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 narrow operating margins leave minimal reserves and low cash on hand, circumstances made worse 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 essential hospitals attempt to rebound from the effects of the pandemic, they continue to face challenges posed by COVID-19, such as rising workforce costs and supply shortages.

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. Communities served by essential hospitals are estimated to have about 22.3 million people who live below the federal poverty line, 370,000 individuals experiencing homelessness, and nearly 10 million people experiencing food insecurity. To meet 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 emerges from the COVID-19 pandemic, we urge the agency to implement policies that will ensure stability for hospitals serving marginalized patients and promoting health equity. CMS should 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 public health emergency (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, therefore, will be sicker and costlier to treat; and prepare for future outbreaks. 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 future outbreaks of 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 work to define the category of hospitals that disproportionately serve marginalized patients and implement policies that will protect and support these essential hospitals’ critical work.**

CMS should adopt payment policies that recognize the unique role of essential hospitals in promoting health equity and should protect essential hospitals from the adverse effects of payment cuts and other policies that affect patient access. The administration has emphasized as a top priority the importance of tackling structural

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racism and promoting equity throughout the federal government. The administration’s commitment is apparent throughout the rule in CMS’ proposals and requests for information related to quality measures, climate change, maternal health, and other issues. From low payment rates in Medicare and Medicaid—insurance on which low-income people rely—to worse health outcomes for people of color, the lingering effects of structural racism drive health disparities and represent a continued public health threat.

Essential hospitals, by virtue of their very mission and diverse communities, are experts in addressing social determinants of health (SDOH) and advancing health equity. This expertise stems from essential hospitals’ firsthand experience witnessing and tackling the effects of structural racism and how it routinely disadvantages and produces cumulative and chronic adverse outcomes for people of color. Racial and ethnic minorities made up half of member discharges in 2019. Patients of essential hospitals are negatively impacted by SDOH that affect their health, well-being, and quality of life.

As essential hospitals, our members are committed to ending health disparities and providing high-quality care to all, including underrepresented and marginalized populations. But the ability to sustain this critical work is hampered by challenges essential hospitals face, including financial instability driven by insufficient payments and skyrocketing costs. Essential hospitals are chronically underfunded, due to their lower share of commercially insured patients relative to other hospitals, their high level of uninsured patients and patients insured by public payers, the disproportionately high amount of uncompensated care they provide, and the volatility of the disparate payment sources on which they rely. Federal policy changes, such as Medicare payment cuts, disproportionately impact these hospitals, which already operate on financial margins narrower than the average hospital. Such policy changes also undermine Medicare beneficiaries’ access to the linguistically and culturally competent care essential hospitals provide. To further the administration’s and essential hospitals’ shared goals of tackling health disparities and promoting health equity, it is imperative CMS recognize these hospitals when crafting Medicare payment and other policies.

a. CMS first should define the select group of hospitals most devoted to promoting health equity and that provide a disproportionate share of uncompensated care and serve a disproportionate share of low-income, insured patients.

CMS can begin this work by first defining this select group of hospitals. Essential hospitals are distinguished by the diverse patients they treat, serving high proportions of Medicaid, Medicare, and uninsured patients, in addition to racial and ethnic minorities. Due to their payer mix, they also provide a much higher share of uncompensated care than the average hospital. In addition to this vital safety net role, essential hospitals serve other key roles in their communities. They:

- provide specialized, lifesaving services, such as level I trauma and neonatal intensive care, emergency psychiatric services, and burn treatment;
- train the next generation of health care professionals to ensure the community’s supply of doctors, nurses, and other caregivers meets demand;
- deliver comprehensive, coordinated care across large ambulatory networks to bring services to where patients live and work;

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• meet public health needs by improving population health and preparing for and responding to natural disasters, public health emergencies, and other crises; and
• advance health equity to meet the needs and challenges of patient populations that face the greatest disparities and barriers to receiving quality care.

By providing this array of services, essential hospitals serve as anchor institutions and providers of choice for their communities. With a clear definition, CMS can identify providers that fill these specific roles in the health care system and assess how current and future Medicare policies impact them. This identification will ensure CMS can target support to this specific group of hospitals and protect them from harmful policies.

b. Once CMS has defined this group of hospitals, the agency should implement policies throughout the Medicare program that can support these hospitals and change those policies that disproportionately harm them.

Once CMS defines this group of hospitals, we urge the agency to identify new policies that will ensure stable funding to these hospitals and evaluate current policies that might disproportionately harm them. For example, as we outline in more detail in the sections below, there are certain areas in the proposed rule where CMS could develop policies targeted to essential hospitals:

• ensuring stable Medicare DSH funding;
• incorporating an essential hospital definition in peer grouping methodology for the Hospital Readmissions Reduction Program (HRRP);
• adding hospital characteristics, including classification as an essential hospital, to the confidential reporting of across-hospital disparity method results;
• ensuring essential hospitals are supported in efforts to address disparities and promote equity measurement; and
• addressing climate change by providing upfront and continued funding for climate resilience and mitigation projects.

In addition to implementing our specific recommendations throughout this letter, CMS should continue this work in future rulemaking to evaluate policies to support and protect these hospitals serving a safety net role.

c. CMS can use its existing statutory authority to implement these changes.

The Medicare statute gives CMS wide latitude to implement many of these changes. In addition, in instances where additional funding for essential hospitals is warranted or protection from proposed and existing payment cuts are necessary, CMS might be able to rely on its statutory exceptions and adjustment authority under Section 1886(d)(5)(I) of the Social Security Act. There is precedent both in this rule, as well as in previous rulemaking, for CMS to protect certain hospitals from financial losses or to increase payments to all hospitals or groups of hospitals. Most recently, CMS has used this authority to:

• provide a supplemental payment to Puerto Rico (PR) and Indian Health Service (IHS) hospitals to make them whole for reductions in DSH payments;
• create a new COVID-19 treatments add-on payment; and
• hold teaching hospitals harmless from the impact of increased beds on indirect medical education (IME) payments during the COVID-19 public health emergency.
In working to identify and support essential hospitals, CMS would advance its commitment to health equity, protect the interests of the Medicare program, and preserve access to care for the most disadvantaged Medicare beneficiaries. We urge CMS to follow these recommendations, and we look forward to working with the agency to advance our shared goals.

2. CMS should increase its proposed annual hospital payment update to account for rapidly rising costs of hospital goods and services.

CMS proposes a net annual payment update of 3.1 percent, resulting from a 3.2 percent market basket update plus a 0.5 percentage point adjustment, as mandated by legislation, minus a 0.4 percentage point productivity adjustment. **We urge CMS to adjust its methodology for calculating the annual payment update for fiscal year (FY) 2023 to ensure it provides a robust payment update that adequately incorporates the effects of inflation and rising workforce costs on hospitals.**

Hospitals continue to incur soaring costs as they recover from the COVID-19 pandemic, feel the effects of inflation, experience unprecedented increases in labor costs, and encounter supply chain issues and shortages. One report cites hospitals’ per discharge labor costs increasing 37 percent from 2019 to 2022. Essential hospitals, in particular, have incurred considerable costs associated with hiring bonuses, retention bonuses, and increased salaries to recruit and retain nurses and other staff in short supply. These challenges have persisted even as COVID-19–related hospitalizations decrease and stabilize. Ongoing challenges from the protracted battle against COVID-19 and the consequential emotional toll on staff remain evident. The pandemic has led to burnout on an unprecedented scale, and essential hospitals have expended significant resources to recruit and retain clinical and non-clinical staff—a costly undertaking in the already competitive marketplace for health care workers. One essential hospital shared that its staffing costs have increased by 300 percent within six months. A recent article in *The New York Times* underscored that these challenges remain for essential hospitals, especially as many high-risk patients seek delayed care for conditions that worsened during the pandemic.

In the context of historical inflation and workforce challenges, a net 3.1 percent payment update is insufficient to truly capture year-over-year changes in hospital costs. **To that end, we encourage CMS to implement a market basket update of at least 5 percent and to use its statutory authority to waive the productivity adjustment in FY 2023.** In determining the annual payment update for hospitals, the CMS Office of the Actuary (OACT) first estimates the market basket percentage increase, which reflects the annual change in the mix of goods and services used for providing inpatient hospital services. OACT’s use of the IHS Global Inc. forecast of the market basket rate of increase clearly does not account for the true cost increases hospitals face. CMS is not bound to use this data source, because the statutory provision at section 1886(b)(3)(B)(iii) of the Social Security Act provides CMS with discretion to “estimate” the market basket percentage increase. Instead, CMS could look to alternative sources of cost data, such as data from Medicare cost reports, as a truer representation of hospital-reported cost increases to support providing a market basket update of at least 5 percent.

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CMS also should waive the negative 0.4 percent productivity adjustment. While this adjustment is required by statute, CMS can either waive it using its Section 1886(d)(5)(I) exceptions and adjustment authority or by invoking its Section 1135 waiver authority, given the ongoing COVID-19 PHE declaration. By adjusting the annual payment update to account for increasing hospital input costs, CMS can ensure hospitals can continue to provide high-quality care and meet the needs of their patients.

3. **CMS should use its authority to maintain stability in total DSH payments, accurately capture the full range of UC costs hospitals sustain when caring for disadvantaged patients, and ensure it is transparent in its Medicare DSH methodology.**

The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC. Our members represent about 5 percent of all U.S. hospitals yet provided 16 percent of all UC nationwide, or about $6.9 billion.7

As mandated by Section 3133 of the Affordable Care Act (ACA), the majority of DSH payments are 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.

We are concerned about the continued DSH payment reductions that have resulted from the ACA DSH methodology. After multiple years of substantial decreases, beginning in FY 2014, and two years of slight increases, aggregate UC-based DSH payments have been decreasing since FY 2020. Based on CMS’ estimates, hospitals will see a steep cut to UC-based DSH payments for a third year in a row in FY 2023—an estimated $660 million reduction from last year, to $6.5 billion. Since 2020, UC-based DSH payments will have decreased nearly $2 billion—by 23 percent. Total DSH payments, including the estimated empirically justified amount, are estimated to be $9.85 billion, or $850 million lower than total DSH payments in FY 2022. For essential hospitals, which treat disproportionate numbers of uninsured and underinsured patients, these cuts are unsustainable. Essential hospitals will feel the impact profoundly in FY 2023, as they continue to recover from substantial financial losses related to COVID-19 and incur higher costs related to inflation and workforce challenges.

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 sustain significant UC costs in various forms, such as from 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. Further, recent Medicaid coverage gains are expected to evaporate when the COVID-19 PHE ends, and the same is predicted for ACA marketplace coverage gains in 2023. This will

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result in an increase in hospital UC and the uninsured rate. As a result, steep cuts to DSH payments are detrimental and unjustifiable for essential hospitals.

We urge CMS to consider how changes in Medicare DSH policy will affect essential hospitals and the communities they serve. In particular, the agency should mitigate losses to essential hospitals related to decreases in the Medicare DSH UC-based pool by implementing a cap on year-to-year losses. CMS also should consider how to accurately estimate traditional DSH payments and capture changes in the uninsured rate, which, in turn, plays a role in determining aggregate DSH payments. In addition, as data sources evolve and coverage patterns change, CMS should continue efforts to accurately capture all UC costs for allocating UC-based DSH payments among eligible hospitals. Finally, 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.

a. CMS should exclude FYs 2020 and 2021 discharges from the calculation of factor 1 for FY 2023, update its case-mix projections, 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 2023 is $660 million lower than the aggregate UC-based payments it finalized for FY 2022. 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 one minus 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 the 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 2023, for the third year in a row, factor 1 in the proposed rule is inexplicably lower than the previous year’s factor 1. In FY 2023, CMS estimates pre-ACA DSH payments at $13.27 billion—$0.72 billion lower than the amount used in FY 2022 and $1.9 billion lower than the amount used in FY 2021.

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

|------------|------------|------------|------------|------------|------------|------------|------------|------------|---------------|
**DSH Funding**


*FR = final rule; NPRM = notice of proposed rulemaking*

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 2019) 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 estimates 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 because of the effect of COVID-19 on Medicare discharges. As expected, 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 unfortunate 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 it has implemented 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. In the FY 2022 IPPS final rule, CMS alluded to the detrimental effect using 2020 data could have on setting prospective payment rates. For example, CMS used FY 2019 claims data instead of FY 2020 data in setting FY 2022 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 in FY 2023, CMS proposes to use three years of hospital discharge data but 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 2021 and 2022. 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. **CMS should be transparent and detailed in explaining its methodology so stakeholders can**

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8 Social Security Act §1886(r)(2)(A).
replicate this information, which directly relates to the aggregate amount of DSH payments paid in a given year.

Last, CMS should update its case-mix factors for FYs 2022 and 2023, which we believe underestimate the complexity of patients hospitals will treat. As patients return to the hospital to seek care they had forgone during the peak of the pandemic, we expect case mix to increase due to underlying acute and chronic conditions these patients will have.9 Recent analyses validate the case mix increase in 2022, as reflected by a nearly 5 percent increase in average hospital length of stay compared with 2021.10

b. 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 OACT. There is a direct relationship between the uninsured rate and total UC-based DSH payments, such that aggregate UC-based DSH payments increase as the uninsured rate increases. Therefore, it is critical CMS accurately project uninsured rate changes. 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.

The NHEA figures used to calculate the uninsured rate for FY 2023 are projections using historical data from 2020. OACT’s projections underestimate the expected coverage losses that will occur when flexibilities tied to the COVID-19 PHE and temporary legislative changes expire. In 2021 and 2022, the uninsured rate decreased due to increases in Medicaid enrollment associated with a continuous enrollment requirement and enhanced federal matching funds, as well as increased health insurance marketplace subsidies enacted by the American Rescue Plan Act. The Medicaid policies will expire when the COVID-19 PHE declaration ends, while the increased subsidies are set to expire in 2023. These changes are expected to lead to substantial coverage losses in 2023. Based on reputable studies by the Urban Institute and the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE), an estimated 15.8 million people could

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lose Medicaid enrollment and another 3 million could lose insurance through the health insurance marketplaces. While many of the disenrolled Medicaid beneficiaries could seek coverage through other programs, this process will take time and will be complex to navigate. Additionally, states will have to redetermine the eligibility of their Medicaid enrollees—a process that is expected to be time-consuming and could lead to states mistakenly disenrolling Medicaid beneficiaries as they rapidly process these redeterminations.

These policy changes will have a pronounced impact on the uninsured rate in FY 2023, which, in turn, would increase the UC-based pool. CMS projects only a minimal increase in the uninsurance rate from 2022 to 2023, from 8.9 percent to 9.3 percent. OACT’s estimates of Medicaid disenrollment in 2022 and 2023 pale in comparison to the estimates published by ASPE and reputable third-party sources. For example, OACT projects 2.6 million Medicaid enrollees would lose coverage from 2022 to 2023, compared with the nearly 16 million predicted by others cited above. CMS must include significant external factors, such as expected Medicaid and health insurance marketplace coverage losses, in its factor 2 estimates. Failing to do so will produce an artificially low uninsured rate, which will result in a low aggregate UC amount. OACT should update its NHEA projections to account for these projected coverage losses and the resulting increase in uninsured rates used to calculate the proposed rule factor 2.

c. CMS should prevent year-over-year decreases in essential hospitals’ Medicare DSH payments attributable to decreases in the overall UC-based pool.

CMS should use its statutory authority to protect essential hospitals, as defined above in section 1, from fluctuations in DSH payments. As described above, CMS’ proposed UC-based pool is projected to decrease for a third consecutive year, by 23 percent compared with FY 2020. These cuts to the UC-based pool trickle down to all hospitals but disproportionately affect essential hospitals, which, on average, provide seven times as much UC compared with other hospitals. The impact of these cuts will be especially pronounced, given the tenuous circumstances in which hospitals find themselves as they emerge from the pandemic and face rising labor and other costs. Although CMS proposes to cut total UC-based DSH payments by $660 million, hospitals actually incurred greater than $1 billion more in UC costs in FY 2019 compared with 2018 (the two years CMS uses to calculate hospitals’ UC costs for FY 2023 DSH payments). It is counterproductive for CMS to reduce overall DSH payments when hospitals are incurring higher levels of UC. Given the purpose of the Medicare DSH program to support hospitals serving high numbers of low-income patients and providing proportionally high amounts of UC, CMS should ensure essential hospitals are shielded from these payment cuts.

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14 Analysis of uncompensated care data in FY 2023 NPRM DSH Supplemental Data File.
As described in section 1, essential hospitals are at the forefront of providing care to marginalized patients and combating health inequity. Given the patchwork of funding on which they rely and the instability inherent in these payment sources, it is critical these hospitals have a steady, predictable funding source through the Medicare DSH program. Using its Section 1886(d)(5)(I) exceptions and adjustment authority, CMS should cap year-to-year losses in UC-based DSH payments for essential hospitals but do so in a way that does not reduce Medicare payments for other hospitals.

CMS proposes to make PR and IHS hospitals whole for DSH cuts related to changes in the factor 3 methodology through a supplemental funding stream under its exceptions and adjustment authority. Similar to the methodology proposed for PR and IHS hospitals, CMS can calculate the amount of UC-based DSH an essential hospital would receive using the finalized factor 3 for the upcoming year and compare it to the amount of UC-based DSH the hospital would have received had the UC-based pool remained steady. Using its exceptions and adjustment authority, CMS could then provide an additional payment to essential hospitals equal to the difference between these two values. For example, CMS would calculate an essential hospital’s UC-based DSH amount using its FY 2023 factor 3 multiplied by the UC-based pool in FY 2020, which was the last year before UC-based DSH payments began to decrease. The difference between this amount and the proposed UC-based payment for the upcoming fiscal year would be the additional payment amount. This policy would serve to protect essential hospitals from the year-to-year variability in DSH payments while still targeting these payments based on relative amounts of UC, allowing these hospitals that disproportionately serve marginalized patients to continue their critical work.

d. 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.”15 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 receives health insurance authorized by a Section 1115 demonstration that provides essential health benefits (EHB), as defined in the Medicaid regulations for an alternative benefit plan. Under the proposed policy, CMS would include days associated with patients who have bought health insurance that provides EHB using premium

15 Social Security Act § 1886(d)(5)(F)(vi).
assistance obtained through a Section 1115 demonstration that is equal to at least 90 percent of the cost of the health insurance. While the inclusion of days associated with patients receiving premium assistance through a Section 1115 is a welcome change from CMS’ proposal last year, it only covers limited instances in which an individual purchases coverage through the health insurance marketplace, likely excluding health insurance premium assistance programs provided in other states that subsidize Medicaid-eligible individuals’ employer-sponsored coverage. The proposal also explicitly excludes patient days paid for through a waiver-based UC pool. 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. In response to those federal court decisions, CMS again is attempting to rewrite the regulations to preclude hospitals from counting UC pool days in their Medicaid fractions.

**CMS should 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 exclude from the Medicaid fraction days associated with patients whose care is paid for by a UC pool. 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.

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.

e. 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 2023, CMS proposes to use two years of data—in this case, from the audited FYs 2018 and 2019 S-10. As CMS relies solely on the S-10 for calculating UC costs, the accuracy and reliability 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.

i. **CMS should mitigate the effect of anomalies in FYs 2020 through 2022 cost report data that will adversely impact UC-based DSH payments in future years.**

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16 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).

17 *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)
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. 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 to prepare 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 to 2022, 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 due to the pandemic. Cost report data from FY 2020 that coincide with COVID-19 likely will be used for FY 2024 rulemaking, and 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 the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. 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 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 using 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

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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 by providing more transparency for its audit protocols. Publishing the audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address findings. Due to 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 are 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 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 cost-to-charge ratio (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 teaching hospitals incur. 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.**
iv. **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 is 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 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 non-reimbursed 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 non-reimbursed 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 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 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.**

v. **CMS should clearly communicate S-10 changes to stakeholders.**

CMS notes it will consider revisions to the S-10 through the Paperwork Reduction Act process. **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 begins to incorporate multiple years of 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 CMS provide necessary guidance to hospital staff tasked with completing Medicare cost reports. Hospitals report that 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 through 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.

4. 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) 2023 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. **CMS should finalize a 90-day reporting period for CYs 2023 and 2024.**
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. But 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 they have implemented innovative strategies to reduce opioid dependence. As leaders in population health, essential hospitals continue to develop programs that prevent opioid misuse among marginalized 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 PIP.

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. This measure has been voluntary since 2019, and CMS now proposes to make it mandatory for the CY 2023 reporting period. While the measure in CY 2023 is a yes/no attestation without numerator and denominator thresholds, we urge CMS to work with stakeholders toward better PDMP integration before requiring this measure.

The PDMP measure is not ready for inclusion in the PIP 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. Although all 50 states now have PDMPs, not all states require the use of PDMPs. 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. As CMS shows in the rule, many states have yet to integrate their PDMPs with EHRs, health information exchanges, and pharmacy dispensing systems. Others do not yet allow for state-to-state PDMP queries. 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.**

c. **CMS should work with other agencies and stakeholders to advance interoperability and information exchange through the Trusted Exchange Framework and Common Agreement.**

CMS proposes a new optional measure under the health information exchange objective: enabling exchange under the Trusted Exchange Framework and Common Agreement (TEFCA). To attest to this measure, a hospital would have to participate as a signatory to a framework agreement and enable secure, bidirectional exchange of information for all unique patients discharged from the hospital or emergency department. **While we appreciate CMS’ support for advancing information exchange through TEFCA, this measure is premature, given the significant progress yet to be made in setting up the infrastructure for TEFCA. Therefore, CMS should postpone this measure until at least 2024.**

As directed in the 21st Century Cures Act, the Office of the National Coordinator for Health IT (ONC) has been working to establish the TEFCA, which outlines a set of principles for trusted exchange to enable interoperability using a network-of-networks approach utilizing qualified health information networks (QHINs), health information networks, hospitals, public health agencies, and other participants. QHINs are intended to serve as the hubs that connect TEFCA participants with sub-participants. Providers will connect with QHINs, which, in turn, will connect with other QHINs to exchange data. However, ONC has been working on establishing TEFCA since 2018 and just released the final TEFCA in January of this year. ONC and its recognized coordinating entity (RCE) have been creating a timeline for rolling out activities under TEFCA. The first and most critical of these will be establishing QHINs. ONC has yet to even begin accepting applications for these QHINs, which are central to information exchange under TEFCA. Once the RCE selects these QHINs, additional work will begin to onboard other participants who will have to sign framework agreements to enable bidirectional exchange through TEFCA. To enable exchange through TEFCA, providers will have to make substantial health IT investments in infrastructure and staff, which will be time consuming and costly. So, to expect providers to conduct bidirectional exchange under TEFCA by 2023 is premature. **CMS should work with ONC and other stakeholders to facilitate information exchange under TEFCA and only finalize this measure when providers have begun exchanging information through TEFCA.**

5. **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 and maternal health.**

CMS should continue to tailor the IQR Program measure set so it helps hospitals improve care quality and benefits the public by accurately reflecting the care hospitals offer. We applaud the administration’s emphasis on health equity and efforts across agencies to evaluate appropriate
initiatives to improve health outcomes and reduce health disparities. America’s Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. We caution that before including measures in the IQR Program, CMS must verify the measures are properly constructed and do not lead to unintended consequences. We provide the following comments for consideration as CMS continues its work to develop policies that promote equity and support the health of all beneficiaries. This includes the development of equity measures for the Medicare or Medicaid programs.

a. CMS should be thoughtful in its approach to equity measurement with a focus on implementing evidence-based practices, ensuring the uniform collection of race and ethnicity data, and allowing providers and patients time to fully learn and understand new measures.

Members of America’s Essential Hospitals not only shoulder a disproportionate share of the nation’s UC but also are at the forefront of cutting-edge medical research and innovation that continues to improve the quality of care patients receive. Through their work with underserved populations, essential hospitals have uniquely focused on the needs and challenges of patient populations that face the greatest disparities and barriers to receiving quality care, including low-income populations and racial, ethnic, sexual orientation, and gender identity minority groups. The barriers these patients face often are compounded by other social issues, such as food and housing insecurity and lack of transportation. This commitment to promote equity of care and eliminate disparities puts our members in a unique position within the health care delivery system.

America’s Essential Hospitals appreciates the leadership of HHS and CMS in prioritizing health equity through cross-agency initiatives to identify disparities and close gaps in care quality. Essential hospitals are committed to addressing health equity and support the creation of policies that drive accountability and transparency. We encourage CMS to be thoughtful in its approach to structuring, collecting, and reporting equity data to improve health outcomes.

i. CMS should further examine evidence-based practices that can be replicated and shared, as appropriate, among providers to improve outcomes and equity.

Hospitals should be armed with as much meaningful information as possible to inform decision-making and quality improvement. For example, over the years, hospitals nationwide have had success addressing rates of health care–associated infections through development of multifaceted infection prevention programs. While these programs vary between organizations, their critical functions often fall into specific categories, including:

- managing data and information (e.g., surveillance, reporting of infections);
- developing and implementing policies to prevent or minimize infection (e.g., isolation precaution policies);
- intervening to prevent disease transmission (e.g., outbreak investigation and control); and
- collaborating with other programs to achieve common goals (e.g., environmental health and safety, microbiology laboratory).19

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Providers are expected to adhere to evidence-based care guidelines and demonstrate that their patients have experienced optimal outcomes as a result. However, we do not yet have an evidence base linking specific health equity activities with improved outcomes. Without this evidence base, the foundation of equity measurement is less reliable and actionable, and providers are left to build on a patchwork of solutions or interventions to demonstrate improved outcomes.

A recent report from ASPE on developing health equity measures lists criteria for evaluating equity measurement approaches. Among the criteria is that the approach be based on available evidence of the relationship between the social risk factor and outcome. Further, the measurement approach should be reliable in that it can distinguish performance between providers or programs and guard against disincentivizing resources for beneficiaries. We urge CMS to help cultivate, through funded projects, the evidence base for equity interventions or standards of care that are tied to improved outcomes as an initial step in developing meaningful equity measures for its programs.

At a minimum, providers and policymakers would benefit from guidance on the appropriate terminology and distinctions between SDOH, social risk factors, and social needs. Agreement on common language to guide activities aimed at addressing these often-interconnected concepts likely would enable partnerships across sectors. Further, this shared understanding and use of terminology provide the standardization needed to support equity measurement and future measure comparison. As ASPE noted in its report, “[a]ddressing health equity issues requires implementing interventions to address the drivers of outcome differences and monitoring outcomes to determine whether equity improved.” Additional research is needed to assess the effect of social services on health outcomes and to identify which policies or programs addressing SDOH have been effective in improving health or health behaviors. CMS should provide guidance and education on shared terminology and definitions to support the development of an evidence base for addressing disparities.

ii. CMS should work to ensure the uniform collection of race and ethnicity data that are accurate, reliable, and valid.

America’s Essential Hospitals appreciates CMS’ work to ensure transparency on disparities in health care and improve care for patients with social risk factors. In 2019, people of color constituted more than half of essential hospitals’ discharges. However, the lack of consistently available and reliable race and ethnicity data in health care continues to be a barrier to measurement. Several components have been noted to improve the collection of race and ethnicity data at an organization, such as having leadership buy-in and support, streamlining

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24 Ibid.
data collection process and structure, standardizing staff education, engaging patients in direct communication, and measuring and monitoring.\(^{25}\)

CMS currently does not consistently collect self-reported race and ethnicity information for the Medicare program; the agency largely relies on Social Security Administration data.\(^{26}\) The lack of consistent standards related to data collection—in particular, that for marginalized population subgroups—challenges adequately collecting, reporting, and tracking information on health disparities. The Office of Management and Budget’s (OMB’s) governmentwide standards, revised in 1997, include five categories for race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and white. The OMB minimum categories for ethnicity include Hispanic or Latino and Not Hispanic or Latino.\(^{27-28}\) Finalized in 2011, HHS data standards for race and ethnicity include additional granularity under the OMB standard categories. For example, the HHS race data standard includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian, which roll up to the broader Asian category of the OMB standard. Likewise, the HHS ethnicity data category provides more granularity for respondents who are Hispanic, Latino, or of Spanish origin.\(^{29}\) In addition to OMB and HHS standards, the U.S. Census Bureau also collects information on race and ethnicity. Improvements to the 2020 Census Hispanic origin questions include revision of the example groups to represent the largest Hispanic origin population groups.\(^{30}\) There is a need for standardization and alignment of federal guidance on racial and ethnic categories to ensure the consistent collection of self-reported data across providers. Further, the U.S. population has continued to become more racially and ethnically diverse.

**Revisions to the OMB standard, aligned with HHS’ additional granularity, would improve the quality of race and ethnicity information federal agencies collect and present.**

Additionally, there is potential benefit in standardizing when data is collected (e.g., upon admission or patient registration), as well as providing consistency in how hospitals respond to patient concerns about the ways in which that data will be used.\(^{31}\) For example, hospitals could provide standardized scripting to assist hospital registration staff in explaining the reasons for

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collecting these data or develop tools and processes that allow patients to accurately self-report their identity. Collecting this sensitive information should build trust—not fear—between patient and provider. We encourage CMS to raise awareness and develop resources to support data collection and sharing, with clear information about how the agency or others will use the data.

iii. CMS should allow providers and patients time to fully learn and understand new measures of equity and to implement processes for data collection, reporting, and analyses. The agency should provide confidential reports of equity data to hospitals before publicly reporting.

Essential hospitals are committed to transparency and accuracy in quality measurement. Our members understand the importance of quality improvement reporting, especially with increasing stakeholder interest in 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.

Building the infrastructure to leverage equity data (e.g., stratification to identify inequities) can be a substantial investment. Further, all health care professionals and others working in the delivery system must be trained in collecting accurate socioeconomic and sociodemographic data and educating patients on why such data are being collected. Providers need time to become familiar with the data and the data collection processes, as well as how equity data might help set priorities and drive outcomes. The magnitude of the issue—health equity—demands a thoughtful, phased approach that accommodates providers at various stages along the path to health equity.

For essential hospitals, which already operate on margins well below those of other hospitals, it is critical the introduction of equity measures does not penalize the very hospitals that are striving to deliver equitable care and needed resources to marginalized and underserved populations. Penalizing essential hospitals that treat populations with significant social barriers to care by not factoring in these barriers when assessing performance creates a vicious cycle that reduces the already scarce resources these hospitals have to treat vulnerable populations. In developing equity measures, we also encourage CMS to provide special recognition and consideration to providers who disproportionately deliver care to disadvantaged populations in areas of high social vulnerability and who suffer the impacts of long-standing inequities.

Additionally, publicly posting equity measures with methods that introduce potential variability and inaccuracy could lead to consumer confusion and would be a misrepresentation of care quality. It is unknown at this point what the data will show; CMS and providers need time to ensure the validity, accuracy, and meaningfulness of this data before it is publicly reported or used in CMS payment programs. We strongly urge CMS to provide confidential reports to hospitals and refrain from publicly posting equity measure results until hospitals become familiar with the collection and reporting of these types of measures and the agency can validate data reliability and accuracy.

b. CMS should refine the Hospital Commitment to Health Equity measure to ensure the measure accurately reports hospital activities to address health equity and is meaningful to consumers. The agency should allow at least one year of voluntary reporting before requiring reporting in the IQR Program.
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.

CMS seeks to use quality measurement to support health care organizations in building a culture of equity. We agree with the agency that 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—Hospital Commitment to Health Equity—would assess a suite of organizational commitments to health equity, such as the inclusion of health equity as part of a hospital’s strategic plan; the degree to which a hospital collects demographic and social determinant of health (SDOH) information; the degree to which a hospital conducts staff training on the collection of such data; whether the hospital stratifies key performance indicators by demographic and/or SDOH variables to identify equity gaps; whether the hospital regularly shares these findings with the leadership and the board; and whether the hospital participates in local, regional, or national quality improvement activities.

Conceptually, the five domains CMS has proposed for the Hospital Commitment to Health Equity measure—equity as a strategic priority, data collection, data analysis, quality improvement, and leadership engagement—are reasonable and aligned with efforts in place at many essential hospitals for some time. Our members are publicly committing to combating structural racism by developing antiracism commitments; acknowledging racism as an SDOH; and developing tools, programs, and action plans to accomplish this work. For example, an essential hospital in North Carolina created a racial justice toolkit to help employees easily access resources to improve cultural competency and fight racial injustice.32 Another essential hospital in Delaware teamed up with a local social justice organization for an eight-week training for health care leaders to improve health equity.33 Many essential hospitals also have received the coveted Human Rights Campaign Foundation’s Healthcare Equality Index (HEI) designation of “LGBTQ+ Healthcare Equality Leader.”34 The HEI was developed to give health care facilities information and resources to ensure LGBTQ+ people have access to truly patient-centered care and to applaud facilities that have shown a commitment to providing equitable care. The proposed Hospital Commitment to Health Equity measure also should provide opportunities for health systems to share best practices and improve, and it should guard against creating a competitive or punitive environment. We urge CMS to be flexible in its approach to the Hospital Commitment to Health Equity measure to account for a variety of activities, such as the examples provided above, that demonstrate a commitment to equity.

We agree with CMS that the Hospital Commitment to Health Equity measure builds on hospitals’ current quality improvement activities, including those of many essential hospitals.

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But some hospitals might be further along than others, particularly with respect to data collection and analysis. For example, Domain 2: Data Collection requires that hospitals attest to three elements to receive one point for this domain; specifically, that the hospital (1) collects demographic and SDOH information on the majority of its patients; (2) has training for staff in culturally sensitive collection of demographic and SDOH information; and (3) inputs demographic and SDOH information collected from patients into structured, interoperable data elements using a certified EHR technology. Domain 3: Data Analysis requires that a hospital attests to stratifying key performance indicators by demographic and/or SDOH variables and to include this information on hospital performance dashboards. Hospitals are at various points on their journey to collect and report on SDOH data. Additionally, hospital demographic data collection capabilities are heavily influenced by EHR capabilities, which, in turn, are closely tied to which tools an EHR vendor offers. It would be unfair to penalize a hospital that is making progress, thereby demonstrating a commitment to equity, but perhaps is not yet sophisticated in its data collection and analysis or undergoing process improvements. **CMS should ensure the Hospital Commitment to Health Equity measure does not penalize a hospital that is making progress.**

CMS proposes to publicly report the numerator of this measure. For example, a hospital that affirmatively attests to each element of the five domains would receive the maximum five points. There is no partial credit for each domain. In other words, if a hospital attests to two of the three elements in a particular domain, the hospital would not receive a point for that domain. This all-or-nothing approach to scoring hospitals’ commitment to equity might fail to capture the scope of a hospital’s efforts. **We urge CMS to give a point for each domain for which a hospital has achieved at least one element, or, at minimum, award partial credit.**

Any approach to equity measurement must also recognize systemic factors that create and reinforce disparities while examining which factors providers can and should address through evidence-based interventions. **Mitigating SDOH at the community level requires collaboration between the health care, public health, and social service sectors, along with community engagement.** But silos continue to exist, often impeding coordination at the local, state, and federal levels. The broader community, including governmental entities, health care providers, social service and community organizations, academic institutions, employer groups, and all individuals, must be involved in developing and implementing solutions to effectively eliminate disparities. Further, equity measures should account for circumstances outside a hospital’s control, such as a lack of community-based social services in a particular geographic area. **We encourage CMS to work with stakeholders to identify barriers that might make it more difficult to connect patients to needed services and mitigate any unintended consequences that these challenges could have on the Hospital Commitment to 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 the collection of this measure might impose administrative and reporting requirements for hospitals. **We urge CMS to begin with at least one year of voluntary reporting so hospitals can become familiar with this type of measure and to provide confidential, hospital-specific reports before any public reporting.**

Additionally, CMS has not submitted this measure for endorsement by the National Quality Forum (NQF). NQF endorsement and Measures Application Partnership (MAP) approval are imperative to ensure measure validity and reliability. Through these processes, measures are
fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders. **We urge CMS to submit the Hospital Commitment to Health Equity for NQF endorsement.**

c. **We encourage CMS to finalize the Screening for Social Drivers of Health measure, align the measure with other equity measures, and provide two years of voluntary reporting.**

CMS proposes two social drivers of health measures—Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health—beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting in CY 2024. The Screening for Social Drivers of Health measure assesses the percentage of patients admitted to the hospital who are 18 years or older at time of admission and are screened for five health-related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety.

Data is a key driver in health care delivery, informing providers of patient needs while engaging patients in their own care in a coordinated way. Recognizing the effects of upstream factors outside a hospital’s control, essential hospitals increasingly work to mitigate social determinants of poor health in various ways. In most cases, the first step is to identify the needs of the patient population. Many essential hospitals screen patients for social needs or are in some stage of working to develop and implement a screening process.

Some hospitals focus on a specific social need across the patient population; for example, an essential hospital in Illinois employs a validated, two-question screening tool to identify food insecurity during patient intake. When a patient screens positive, the hospital offers them vouchers for fresh produce and referrals to the Supplemental Nutrition Assistance Program; Women, Infants and Children program; and other benefits, as appropriate. At another essential hospital in Texas, patients who screen as food insecure are eligible for a prescription for at least one trip to a food dispensary and connection to social programs and community resources. Other hospitals focus on screening for social needs within a program that serves a specific subpopulation. For example, several essential hospitals incorporate a social needs screening component when implementing interventions specific to patients admitted to the hospital after sustaining a violent injury. Given the strong interrelationship between social determinants of health and patients who are victims of interpersonal violence, screening for and mitigating their social needs helps prevent violent reinjury and generally improves health.

**We support the screening of patients for the HRSNs, as proposed.** However, screening processes often are labor and time intensive, particularly for essential hospitals already operating with low margins and disproportionately serving those who are marginalized and often facing one or more HRSNs. The mode of SDOH data collection can heavily impact patient care workflows. For example, some essential hospitals administer screening electronically, via a bedside application provided to all inpatients, while others might have health care workers screen at the point of care, which can consume considerable amounts of time and can seem intrusive or unnecessary from the viewpoint of patients and families. Other essential hospitals use a standard, self-reported questionnaire provided through a patient portal, which has the potential benefit of more accurate answers to sensitive questions but requires that the application used be interoperable with existing EHRs to allow data to be transferred seamlessly into a patient’s record. **We appreciate the flexibility CMS proposes in the use of any screening tool, provided the five HRSNs are covered by the tool selected. We encourage CMS to recognize the time and resources required**
to implement screening of all patients, as well as training for staff in the collection of such data.

Considerations beyond the screening tool itself also must be taken into account, including patient health literacy levels, language options for those with limited English proficiency, and access to the software on which the screening survey might be hosted. Further, all health care professionals and others working in the delivery system must be trained on collecting accurate socioeconomic and sociodemographic data in a culturally sensitive manner and educating patients on why such data are being collected and used. We urge CMS to provide two years of voluntary reporting to allow providers, patients, and EHR vendors to improve their capacity for and implementation of more systematic screening for all five HRSNs proposed.

CMS notes that criteria in developing this measure included that the HRSNs “can be screened and identified in the inpatient setting prior to hospital discharge, addressed by community-based services, and potentially improve healthcare outcomes.” Screening for HRSNs is an appropriate first step in advancing health equity. However, engaging in screening as a task will not be successful without integrating it into clinical decision-making and ensuring patients view those who are engaged in referrals and follow-up as part of their care team.35 If a provider is unable to outline the resources the hospital has at its disposal, or through referral, to address an identified HRSN, both provider and patient might experience frustration, unfulfilled expectations, or mistrust. The proposed Screening for Social Drivers of Health measure does not address the need for referral and bidirectional communication with community-based services to track outcomes. We encourage CMS to ensure screening measures align with and complement other equity measures, including the proposed Screen Positive Rate for Social Drivers of Health measure.

d. We urge CMS to recognize the need to link the Screen Positive Rate for Social Drivers of Health measure to referral to resources and provide two years of voluntary reporting.

The Screen Positive Rate for Social Drivers of Health structural measure would identify the proportion of patients who screened positive on the date of hospital admission for one or more of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Hospitals would report this measure as five separate rates.

Essential hospitals’ work to mitigate HRSNs generally falls into two categories: direct responses to the social needs of the individual patients they serve (e.g., referral to needed services); and efforts to ameliorate the social conditions in the community at large (e.g., improving infrastructure). The latter represents community-integrated health care, where efforts to influence social determinants are made in partnership with other sectors beyond health care. For many hospitals, these activities are complementary, not mutually exclusive, to efforts that address direct patient needs.

Essential hospitals work tirelessly to sustain effective collaboration between health care delivery and community-based services organizations to meet the unmet needs of underserved populations. However, care coordination is resource intensive for essential hospitals that serve

a population with complex social needs. Significant challenges exist in developing partnerships, building needed infrastructure, engaging patients, measuring progress, and creating sustainable funding models. **We urge CMS to examine the challenges to linking data from medical and nonmedical sources.** Further, we know from the literature that patients most in need of being connected to resources and, in particular, non-Hispanic Blacks often report more discomfort with being screened for risk factors.\(^{36}\) **We encourage CMS to develop universal information that can be provided to all patients or beneficiaries about the reasons for screening, use of such information, and community resources available, recognizing the limitations of a health system to resolve all issues.**

We agree with CMS that it is important to know both if a hospital or health system is using a screening tool (proposed Screening for Social Drivers of Health measure) and the results from the screening (proposed Screen Positive Rate for Social Drivers of Health measure). These two measures should work together to inform hospitals of the level of unmet social needs among patients. Internal quality improvement processes and collaborative efforts with community-based providers rely on this level of data. For example, several of our members use sophisticated resource linkage software that enables staff to screen patients for social needs; link patients that screen positive to appropriate resources and agencies; track follow-up; and measure impact.\(^{37}\) This type of software requires significant investment, along with training and staff time. Given the up-front investment for screening and challenges to connecting to community resources, **CMS should provide two years of voluntary reporting and construct policies that reward successful referral and/or follow-up.**

Additionally, in terms of quality measurement, it is unclear what CMS believes is a “good” rate for each domain and what constitutes improvement in performance. There are many factors that could influence a screen positive rate. For example, if a hospital reports a high screen positive rate for housing instability, this could indicate a hospital’s commitment to screening all patients and patients’ comfort in answering the question, rising housing costs in a particular area, a lack of medical respite programs in the community, or all of the above. If publicly posted, there is potential for consumer confusion about the meaning of these rates when seeking care or evaluating care quality. CMS notes this measure is “not for comparison between hospitals.” We agree and, therefore, believe this measure should be limited to internal quality improvement, to identify the needs of patients, and to better connect patients with available community resources. **We urge CMS to refrain from publicly reporting this measure and instead provide confidential reports to hospitals** similar to CMS’ Disparity Methods stratified reports in the HRRP.

- CMS should refine the Cesarean Birth and Severe Obstetric Complications electronic clinical measures (eCOMs) to account for socioeconomic and sociodemographic factors, where appropriate, and provide an additional year of voluntary reporting.

America’s Essential Hospitals supports 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 and do not penalize hospitals that disproportionately serve patients with complex clinical and social needs.

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Through focus, consistency, and organization, measures can help drive overall effectiveness in improving health system performance and patient outcomes.

CMS proposes two eCQMs, Cesarean Birth and Severe Obstetric Complications, in the Hospital IQR Program measure set that hospitals can self-select to report in CY 2023. CMS proposes mandatory reporting of both measures, beginning with the CY 2024 reporting period and for subsequent years.

A Cesarean section (C-section) is a procedure that entails surgical and anesthesia risks and requires mothers to undergo several days of inpatient, post-operative recovery. A C-section may be elective or nonelective. As part of the administration’s broader health equity efforts and in response to increases in low-risk C-sections, HHS included a goal of reducing low-risk C-sections by 25 percent in the next five years as part of the Maternal Action Plan.38

The Cesarean Birth eCQM assesses the nulliparous, term, or singleton vertex (NTSV) pregnancies delivered via C-section. The goal of the measure is to reduce non-medically indicated C-sections. The National Quality Forum (NQF) has endorsed the chart-abstracted form of this measure. The measure steward submitted the eCQM to the NQF for consideration during Spring 2022. We urge CMS to receive NQF endorsement before adopting the measure in the IQR Program. Additionally, CMS should emphasize that this measure is not intended to discourage practitioners from performing medically indicated C-sections.39

CMS also proposes a Severe Obstetric Complications eCQM to focus on the high maternal morbidity and mortality rates in the United States. Notably, racial and ethnic disparities are closely linked to the high U.S. pregnancy-related mortality rates. Black women are dying from pregnancy-related causes at a rate three to four times higher than white women.39 This quality gap is growing, with non-Hispanic black women having 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.40

The Severe Obstetric Complications eCQM assesses the proportion of patients with severe obstetric complications that occur during the inpatient delivery hospitalization. The measure reports two outcomes: one that includes all patients and one that excludes patients receiving blood transfusions. The Measures Application Partnership (MAP) reviewed and conditionally supported the measure, pending NQF endorsement. The measure risk adjusts for housing instability, due to its availability in the EHR. While we appreciate the inclusion of this social risk factor, additional demographic and social risk factors should be examined. Outcomes measures, such as the Severe Obstetric Complications eCQM, do not accurately reflect hospitals’ performance if they do not account for social risk factors that can impact health, such as a lack of access to healthy foods. We urge CMS and the measure developer to complete testing to evaluate the ideal risk adjustment methodology, including approaches that consider stratification by race and ethnicity.40

Before introducing either eCQM, it is necessary to balance the usefulness of information reported through EHRs with the challenges of extracting such data and the accuracy of the information captured. Providers still are working to incorporate EHR data entry into their workflows; additional feasibility testing across a broad array of providers and settings is necessary to ensure accuracy and validity. **We urge CMS to examine whether these eCQMs are a viable option for all hospitals and to allow an additional year beyond CY 2023 for hospitals to self-select to report the Cesarean and Severe Obstetric Complications eCQMs.**

6. **CMS should work with patients and providers to establish meaningful indicators of high-quality maternal care and share best practices and interventions to address maternal health disparities.**

CMS proposes to establish a hospital designation related to maternity care to be publicly reported on a public-facing website beginning in fall 2023. This designation would be awarded to hospitals based on their attestation of submission of the Maternal Morbidity Structural measure, finalized in the FY 2022 IPPS rule. The Maternal Morbidity Structural measure asks whether a hospital currently participates in a structured state or national perinatal quality improvement collaborative and whether the hospital is implementing patient safety practices or bundles as part of these quality improvement initiatives. CMS intends to propose a more robust set of criteria for awarding the designation that might include other maternal health–related measures that might be finalized for the Hospital IQR Program, such as the two eCQMs (Cesarean Birth and Severe Obstetric Complications) proposed this year.

From the very beginning of their lives, many people in this country have a relationship with an essential hospital—one in 10 U.S. residents are born at an essential hospital.\(^\text{41}\) Our members are adept at caring for 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 social risk factors, such as food insecurity or housing instability. Providing comprehensive benefits for pregnant and postpartum people should reach beyond the provision of traditional health care services and include addressing social determinants of health that often influence health outcomes (e.g., access to child care, support for feeding infants, testing for lead, etc.).

A maternal care designation should emphasize patient-centered and evidence-based interventions. **We support the use of structural measures as indicators of a hospital’s commitment to and participation in evidence-based maternal health practices.** Many essential hospitals are currently participating in perinatal collaboratives and associated patient safety bundles. For example, one essential hospital in Connecticut was an early adopter of perinatal quality and safety initiatives, including team training initiatives, as well as employing a dedicated perinatal quality and safety nurse and having an interdisciplinary Perinatal Quality and Safety Committee. This same essential hospital also developed a perinatal safety scorecard, in use for nearly a decade. We support CMS looking at participation in these collaboratives as evidence of a hospital’s efforts to improve or maintain a high level of maternal care quality. Further, we encourage CMS to engage stakeholders in identifying additional collaboratives or designations that might matter to consumers when choosing a provider for maternal care. For example, some essential hospitals are “Baby-

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“Friendly” designated facilities, with standards for mother/baby care practices related to infant feeding, as accredited by Baby-Friendly USA, Inc., the U.S. branch of the international Baby-Friendly Hospital Initiative developed by the World Health Organization and the United Nations Children’s Fund. In future rulemaking, CMS intends to propose a more robust set of criteria for awarding the maternal care designation that might include other maternal health–related measures finalized for the Hospital IQR Program. In particular, CMS notes the two eCQMs proposed in this year’s rule—Cesarean Birth and Severe Obstetric Complications—as measures that could be added to future criteria of a maternal care designation. CMS must be thoughtful in its approach to adding measures to this type of designation. For example, a designation based on outcome measures that lack appropriate risk adjustment for socioeconomic and sociodemographic factors could be misleading and not accurately represent maternal care quality at essential hospitals that serve the marginalized and patients with social risk factors that impact health.

CMS should engage stakeholders in identifying reliable and meaningful indicators of high-quality maternal care.

Additionally, as part of Vice President Kamala Harris’ call to action to reduce maternal mortality and morbidity, CMS encouraged hospitals to consider interventions to address key contributors to maternal health disparities and to support the delivery of equitable, high-quality care for all pregnant and postpartum individuals. It is critical maternal care addresses SDOH and disparities in a meaningful way. For example, an essential hospital in Arizona employs specific initiatives for the underserved—community navigators for refugees, teen pregnancy programs, transgender care, and addressing barriers to family planning and contraception. We encourage CMS to promote the dissemination of best practices and interventions to address maternal health disparities.

7. CMS should promote the standardized reporting of social risk factors, including the use of Z codes, to better understand the severity of illness and resources necessary to treat adverse health outcomes caused by social barriers to care.

America’s Essential Hospitals 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. But there are challenges to collecting and reporting SDOH data, including a lack of alignment across screening tools and standards for adding to and extracting SDOH data from EHRs.

The last chapter of the International Statistical Classification of Diseases, 10th revision (ICD-10) provides codes (Z00-Z99) to specify other factors that influence a patient’s health status. Providers since 2015 have used Z codes to capture SDOH information for Medicare FFS beneficiaries. However, an analysis from CMS found less than 2 percent of Medicare FFS beneficiaries in 2019 had a Z code associated with a claim. Limited documentation of SDOH data hinders our capacity to understand and adequately address social barriers to positive

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health outcomes. By encouraging the collection of this data in a standardized manner, CMS can better understand the severity of illness and resources necessary to treat adverse health outcomes caused by social barriers to care.

For many essential hospitals, Z codes are not systematically reported. Barriers include time, lack of policy incentive, and lack of awareness and understanding of the importance of these codes. Often, the use of Z codes requires health information management (HIM) professionals to review the entire medical record and to code clearly documented SDOH variables, which can be time and labor intensive and considerably impact HIM workflows. There is a need for better integration of SDOH into corresponding, structured EHR fields, which would allow for more efficient Z coding by HIM professionals. We urge CMS to address barriers to adopting and provide education on the importance of reporting Z codes, including their potential use in risk adjustment methodologies. Further, we urge CMS to seek alignment of the use of Z codes and policies on the screening for and collection of SDOH, including the newly proposed screening measures in the Hospital IQR Program. It is critical providers and patients understand how these policies work together and how they can be streamlined, to the extent possible, to avoid unnecessary burden.

CMS also seeks feedback on which SDOH Z codes are most likely to influence (i.e., increase) hospital resource utilization related to inpatient care. In particular, CMS is interested in providers’ use of the homelessness (Z59) code. Essential hospitals understand that issues associated with housing have profound impacts on health. The most dramatic of these is homelessness, but housing instability also includes difficulty paying rent, spending more than 50 percent of household income on housing, frequently moving, living in overcrowded conditions, or staying with friends and relatives.45 Housing instability and poor health can create a vicious cycle. Homelessness and unstable housing produce significant stress and make it difficult to adhere to medications, healthy eating, and proper hygiene.

Essential hospitals serve communities where more than 370,000 individuals struggle with homelessness.46 These individuals are more likely to use the emergency department and be admitted to the hospital for conditions that would have been amenable to primary care.47 Several essential hospitals work to mitigate this SDOH by offering temporary housing or long-term rental assistance, developing new affordable housing capacity, and other approaches. For example, in Illinois and Vermont, essential hospitals provide temporary housing and case management to meet the needs of patients experiencing homelessness.

In the FY 2020 IPPS rule, CMS recommended changing the severity level designation of Z59 (homelessness) from a non-comorbid condition to a comorbid condition. CMS cited data suggesting that when the Z59 diagnosis code is reported as a secondary diagnosis, the resources involved in caring for the patient justify increasing the severity level to a comorbid condition. However, CMS chose not to finalize this policy.

Classifying Z59 (homelessness) as a comorbid condition is a step toward recognizing that SDOHs impact the resources provided by a hospital to improve outcomes for a patient experiencing homelessness. **We urge CMS to change its severity level designation for the Z59 homelessness code.** Further, we encourage CMS to examine the full spectrum of SDOH Z codes, including food insecurity, lack of transportation, and unemployment, to determine the hospital resource utilization related to addressing these factors and whether additional SDOH Z codes should be classified as comorbid conditions.

8. **CMS should finalize the proposed continuation of its suppression policy for quality measures across programs impacted by the COVID-19 PHE 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 related to hospitalizations and transfers; increasing community food insecurity; staffing and supply shortages; and funding scarcity. Further, because COVID-19 prevalence remains inconsistent across the country, hospitals in different areas have been affected differently at various times throughout the pandemic.

Due to the likelihood significant distortions in quality measurement will continue, CMS proposes to maintain its suppression policy, adopted in the FY 2022 IPPS final rule to provide short-term relief to hospitals. The cross-program measure suppression policy would continue to be applied in the Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition (HAC) Reduction Program. We appreciate CMS' recognition that hospitals in these quality programs should not be negatively affected when their quality performance suffers due to external factors rather than actual care provided.

For the FY 2023 program year, CMS proposes to suppress the CMS Patient Safety Indicator (PSI) 90 measure and the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection measures when calculating measure scores and Total HAC Score, thereby not penalizing hospitals in the HAC Reduction Program. **We support the 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.

For the VBP Program, CMS proposes to revise the scoring and payment methodology for the FY 2023 program year, such that hospitals will not receive Total Performance Scores. Instead, CMS would assign each hospital a value-based incentive payment percentage that results in a value-based incentive payment amount that offsets the 2 percent reduction to the base operating diagnosis-related group payment amount (i.e., the 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 in the VBP Program.**

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 and policies in Medicare that are tied to payment. CMS must ensure the 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 those analyses. 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.

9. CMS should adopt policies in the HRRP that account for the impacts—direct and indirect—of COVID-19 on patient outcomes and incorporate social risk factors into the HRRP methodology.

CMS notes that the suppression policy adopted in the FY 2022 IPPS rule was a short-term, equitable approach during an unprecedented PHE. The policy was not intended for indefinite application. While the agency recognizes some measures might not return to levels seen prior to the PHE, it no longer will suppress the pneumonia readmission measure in the HRRP, beginning FY 2024. CMS believes the clinical proximity of the measure’s focus no longer is sufficiently close to the health impacts of the COVID–19 PHE for the suppression factor to continue to apply. The agency also proposes to add a covariate to adjust for a history of COVID–19 diagnosis, acknowledging the lasting effects of COVID-19 and their potential influence on a patient’s risk factors for readmission.

a. CMS should monitor for unintended consequences of resuming the pneumonia readmission measure in FY 2024.

CMS proposes to resume use of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure, with modification to exclude patients with a primary or secondary diagnosis of COVID–19, beginning with the FY 2024 program year.

Throughout the COVID-19 pandemic, providers have been challenged by the complexity of determining whether a patient’s pneumonia resulted from COVID-19 or another clinical process and how to document and accurately code these cases. To avoid the potential under-reporting of pneumonia due to COVID-19, effective January 1, 2021, CMS instituted a new code, J12.82 (Pneumonia due to coronavirus disease 2019). If a patient presents with an acute manifestation of COVID-19, such as pneumonia, CMS instructs the use of code U07.2 (COVID-19) as the principal or first diagnosis. Code J12.82, Pneumonia due to coronavirus disease 2019, would be assigned as an additional diagnosis. J12.82 is not included within the cohort of the pneumonia readmission measure. So, readmission rates for patients with an index admission of COVID pneumonia (J12.82) are not captured by this measure, as of January 1, 2021.

In proposing to resume use of the pneumonia readmission measure, CMS cites improved coding practices, including the increased use of J12.82 after January 1, 2021. But pneumonia continues to be a typical characteristic of individuals infected with COVID-19, and coding practices still might reflect difficulty in differentiating patients with COVID-19 from pneumonia patients without COVID-19. **We urge CMS to monitor measure data and coding practices and mitigate any unintended consequences of prematurely resuming the use of the pneumonia readmission measure.**

b. CMS should finalize its proposal to add a covariate that adjusts measures in the HRRP to account for a history of COVID-19 and ensure coding is comprehensive enough to allow for such an adjustment.
For some patients, COVID-19 continues to have lasting effects, including fatigue, cough, palpitations, and others potentially related to organ damage, post-viral syndrome, post-critical care syndrome, or other reasons. CMS policies must remain flexible to accommodate changes in our understanding of the disease course. For example, along with pneumonia, blood clots, and other serious health concerns caused by SARS-CoV-2, the COVID-19 virus, studies have identified a connection to diabetes after an acute COVID-19 infection.\(^\text{48}\) In a recent CDC study, it was reported that one in five COVID-19 survivors ages 18 to 64 years experienced at least one incident condition that might be attributable to a previous COVID-19 infection.\(^\text{49}\) Further, 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.

CMS proposes modifying all six condition- and procedure-specific measures in the HRRP to include a covariate adjustment for patient history of COVID-19 within one year prior to the index admission, beginning with the FY 2023 program year. **We support the technical measure specification update to adjust for a history of COVID-19 diagnosis and thank CMS for recognizing long-COVID and its clinical implications.**

To implement such an adjustment, CMS likely will rely on ICD-10 code U09.9 (Post COVID-19 condition, unspecified), which was approved for implementation as of October 1, 2021. While there was early recognition of this condition, due to patients suffering residual effects and providers attempting to categorize common symptoms, the diagnosis code for long-COVID (U09.9) was delayed. As a result, research is ongoing to analyze diagnoses most commonly co-occurring with U09.9 and apply patterns to flag probable long-COVID cases occurring before the existence of U09.9.\(^\text{50}\) It is important patients with earlier cases of long-COVID are no less ascertainable for current and future research and treatment opportunities, as well as quality reporting policies. **We urge CMS to ensure the covariate adjustment is comprehensive and able to capture the full extent of long-COVID cases, including those occurring before the existence of U09.9.**

c. **CMS should incorporate social risk factors beyond dual-eligibility in the HRRP methodology.**

Beginning in FY 2019, CMS has applied a peer grouping methodology in the HRRP that allows for comparisons of similar hospitals based on their proportion of dually eligible beneficiaries. CMS notes that it uses dual-eligibility status (i.e., patients eligible for both Medicaid and Medicare) in this peer grouping methodology as an indicator of beneficiaries' social risk. In the proposed rule, CMS solicits comments on updates to the HRRP to incorporate hospital performance for socially at-risk populations—for example, the use of variables associated with or measures of social risk and beneficiary demographics, in addition to dual eligibility.


Studies examining the impact of CMS’ peer grouping approach note that the old HRRP methodology forced essential hospitals and other providers that serve vulnerable patients to absorb a greater proportion of readmissions penalties, leaving them with even fewer resources to treat disadvantaged people. These studies acknowledge that the new methodology, using peer grouping to compare hospitals, is a step in the right direction. But they also conclude that the new payment adjustment method has not eliminated the disproportionate penalty burden on essential hospitals. The studies’ authors believe more work is needed to address disparities in readmissions related to factors, beyond dual-eligibility, as proxies for poverty.\textsuperscript{51,52}

A large and growing body of evidence shows that sociodemographic factors—age, race, ethnicity, and language, for example—and socioeconomic status, including income and education, can influence health outcomes.\textsuperscript{53,54} These factors can skew results on certain quality measures, such as those for readmissions, and make it difficult for certain hospitals to obtain incentives or share in savings. Further, when performance measures used in value-based payment programs do not account for providers serving patients who face a more complex set of life circumstances and social needs, these programs can exacerbate health care disparities, moving us further from achieving health equity. \textbf{We urge CMS to include factors related to a patient’s background—such as sociodemographic status, language, and postdischarge support structure—when risk adjusting quality measures in the HRRP.} CMS also should examine factors, such as the 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.

It is critical essential hospitals are not disadvantaged for serving medically and socially complex beneficiaries and that they have the resources to continue providing vital services to their communities. When evaluating updates to the HRRP, and, in particular, the peer grouping methodology, \textbf{we encourage CMS to group essential hospitals together, based on a future codified definition of this unique class of hospitals,} as we outlined in Section 1. By examining this core group of providers, which share a mission of caring for marginalized people, CMS can mitigate any unintended consequences of the current HRRP methodology that exacerbate health disparities and deplete resources from already under-resourced communities.

\textbf{10. CMS should provide clear, interpretive guidance on data reporting before the end of the COVID-19 PHE, continue to review the scope of frequency of current data reporting, and avert burdensome requirements for future PHEs.}

Hospitals, including essential hospitals, were the first providers to voluntarily supply quality data for the public and have been doing so for more than a decade. Our members understand the value of data and have been reporting COVID-19 data throughout the pandemic. These data

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on intensive care unit bed capacity, drug and personal protective equipment supply, and incidence of confirmed COVID-19 offer insight into how the federal government can work with our members to identify trends and address issues of critical importance.

Since August 2020, hospitals have been required to report certain COVID-19 data as part of their conditions of participation (CoP) in Medicare and Medicaid. CMS established the new CoP requirements for tracking the incidence and impact of COVID-19 for the duration of the PHE. CMS now proposes to revise the hospital infection prevention and control CoP requirements to extend the COVID-19 reporting requirements beyond the end of the current COVID-19 PHE declaration, through April 30, 2024.

Throughout the COVID-19 pandemic, hospitals have relied on ad hoc guidance documents outlining various reporting mechanisms, deadlines, and formats. Often, this leads to confusion and unnecessary use of limited resources. A streamlined approach to data reporting, along with consistent processes, is critical and should include specifying the channels through which hospitals will be informed about changes in reporting scope, frequency, and format. **CMS should prioritize the development of interpretive guidance to ensure a smooth transition in hospital reporting after the PHE.** Such guidance should clearly outline what will stay the same, what will change, and the timeline for these transitions. Further, we encourage CMS to allow providers to review, ask questions about, and identify potential unintended consequences of new policy guidance before it is released.

**During the period after the PHE ends and through April 30, 2024, CMS should continue its review process to determine the need for changes to reporting (scope and frequency).** Further, given that most states collect, compile, and analyze information on flu activity year-round, with weekly reports during flu season (October through May), we urge CMS to use existing public health data reporting methods to the greatest extent possible, so hospitals can focus on patient care and responding to surges or future PHEs.

CMS also proposes additional requirements to address future PHEs related to infectious disease. The agency proposes that when a PHE has been declared, hospitals would be required to report specific data elements to CDC’s NHSN or other CDC-supported surveillance systems daily, unless a lesser frequency is specified. **We support CMS’ proposal to build on existing reporting systems that are familiar to hospitals, such as the NHSN.** But it is unclear in what ways the requirements for future PHEs differ from the reporting requirements that would begin after the COVID-19 PHE and run through April 30, 2024. **CMS should clarify the differences in reporting requirements tied to future PHEs related to infectious diseases versus the reporting that would continue after the COVID-19 PHE.**

CMS also proposes for future PHEs to require that hospitals report “person-level data,” including medical record identifier, race, ethnicity, age, sex, residential county and ZIP code, and relevant comorbidities for affected patients. The COVID-19 pandemic hit the patients and communities served by essential hospitals particularly hard—especially people in racial and ethnic minority groups. 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. Person-level data is important; however, for facilities that have not automated their reporting systems and might be dealing with interoperability issues and workforce shortages, adding person-level data might not be feasible. **We urge CMS to weigh the health and safety benefits of requiring patient-level data, including comorbidities, with the likely burden this level of reporting**
will impose on hospitals responding to a future PHE while still recovering from the current COVID-19 PHE.

11. Advancing Maternal Health Equity Request for Information (RFI)

In addition to CMS’ proposed establishment of a publicly reported hospital designation for maternal care, the agency also seeks feedback on other activities to advance maternal health equity. Specifically, the agency is exploring how to address our nation’s maternal health crisis through policies and programs, including, but not limited to, CoP and quality measures.

America’s Essential Hospitals supports the development of meaningful quality measures to improve maternal health outcomes and eliminate health disparities. Quality measures should enhance, streamline, and improve data collection on maternal mortality, specifically ensuring race and ethnicity information are captured when collecting data and analyzing quality measures. As CMS considers developing future quality measures and reporting requirements on maternal health, we urge the agency to ensure quality measures are patient-centered, meaningful, and provide a fair and accurate evaluation of essential hospitals’ performance and that reporting requirements do not add administrative burden to essential hospitals.

Additionally, maternal health measures should advance patient safety in a meaningful way, including eliminating gaps in health equity among certain populations. The unconscionable racial disparities in maternal health outcomes are a glaring example of the health inequities experienced by minority populations. As NQF noted 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.”

We encourage CMS to further examine factors, such as language access, structural racism, mental health, and implicit bias, that can influence maternal health outcomes.

Integrating behavioral health and social work in the clinical setting is critical to improving maternal health outcomes. A retrospective analysis of pregnancy and postpartum deaths performed by an essential hospital in Utah found that drugs—chiefly opioids—contributed to the majority of these fatalities. Essential hospitals across the country are on the front lines of responding to the nation’s opioid crisis, with many hospitals specifically responding to the unique needs of pregnant and postpartum patients with opioid use disorders. An essential hospital in Ohio, for example, treats opioid use disorders in prenatal and perinatal patients by identifying those with high-risk pregnancies and connecting them to innovative treatment and programs designed to improve maternal and infant health.

Other essential hospitals have programs specifically for pregnant and postpartum people with diabetes. These types of models allow providers to focus on disease-specific issues that might impact expecting and new birth parents disproportionately or differently than the general population. America’s Essential Hospitals encourages CMS to consider the role of disease-specific initiatives designed for pregnant and postpartum individuals as part of a larger strategy to advance equity in maternal health outcomes.

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Essential hospitals rely on coordination and collaboration to achieve efficiency, address equity, and improve health outcomes. For example, an essential hospital in California operates the Solid Start program, a service delivery hub of integrated direct services focused on prenatal and developmental years. Working across community and hospital systems, Solid Start promotes comprehensive, patient-centered care and health equity. Essential hospitals also support and promote diversity among prenatal care teams, including allied health professionals, social workers, and community health workers. Our members across the country integrate community health workers into their care teams to help engage patients and navigate issues impacting patient wellness outside the hospital walls. Essential hospitals have shown that comprehensive collaborations can help improve the overall health and wellness of individuals and communities. We encourage CMS to consider ways Medicare and Medicaid can help stimulate the development of cross-discipline collaborations to improve maternal health outcomes.

CMS seeks feedback specifically on the use of maternal health–focused CoP to incentivize improvements in maternal care. Given that the result of noncompliance with CoP is removal from the Medicare and Medicaid programs, we do not feel CoP are an appropriate lever for CMS to address the maternal health crisis. Rather, we encourage the agency to examine hospitals’ engagement in activities targeting maternal health outcomes, such as the National Perinatal Information Center (NPIC). Membership in the NPIC database allows hospitals to benchmark several maternal and child health operational and quality measures and includes a race and ethnicity dashboard. This type of information then can be shared with a hospital’s quality and safety committees and more broadly across an organization.

12. Approaches to Incorporating Equity Request for Information

As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify existing gaps in care quality and eliminate disparities, as a matter of public health. It is critical health equity is integrated and aligned across CMS programs. We applaud the administration’s continued emphasis on health equity and CMS’ stated, ongoing effort across the agency to evaluate appropriate initiatives to reduce health disparities, including the proposed rule’s RFI about overarching principles for measuring health care quality disparities across CMS quality programs.

Since 2018, CMS has provided hospital-level confidential results stratified by dual eligibility for the six condition-specific readmission measures currently in the HRRP. These CMS disparity method reports are intended to educate hospitals and other stakeholders about the two disparity methods—within-hospital and across-hospital—and allow hospitals to review their results and data. We encourage CMS to include in its disparity methods reports social risk factors, beyond dual eligibility and race and ethnicity, to capture the full array of variables that might impact the quality of care.

Essential hospitals are committed to transparency and accuracy in quality measurement. Our members understand the importance of quality improvement reporting, especially with

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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.

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. **We urge CMS to continue to confidentially report results to hospitals and refrain from public reporting.**

Further, as CMS evaluates opportunities to expand its measure stratification reporting initiatives, such as the disparity methods reports, **we encourage the agency to consider adding hospital characteristics to the confidential reporting of across-hospital disparity method results. We also encourage CMS to deem essential hospitals as a unique class of facilities for purposes of across-hospital reporting.** As outlined in Section 1, essential hospitals play a distinct role in their communities, share a set of unique characteristics, and serve the marginalized and most at-risk patients. By formally defining essential hospitals, CMS could add this characteristic to its disparity methods reports to provide comprehensive information on disparities and support collaboration among hospitals working to improve equity.

America’s Essential Hospitals and its members are committed to tackling these important topics and look forward to additional opportunities for stakeholder engagement.

**13. Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity—Request for Information**

When considering the many threats of climate change and environmental hazards, patients of essential hospitals—disproportionately low-income, uninsured, racially and ethnically diverse, and medically complex—are among the most exposed, most susceptible to health and economic problems, and those with the fewest individual resources to prepare for and respond to health threats.\(^60\) For example, in the long term, communities of color face higher-than-normal exposure to pollutants that cause health problems, and during flooding or a hurricane—events that often cause stays at crowded shelters—low-income communities are exposed to higher physical and mental stress.

Essential hospitals are vital anchor institutions profoundly connected to the well-being of the people and communities they serve. This connection extends beyond the treatment of illness and disease and into work to influence the social factors and lived environment that impact health. As climate change alters that lived environment, essential hospitals recognize the importance of their role in addressing this crisis. As hospitals upgrade systems and facilities to mitigate their impact on the environment, they require special considerations related to costly infrastructure changes, which are complicated by regulations and unique resource constraints. Essential hospitals provide a disproportionate share of the nation’s uncompensated care and, on average, operate with little or no margin, affecting their ability to fund practices that

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mitigate climate change or build climate resilience. While hospitals perform upgrades that support climate resilience, resources to support essential hospitals and their special constraints are lacking.

Despite this, essential hospitals are working to reduce their emissions and waste while addressing SDOH, such as food insecurity and the lack of affordable housing. Here are examples:

- A member hospital in Ohio has diverted nearly 100 tons of single-use medical devices from landfills through a reprocessed medical device program; and reduced the use of the anesthetic desflurane in the operating room, which has 10 times the global warming potential as sevoflurane, a similar alternative. Further, during the COVID-19 pandemic, the hospital partnered with a community-based organization to provide meals to community members.
- An essential hospital system in North Carolina was awarded the U.S. Environmental Protection Agency’s Energy Star Partner of the Year for three consecutive years, operating and maintaining Energy Star certification at 13 facilities, including its four largest hospitals, while donating $10 million toward affordable housing.
- An essential hospital in New York has changed the way it bathes patients to reduce wastewater and the need for plastic wash basins. It now uses pre-moistened towels, made from recycled paper, that decompose. The hospital also has its own farm, which supplies food to patients; the Women, Infant, and Child Nutrition Program; the campus food pantry; and local charities.

But essential hospitals cannot do this alone. While our member hospitals provide high-quality care, address SDOH in their communities, and work to decrease their environmental impact, hospitals and health care systems do not have the financing or expertise to tackle the health sector’s environmental impact on their own.

Health care providers—in particular, essential hospitals—are at various stages of readiness to address their environmental impact. The COVID-19 pandemic compounded the financial strain on essential hospitals, hamstringing their ability to invest in and focus on climate-related initiatives. The public health crisis hit the patients and communities essential hospitals serve particularly hard, especially people of color and those with underlying health conditions. COVID-19 also exacerbated the health care provider shortage crisis, straining an already exhausted and overtaxed workforce.

Further, support, or lack thereof, from local and state government, as well as community partnerships, makes a significant difference in a hospital’s ability to ramp up work to reduce its environmental impact. Most of our member hospitals that are pioneers in this area collaborate with local government agencies and partners, set collective emission reduction goals, and find creative funding solutions mutually beneficial to all parties. They often receive funding from local and state governments. This support and financing are absent for many member hospitals just beginning to address their climate impact.

This is the backdrop against which hospitals make decisions about climate initiatives and the critical factors our members must weigh when allocating their limited financial and personnel

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resources to organizational priorities. Without proper on-ramps, resources, and funding, it will be difficult for many essential hospitals to address their contributions to climate change and build climate resilience. **HHS and CMS must properly fund and support essential hospitals to reduce the health sector’s impact on climate.** Not doing so risks exacerbating the very disparities these efforts seek to address.

a. **HHS and CMS must provide up-front and sustainable funding to essential hospitals to meet climate resiliency and mitigation goals.**

As safety net providers, essential hospitals must balance efforts to advance climate initiatives with resources needed for direct patient care. Essential hospitals cannot pass the cost of climate resilience and mitigation projects onto their patients as other businesses can pass the cost along to their customers, nor can they benefit from tax credits, as they are either government-owned or private nonprofits.

i. **Essential hospitals require more up-front financing for capital projects to build climate resilience and mitigation.**

Federal funding for initial capital investments will be key to helping essential hospitals upgrade their facilities and equipment to be more energy efficient and to reduce emissions. This is especially true for hospitals that must finance their own upgrades without grants or low-interest loans from local and state governments or community partners. While HHS promotes funding for climate mitigation projects through the return on investment from those projects, HHS fails to understand that even with those savings, some hospitals still cannot raise the initial funding. For example, a member hospital in New Mexico wanted to install solar panels on its new parking garage but could not afford it, even with the projected energy savings. Another member hospital in Arizona was building a new facility and intended for it to be Leadership in Energy and Environmental Design (LEED) certified but could not afford the additional costs associated with the certification. These up-front costs are not insignificant. Many members operate in facilities so old the buildings’ energy systems cannot be upgraded to realize cost savings, let alone facilitate new processes to reduce waste or other climate mitigation projects. In such cases, more capital funding is needed.

Further, special consideration should be given to rural and other hard-to-reach hospitals. Due to their remote locations, they pay an increased price for materials, shipping, and labor, as well as per diems for food and lodging for out-of-town craft workers to complete construction projects. Without additional funding to pay for these increased costs, these hospitals are disadvantaged in their efforts to build climate resilience and climate mitigation.

HHS should work with Congress to replenish the Hill Burton Act with a focus on climate resilience and mitigation to help essential hospitals address high up-front costs for infrastructure projects. HHS and CMS also should fund climate resilience and mitigation efforts across the U.S. health care system through the Network of Quality Improvement and Innovation Contractors (NQIIC) program. This program allows preselected contractors to work with the health care field to address public health, behavioral health, patient safety, and chronic disease self-management, all of which are greatly impacted by climate change and climate inequity. We encourage HHS and CMS to leverage this program as a critical tool for investing in climate resiliency and mitigation projects in the health care sector. Either way, **HHS must help secure the initial funding for climate-related projects at essential hospitals.**
ii. **HHS and CMS must create incentive programs to ensure sustainable funding for climate resilience and mitigation projects.**

Essential hospitals will require formal reimbursement or other incentives to help them with the initial and ongoing costs of climate-related investments. These incentives would be in addition to capital investments to influence how the supply chain, energy and water use, waste production, and use of gases and toxic chemicals impact hospitals’ environmental footprint. Getting these incentives right is critical. There should be recognition for improvement, not just achievement that realistically aligns with a hospital’s baseline measurement.

Given the variation in scope and scale of climate resilience and mitigation projects, incentive programs must be flexible to match. Staffing, training, equipment, and supplies all vary, depending on the project, such as transitioning to reusable dishware in the cafeteria, greening the operating room, establishing and maintaining a rooftop garden, and reducing wastewater and harmful chemicals. Additional payments can be provided through a value-based payment model for any hospital working on a climate-related project. CMS could boost the operating and capital costs portion of the IPPS payment or offer a Center for Medicare & Medicaid Innovation (CMMI) demonstration project with capital for hospitals to work on climate-related projects. Finally, CMS could approve climate-related projects or programs through Section 1115 waiver authority, as building hospital climate resilience and mitigating environmental impact address several SDOH and health inequities for Medicaid beneficiaries.

As noted earlier, all our member hospitals are government-owned or private nonprofit entities and are unable to benefit from many tax incentives for climate-related investments. So, alternatives to tax incentive policies are vital. The federal government could set up incentive programs for nonprofits that are grant-based, removing the necessity for having for-profit intermediaries, which raises overall project costs.

**HHS and CMS must establish ongoing incentives to sustain climate-focused projects at essential hospitals.**

iii. **HHS and CMS must prioritize essential hospitals for climate resilience and mitigation projects.**

With slim operating margins and competing funding priorities, essential hospitals often must choose between maintaining a service for patients or a climate-focused project. For example, one member hospital described it this way:

“We deliver level I trauma services, and the CT scanner in the emergency department is at the end of its life, and for us to continue to have that designation [level I trauma] and provide high-value care, do we spend $1.2 million on a CT scanner or do we spend $1.2 million on this energy piece?”

The reality is that essential hospitals must do both but do not receive the funding to do so. Not only do essential hospitals account for a third of the nation’s level I trauma centers and 40

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percent of the nation’s burn care units. They also might function as a haven during extreme weather events. For example, despite evacuation orders during Hurricane Irma in 2017, an essential hospital in Florida provided shelter for more than 800 patients, in addition to family members and staff, because the risks of moving patients receiving specialized services from the hospital’s level I trauma center and burn unit, both of which serve the region, were too great. Further, if patients lose power during a weather event and cannot operate their medical machinery at home, they will come to our member hospitals to provide the care and support necessary to weather the storm.

This level of readiness to provide highly specialized services while experiencing an extreme weather event is expensive, particularly at facilities not designed to withstand extreme weather, and will take significant planning and resources. One essential hospital in the Southeast and another in the Southwest each have experienced five extreme weather events in the past five years and are just beginning energy-saving projects. They have little to no local or state support, are working with shoestring budgets, and are still dealing with the COVID-19 and workforce crises. Another essential hospital in the Pacific Northwest serves as the level I trauma center for four states in a building that is almost 100 years old. A building that old neither was designed to handle the extreme heat that continues to threaten that area of the country nor lends itself to easy modification to withstand the extreme heat.

For HHS and CMS to reach their goals in advancing climate and health equity, they must prioritize essential hospitals. Leveraging a codified definition of essential hospitals, as we explored in Section 1, will be a critical step toward achieving this goal and supporting essential hospitals in their climate-related endeavors.

b. HHS and CMS must provide a wide scope of technical assistance to prepare essential hospitals to become more climate resilient and mitigate their environmental impact.

Along with funding, HHS and CMS must provide guidance, tools, and resources to help essential hospitals develop the implementation plans and partnerships they need to ramp up their climate resilience and mitigation efforts. As discussed above, our climate champions have access to multiple sources of support and funding to achieve these goals.

i. HHS and CMS must prioritize education to secure essential hospital buy-in.

Essential hospitals are at varying levels of understanding, capacity, and readiness to pursue climate resilience and mitigation projects. HHS and CMS should conduct more educational outreach to these hospitals. As discussed in the 2019 report from the Essential Hospital Institute, The State of Climate Resilience and Climate Mitigation Efforts at Essential Hospitals, hospital leadership buy-in was key for uptake and funding of new technology and practices to address climate change within health systems and hospitals. Awareness of the local political landscape and attitudes toward climate change also will be important, as some localities might not be ready to tackle the impact of climate change but are eager to address community safety and preparedness for extreme weather events. Education and training

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must meet hospital leaders at their level of understanding of and approach toward climate change to best mobilize them to act on climate resilience and mitigation at their hospital or health system.

ii. **HHS and CMS must invest in capacity building to support partnerships.**

As documented in the 2019 report and demonstrated by essential hospitals that have made progress in reducing their emissions and other waste, partnerships are critical to mitigate the health care sector’s impact on climate. Partnerships bring together climate expertise, community knowledge, and government resources to address local environmental issues in a culturally appropriate way. They build camaraderie, establish shared goals and distribute the work to ensure no single entity is working alone. **HHS and CMS should provide funding, technical assistance, and general support for capacity building to help essential hospitals and other stakeholders engage in climate-related projects.**

iii. **HHS must mobilize other sectors to partner with essential hospitals on climate-focused investments.**

Further, policies addressing climate change do not exist in a vacuum. Progress to reduce the health care sector’s impact on the environment will be stymied without support from and partnerships with local and state governments and community partners, such as energy companies, financiers, waste management companies, and suppliers. Partners in the supply chain are particularly critical, as 80 percent of health care sector emissions come from the supply chain yet many factors within the supply chain are outside the control of health care providers. HHS must engage other federal agencies and work with local and state health departments to educate and build capacity at these partners to collaborate on climate-focused projects at essential hospitals. Together, these groups can determine the appropriate emission reduction goals and other climate mitigation measures that fit the locality’s needs and resources. **HHS must work with other sectors to mobilize support for essential hospitals engaging in climate resilience and mitigation projects.**

iv. **HHS and CMS must create climate-related measures appropriate for essential hospitals.**

There is considerable variation among essential hospitals in monitoring, measuring, and publicly reporting the energy they consume, waste they generate, and carbon they emit. In the 2019 report from Essential Hospital Institute, the Institute surveyed approximately a third of our members, and almost all of them monitored their energy use, and most monitored their water consumption. Less than half had set targets for energy consumption; a third had set targets for waste generation; and only a fifth had set public goals related to climate change mitigation. These numbers likely will increase as essential hospitals commit to the HHS pledge to reduce emissions. But for some essential hospitals, reducing their organization’s emissions by 50 percent by 2030 or becoming net zero by 2050 is less realistic, given their current resources.

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65 Ibid.
67 Ibid.
Further, reducing emissions from the supply chain presents distinct challenges for essential hospitals. As they work with their supply chain and group purchasing organizations to increase purchases of environmentally preferable products, they must balance that with their mission to serve low-income patients and take care not to increase costs that might be passed on to their patients. In addition, rural hospitals will be limited in their ability to reduce emissions from their supply chain, as they already are limited in how and where they can get supplies.

HHS and CMS should provide guidance on emissions goal-setting that is appropriate for a range of essential hospitals. Some essential hospitals are public hospitals, and their facilities are owned by a city, county, or state. These hospitals are subject to the locality’s budget and have little control over the funding they receive for systems upgrades or new facilities, making it difficult for them to invest in emission-reducing or other climate mitigation projects. Other essential hospitals are smaller, stand-alone, community hospitals that do not benefit from the economies of scale available to larger health systems or from affiliations with academic centers, where they can benefit from combined resources, system best practices, and shared goals. While these essential hospitals might seem a small part of the health care sector, their patients are the most vulnerable to the health impacts of climate change; ignoring their unique needs would widen the inequities their patients experience.

From small public community hospitals to large, university-affiliated health systems, essential hospitals are spread across a continuum in their ability to invest in climate-focused projects. HHS and CMS must incorporate the unique circumstances of essential hospitals in the creation of emissions reduction targets and other climate mitigation measures for guidance, grants, and incentive programs.

HHS and CMS can best prepare essential hospitals for the impact of climate change and mitigating their contributions to it by providing resources and guidance applicable to their current capabilities for climate-related efforts. The agencies must educate hospital leaders, build capacity for collaboration, mobilize partners, and establish metrics that are meaningful to essential hospitals. When this work is in place, more essential hospitals will be ready for HHS and CMS guidance related to implementation plans and public-facing goals for climate resiliency and mitigation projects.

In many ways, essential hospitals are emerging from a fog of operating in crisis mode daily for more than two years, due to the COVID-19 pandemic. Many are still operating in crisis mode. Combined with the lack of financial resources and the high up-front costs of many climate mitigation projects, tackling their contribution to climate change seems overwhelming and insurmountable.

To effectively engage essential hospitals, HHS and CMS must support essential hospitals with the appropriate resources. The agencies must lay the foundation of understanding, create communities of support, and finance initial actions and projects to build climate resiliency and mitigate climate change. Climate change has dire consequences, which will be experienced most acutely by the populations essential hospitals serve if these hospitals are left behind.

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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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