November 4, 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

Request for Information: Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the above-captioned request for information. America’s Essential Hospitals appreciates the Centers for Medicare & Medicaid Services (CMS) seeking input from stakeholders on health care access and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of regulatory waivers and flexibility in response to the COVID-19 public health emergency (PHE). Essential hospitals work tirelessly to address social drivers of health and provide efficient, high-quality care to all. As the agency looks for opportunities to improve and increase the efficiency of its policies and programs, we ask that it considers 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, ensure their continued stability, and enable them to thrive within value-based care models.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on a 3.2 percent margin, on average, compared with 7.7 percent for all hospitals nationwide.¹

Essential hospitals’ commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose special challenges. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven and a half million people in

essential hospital communities have limited access to healthy food, and nearly 16 million live below the federal poverty line. Essential hospitals are uniquely situated to target these social determinants of health and are committed to serving these marginalized patients. But these circumstances compound challenges and strain resources, requiring flexibility to ensure essential hospitals are not unfairly disadvantaged for serving people who face financial and social hardships and can continue to provide vital services in their communities.

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

**Topic 1: Accessing Health Care and Related Challenges**

**Essential Hospital Designation**

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 prioritized the importance of tackling structural racism and promoting equity throughout the federal government. 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. Recent research underscores the magnitude of this chronic underfunding of hospitals that serve people of color, finding that hospitals serving the highest share of Black patients received starkly lower payments than other hospitals—on average $26 million less per Black-serving hospital.

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.

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2 Ibid.


We urge CMS to begin by 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 and have far fewer commercially insured patients than the average hospital. 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;
- 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 the backbone of the health care safety net in 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 policies impact them. This identification will ensure CMS can target support to this specific group of hospitals, identify new policies that will ensure the stability of funding for these hospitals, and evaluate current policies that might disproportionately harm them. In working to identify and support essential hospitals, CMS would advance its commitment to health equity and preserve access to care for the nation’s most unserved populations.

Culturally and Linguistically Appropriate Care

Given that more than 300 languages are commonly spoken in the United States and more than 100 are spoken among patients of essential hospitals, it is not uncommon for health care providers to encounter multiple spoken languages in their care settings and to find themselves ill-prepared to communicate effectively with their patients. Language barriers put the health of many limited English proficiency (LEP) individuals, and that of their communities, at risk by affecting their ability to access care and communicate with their health care providers. This, in turn, increases the risk of life-threatening errors, wrong procedures, preventable readmissions, and other adverse events.5

Empowering patients to take charge of their own health and work collaboratively with their providers is critical to achieving high-quality health care, especially in settings that serve marginalized people. America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. But more work is needed to ensure patients from marginalized communities are properly represented in evaluations of care quality, such as patient experience surveys and patient-reported outcomes measures. If surveys

have too high of a health literacy level, there is a risk patients with lower health literacy levels are not being captured adequately.

Also, federal policy changes, such as Medicare payment cuts, disproportionately impact essential hospitals, which already operate with an average financial margin less than half that of other U.S. hospitals. Such policy changes undermine Medicare beneficiaries’ access to the linguistically and culturally competent care these hospitals provide. To further the administration’s and essential hospitals’ shared goals of tackling health disparities and promoting health equity, it is imperative CMS recognizes the resources these hospitals require to support the language access needs of their diverse patient populations.

Sufficient Rates for Medicaid Providers
The clear link between adequate reimbursement for Medicaid providers and access to care for beneficiaries cannot be overstated. When rates fall, many providers either cannot afford or choose not to treat Medicaid patients. Those that do often are forced to shift the unreimbursed Medicaid costs onto other payers. While we can still rely on the commitment of essential hospitals to serve Medicaid patients, their ability to meet that commitment becomes severely compromised when reimbursements fall far below costs. Unlike many other hospitals, essential hospitals cannot offset those losses with commercial insurance payments, as only about a quarter of their patients are commercially insured. In short, by reducing either the number or capacity of providers serving Medicaid patients, inadequate Medicaid rates harm beneficiaries’ access to care, particularly as compared with the access available to the general population.

CMS should require that states demonstrate that payments remain compliant with the standards of Section 1902(a)(30)(A) of the Social Security Act, which requires states to “assure that payments...are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” This requires strengthening CMS’ current access review requirements under the statute. In particular, CMS should explicitly incorporate a comparison of Medicaid reimbursement to payments from other payers in the same market in access reviews. A state should meet the requirement if a state can document that Medicaid rates either (i) cover the average costs incurred by providers; (ii) are equivalent to what Medicare would have paid; or (iii) equal the prevailing commercial rates in the geographic region.

CMS should ensure this payment analysis does not mask underpayment for certain specific services that could lead to access issues. For example, essential hospitals provide many vital inpatient services (such as trauma care, burn care, neonatal intensive care, psychiatric inpatient care, etc.) that are not available elsewhere in their communities but are significantly underpaid and each year result in losses to the hospitals. Further, a review of payment for physician services might not reveal issues of access to particular specialties, such as behavioral health specialties.

Moreover, CMS should consider the impact on access when adopting policies related to Medicaid supplemental payments and their related nonfederal share financing. If base rates were adequate and fully funded by state general revenues, there would be no need for supplemental payments. Unless and until that happens, CMS must be mindful when regulating these necessary sources of safety net funding. To that end, we encourage CMS’ treatment
of supplemental payments to be based on clear policy objectives related to ensuring reasonable and adequate payments as a means of ensuring access.

Quality Standards and Ratings
America’s Essential Hospitals is committed to transparency and improving the quality of care for our patients. Public health data systems, including those used by the Centers for Disease Control and Prevention, are critical in monitoring quality improvement and driving health outcomes. **We urge CMS to modernize public health data systems to improve data collection and simplify reporting by providers.** Further, we encourage the agency to enhance the interoperability of current systems with health information technology, including the development of standards that ensure the seamless exchange and use of health information and adequate testing of these standards.

Increasingly, patients and providers are working as a team in the delivery of care. As such, both parties must be confident the information for the care process is accurate and meaningful to ensure shared decision-making is not confusing or misleading. It is crucial that the information provided to consumers, including through CMS’ Care Compare website, be accurate so it can help them make important decisions about their health care. The use of overall hospital star ratings is not an appropriate measure of quality and can lead to unintended consequences and consumer confusion. There is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most disadvantaged patients.

Given significant issues with the overall hospital star ratings system, including a lack of appropriate risk adjustment for sociodemographic factors, we are concerned it does not serve consumers well, as the information is inaccurate and misleading. **We urge CMS to reexamine the star ratings program and make changes to the methodology to ensure the validity and fairness of information reported to consumers.**

Risk Adjustment
Current quality metrics in Medicare payment models to evaluate performance and determine shared savings or incentive payments do not incorporate social risk factors. It is critical that 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. Performance measures must account for the socioeconomic and sociodemographic complexities of patient populations to ensure a level playing field across all hospitals. **CMS should examine ways to account for social risk factors in Medicare programs and continuously engage stakeholders to ensure transparency and reduced administrative burden.**

Essential hospitals support quality and accountability. What they want—and what their patients and communities deserve—is to be on equal footing with other hospitals for purposes of evaluating quality. When evaluating quality, Medicare programs should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure hospitals are assessed on their work rather than on the complexities of the patients they serve. Differences in patients’ backgrounds might affect complication rates and other outcome measures; by ignoring these differences, CMS will skew quality scores against hospitals that provide essential care to the most complex patients, including those with sociodemographic challenges and the uninsured.
Further, failing to appropriately risk adjust can mislead and confuse patients, payers, and policymakers by not accounting for the effect of community factors that contribute to worse outcomes. CMS should develop analytic methods for integrating patient data with information about contextual factors that influence health outcomes at the community or population levels.

Infrastructure Needs and Climate Resiliency
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. 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 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 build their climate resiliency, 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 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. Without proper on-ramps, resources, and funding, it will be difficult for many essential hospitals to address their climate resiliency. HHS and CMS must properly fund and support essential hospitals’ climate-related infrastructure needs. Not doing so risks exacerbating the very disparities these efforts seek to address.

UP-FRONT FINANCING FOR CAPITAL PROJECTS
As safety net providers, essential hospitals must balance efforts to advance infrastructure upgrades with resources needed for direct patient care. Essential hospitals cannot pass the cost of climate resilience projects onto their patients as other businesses can pass the cost along to their customers. 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 upgrades without grants or low-interest loans from local and state governments or community partners. While climate resiliency projects will save costs in the long run, many hospitals still cannot raise the initial funding to start these projects. For example, a 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 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 be upgraded to withstand extreme weather. 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.

HHS should work with Congress to replenish the Hill Burton Act, with a focus on climate resiliency to help essential hospitals address high up-front costs for infrastructure projects. HHS and CMS also should fund climate resiliency 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.**

**PRIORITIZE ESSENTIAL HOSPITALS FOR CLIMATE RESILIENCE 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 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 receive 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,

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are working with shoestring budgets, and are still dealing with the pandemic and its related workforce crisis. 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 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 above, will be a critical step toward achieving this goal and supporting essential hospitals in their climate-related endeavors.

**Challenges in Accessing Care in Underserved Areas, including Rural Areas**

Communities served by essential hospitals face unique health and social challenges. CMS should account for these challenges and preserve adequate reimbursement rates for essential hospitals’ provider-based departments (PBDs), which will increase access in underserved areas. Site-neutral payment policies for PBDs disproportionately affect essential hospitals and the patients they serve. CMS should use its authority to protect the newly defined category of essential hospitals (as defined above), from payment cuts to their PBDs.

Given essential hospitals’ expansive networks of ambulatory care in otherwise underserved communities, site-neutral payments will continue to have a profoundly negative effect on their patients. In most communities, essential hospitals are the only providers willing to take on the financial risk of providing comprehensive care to low-income patients, including the uninsured and beneficiaries dually eligible for Medicare and Medicaid. PBDs enable hospitals to expand access for disadvantaged patients in communities with no other options for basic and complex health care needs. Essential hospital PBDs often are the only clinics in low-income communities that provide full primary and specialty services. Inadequate payment rates affect patient access by limiting the ability of essential hospitals to bring health care into these communities of need. CMS’ implementation of Section 603 of the Bipartisan Budget Act (BBA) of 2015—especially the inadequate payment rate—already has caused essential hospitals to reevaluate plans to expand their provider networks into underserved areas.

CMS’ site-neutral payment policies have played an undeniable role in limiting health care access for the country’s most disadvantaged patients and will only further exacerbate health disparities. Essential hospitals are committed to advancing the Biden administration’s goal of advancing racial equity throughout the federal government, including by addressing health disparities. The patients treated at essential hospitals’ off-campus PBDs typically are low-income people and people of color. Compared with patients at other hospitals, a significantly higher proportion of patients treated at essential hospital PBDs are dually eligible for Medicare and Medicaid, which is a key indicator of patient complexity. Dually eligible beneficiaries tend to be in poorer health status, more likely to be disabled, and costlier to treat compared with other Medicare beneficiaries. In fact, CMS uses a hospital’s proportion of dually eligible beneficiaries as a proxy for adjusting the hospital readmission measures to recognize

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differences in sociodemographic factors. Excessively restrictive policies on essential hospitals’ PBDs undoubtedly have downstream effects, including limiting patient access.

Essential hospital clinics often fill a void by providing the only source of primary and specialty care in their communities. Because of their integrated health systems, essential hospitals can help drive down overall health care costs, including for the Medicare program, by efficiently providing coordinated care through ambulatory networks. Providing care in the outpatient setting allows hospitals to avoid unnecessary emergency department (ED) visits, manage patients with chronic conditions, provide follow-up care to patients to avoid readmissions, and, in the process, reduce costs for the health care system at large. These are goals CMS should promote, not stifle, through policies that protect patient access to vital clinic visits in essential hospital PBDs.

To align with the administration’s policy goals, the agency must revise its site-neutral policies to the fullest extent permitted by statute to protect essential hospitals and their patients, rather than causing further harm. Essential hospital PBDs are disproportionately impacted by site-neutral payment policies. For hospitals operating on narrow (often negative) margins, these substantially lower payments are unsustainable and will affect patient access in areas with the greatest need for these services. Essential hospitals operate on a negative 16 percent Medicare outpatient margin—9 percentage points lower than Outpatient Prospective Payment System (OPPS) hospitals nationally. Continuing these cuts without revision would reduce essential hospitals’ outpatient margins even further.

Shielding essential hospital PBDs from the detrimental impact of these cuts would ensure essential hospital PBDs can continue to cover the costs associated with providing comprehensive, coordinated care to complex patient populations in underserved areas and advance the administration’s health equity goals. Specifically, CMS can:

- use its authority under Section 603 of the BBA to set an appropriate payment rate of at least 75 percent of the OPPS rate for non-excepted PBDs of essential hospitals; and
- ensure access for patients that rely on off-campus, excepted PBDs by excluding essential hospital PBDs from its discretionary clinic visit policy.

**Topic 2: Understanding Provider Experiences**

**Health Care Workforce Shortage and Well-Being**

The United States faces a significant and pervasive workforce shortage, especially in underserved communities. The pandemic has placed an enormous strain on essential hospital employees, with burnout at an all-time high. Demand for care forces essential hospitals to compete for staff with more financially stable, for-profit systems, making recruitment and retention immediate concerns. Provider shortages have the potential not only to affect patient care but also to stretch staff's mental health to the limit, exacerbating challenges to maintaining a healthy workforce at sufficient levels. HHS should create, expand, and financially support training and residency slots for allied health professionals, nurses, and physicians, not only to address the current workforce shortage, but also to meet the changing demands of tomorrow’s health care system. Additional slots should be targeted to meet the needs of underserved communities. Further, essential hospitals must be reimbursed adequately to achieve their missions while offering salaries and benefits that enhance recruitment and retention of staff in today’s increasingly competitive market.
To address provider well-being, public policies must support a safe working environment for all health care workers and invest in health care workers’ well-being. Working in health care is customer-focused, fast-paced, and physically demanding, leaving little room for self-care. Further, violence and intimidation in health care settings are increasing, and there has been an unprecedented increase in violence in recent years, partly due to the COVID-19 pandemic.

Both the U.S. Surgeon General\textsuperscript{11} and the National Academy of Medicine\textsuperscript{12} released recommendations to address health care workforce burnout and well-being. Common themes include retaining a diverse and inclusive workforce, supporting staff with mental health and substance use services, reducing administrative burdens, and creating and sustaining a positive work environment, among others. Recommendations require action from all stakeholders, though many focus on actions by hospitals and health care systems. But the health care workforce shortage and current reimbursement models will make progress difficult. At essential hospitals, patients will continue to come first, despite these concerns, leaving little time and funding to implement well-being initiatives, let alone initiate organizational cultural change. \textbf{HHS will need to invest in both evidence-based practices for health worker well-being and reimbursement models to make a real change in health care worker well-being.}

Benefits to and Burdens on the Workforce of Digital Health Technology, including Remote Services
America’s Essential Hospitals appreciates CMS’ work, through the Office of Burden Reduction & Health Informatics, to reduce regulatory burden associated with the use of health information technology (IT). Essential hospitals are committed to using health IT to improve the lives of their patients, including by using IT in population health efforts; telehealth to reach patients who face barriers to transportation; and electronic health record (EHR) data to reduce unnecessary readmissions, improve outcomes, and address SDOH. Appropriate and targeted use of technology also can reduce provider burden—such as providers using telehealth to more efficiently and conveniently deliver care to patients in their home. Despite these successes, burdensome regulatory requirements drain staff time and resources hospitals could better devote to delivering high-quality, patient-centered care. As CMS works to reduce administrative and regulatory burdens, we encourage the agency to revise existing federal programs, enabling providers to fully leverage the potential of health IT without the constraints of rigid program requirements.

First, CMS can reduce administrative burden on hospitals in the Medicare Promoting Interoperability (PI) Program and allow hospitals to dedicate their resources to providing patient-centered care. While the collection of data in EHRs serves many uses in addressing SDOH, improving patient satisfaction, and improving the quality of care, an excessive focus on clerical data entry requirements diverts provider resources from direct patient care. \textbf{CMS can take steps to reduce burden in the PI Program including by:}

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• providing a 90-day reporting period for calendar years 2023 and 2024, which will offer much-needed relief as providers continue to work toward interoperability;
• eliminating burdensome measures and providing flexibility in scoring methodology and measure choices. For example, CMS should keep the prescription drug monitoring program (PDMP) measure voluntary until the agency has adequate standards and specifications;
• continuing its efforts to advance interoperability and information exchange through the Trusted Exchange Framework and Common Agreement (TEFCA). 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. 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. **CMS should work with ONC and other stakeholders to facilitate information exchange under TEFCA, which ultimately will bolster interoperability and information sharing.**

Beyond the PI Program, CMS should continue to extend flexibility that allows providers to provide services remotely through telehealth, which we discuss below in the COVID-19 PHE flexibility section. In addition to promoting telehealth services, which are paid through the Physician Fee Schedule, CMS should facilitate the provision of virtual care by allowing providers to provide these services from locations other than a hospital, including at the provider’s home. When reimbursing for remote services through the OPPS, CMS currently requires that the clinical staff be in the hospital while providing the remote service. **We urge CMS to remove this requirement, because hospital clinical staff providing important virtual services have been able to leverage technology to provide services remotely while they are in other settings, including their home.**

This has been an indispensable part of essential hospitals’ care delivery model, particularly for mental health services during the COVID-19 PHE, and requiring hospitals to revert to having their staff in the hospital for these services would be disruptive. For example, amid severe workforce shortages, one essential hospital has been able to expand its behavioral health workforce by allowing some mental health providers to work from home, which creates space in their outpatient departments for other vital staff who need to be physically onsite. CMS can allow hospital clinical staff to provide these services while in locations other than the hospital, as these staff fall under general supervision requirements, meaning the physical presence of a physician in the same location is not necessary. Also, with the ability of staff to securely access communications technology from home, including being able to access the hospital’s electronic health record, clinical staff’s presence in the hospital during the provision of a mental health service is not always necessary.

**Finally, CMS should work with HHS and ONC to delay information blocking requirements for which providers are not yet ready.** As part of the 21st Century Cures Act, providers are prohibited from engaging in information blocking, unless they meet one of the eight specified exceptions to information blocking. The information that must be shared to avoid a finding of information blocking, known as electronic health information, was previously limited to the United States Core Data for Interoperability. But beginning October 6, providers must share a much broader dataset that aligns with the definition of electronic protected health information under Health Insurance Portability and Accountability Act (HIPAA) regulations.
The types of information included in this definition include data not produced in certified EHR technology itself but from external sources, including information about insurance eligibility, as well as payment billing and information. Storing, compiling, and sharing this data will be cumbersome for providers, as they will have to collect data from various sources and verify they are not missing information provided by an external source that is not in the EHR. This data likely would be unstructured and not subject to data standards, further compounding existing issues with information exchange that stem from a lack of standardization.

Value-Based Care

As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify gaps in care quality and eliminate disparities. The potential benefits of value-based care include improved health for patients, reduced effects and incidence of chronic disease, and lower overall costs to the health care system. Given the benefits of value-based care to patients, providers, payers, and society, it is critical a broad array of stakeholders participates in value-based payment reforms—particularly providers that serve low-income, medically complex, marginalized, and underrepresented communities. In designing new value-based payment models, CMS should support providers that disproportionately deliver care to disadvantaged populations impacted by historical inequities.13

Care cannot exist in silos. Essential hospitals are cornerstones of care in their community, with deep ties to the people who live there. This gives them an intimate understanding of the nonclinical influences on patients and population health. A coordinated approach to patient care—including clinical and nonclinical partners—can lead to better outcomes, higher patient satisfaction, and less care duplication. But care coordination is resource intensive for essential hospitals, which 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.

Additionally, quality metrics—used in Medicare value-based payment models to evaluate performance and determine shared savings or incentive payments—do not yet incorporate social determinants of health (SDOH), such as food insecurity, housing instability, and lack of transportation. By ignoring these factors, value-based payment models disproportionately penalize providers, such as essential hospitals, that support patients’ broader health and social needs.

CMS should ensure value-based payment models do not inadvertently exacerbate health disparities by rewarding providers that cherry pick healthier, less diverse patients to achieve better quality scores and financial success. Future payment models should mitigate unintended consequences, such as incentives to selectively treat lower-acuity patients or avoid treating the uninsured or dually eligible population, which could worsen disparities.

Core Measures

Essential hospitals have long supported quality measurement and pay-for-performance initiatives as vitally important tools for improving value. However, continued work to reduce the number of measures and reporting requirements is needed. CMS should streamline

quality measures across its programs to focus on high-impact, high-value quality measures that are meaningful to patients and promote improved outcomes while minimizing costs. A set or several sets of “core measures” should be identified that could be used across CMS quality programs and private payer pay-for-performance programs.

Agreed-upon principles should guide the selection of quality measures. For example, measures should continue to be evidence-based. Further, provider behavior must influence the outcome(s) being measured, and the measures must have strong evidence that their use will lead to better care and outcomes. Generally, measures should be used in programs only if they reveal meaningful differences in performance across providers, although some might be retained or re-introduced to reaffirm their importance and verify continued high levels of importance.

CMS’ Meaningful Measures Initiative introduced a set of priority areas aimed at focusing quality improvement efforts. But more work is needed to effectively apply this framework to all levels of quality measure development, reporting, and assessment. Quality measures should be properly constructed, administratively simple to collect and report, and not lead to unintended consequences or place a significant administrative burden on hospitals and providers.

Alignment of Measures
A system designed to measure and report quality in health care delivery must recognize that the delivery of health care is ever evolving, as evidenced by the shift from fee-for-service toward value-based payment models. Under these new models, providers are accountable for the quality and cost of the care they deliver, creating a financial incentive to coordinate care for their patients. To the extent measures are used in multiple CMS programs, and recognition that outcomes often are tied to more than one provider or setting within the health care system, the efforts of hospitals, physicians, and others along the care continuum should be aligned to reduce unnecessary data collection and reporting efforts. We also urge CMS to engage in a robust dialogue with clinicians about their clinical workflows and data collection methods using different submission systems, as well as challenges they have to collecting and reporting quality data. For example, hospitals often must contract with (and pay for) external vendors to collect and report data, which is costly and burdensome. For essential hospitals already operating on low margins, these costs have significant implications. Through this type of information sharing, the day-to-day “costs” of quality reporting can be captured and incorporated into considerations for removal of measures.

Topic 3: Advancing Health Equity

Standardized Collection of Race, Ethnicity, and Language (REL) Data and Information on Other Social Risk Factors
America’s Essential Hospitals supports CMS’ efforts to gather accurate, standardized data on patient demographics. We believe collecting REL data supports hospitals’ efforts to identify preferences and needs and to tailor a care plan to specific patient characteristics. For example, collecting preferred language helps identify appropriate interpreter services, as necessary. The ability to monitor and stratify data also helps front-line staff identify problems and standardize efforts across hospitals.
But 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 data collection processes and structure, standardizing staff education, engaging patients in direct communication, and measuring and monitoring these activities.\(^{14}\)

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.\(^{15}\) 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. There also is a 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.\(^{16}\) We encourage CMS to raise awareness and develop resources to support REL data collection and sharing, with clear information about how the agency or others will use the data.

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

Additionally, screening for health-related social needs (HRSNs) often is labor and time intensive, particularly for essential hospitals, which operate with low margins and disproportionately serve marginalized people who often face one or more HRSNs. The mode of data collection can heavily impact patient care workflows. For example, some essential hospitals administer screening electronically, via an application provided to all inpatients, while others might have health care workers use paper screening that requires subsequent data entry, which can consume considerable time and 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 encourage CMS to recognize the time and resources required to implement screening of all patients for HRSNs, as well as training for staff in the collection of such data.

### Health Care Workforce Shortage and Health Equity


The composition, distribution, and training of the health care workforce influence health equity and outcomes. Today, Black, Latino, and Native Americans are significantly underrepresented in the health care workforce. Challenges to finding a health professional similar to a patient’s race and ethnicity can negatively impact their experience and outcomes. In addition, the impacts of the overall provider shortage in this country can be even greater for underserved populations, including people of color. Exacerbating the problem, providers serving Medicaid beneficiaries and the uninsured face high turnover rates and struggle to compete for staff with more financially stable systems serving less medically complex patients.

**HHS must develop and sustain a diverse, inclusive, and cohesive health care workforce that will reflect the country’s multicultural communities, address health disparities, and ensure quality and patient safety.** As discussed in America’s Essential Hospitals white paper, *Leveraging Section 1115 Demonstrations to Drive Equity in Medicaid* and above, more training opportunities for physicians, nurses, allied health, and nontraditional providers are needed, as well as initiatives that will increase the diversity of the health care workforce and establish career pathways to not only address the health care workforce shortage but also to lessen the impact on patients.

This is particularly true for the behavioral health workforce, as demand for services has increased, due to the COVID-19 pandemic. Patients need timely access to culturally appropriate, trauma-informed care across the behavioral health continuum. New payment models that integrate and support evidence-based behavioral health care delivery must be developed and implemented.

**Topic 4: Impact of COVID-19 PHE Waivers and Flexibility**

**Extension of Telehealth Flexibility**

During the COVID-19 PHE, CMS has enhanced flexibility by expanding the list of reimbursable telehealth services; waiving geographic and site-of-service restrictions on the originating site; and allowing hospitals to bill an originating-site fee. This pandemic has demonstrated the effectiveness of telehealth in providing high-quality, cost-effective care while protecting patients and health care personnel from unnecessary exposure to illness. While this telehealth policy flexibility has been critical during the COVID-19 PHE, continuing it beyond the PHE will be indispensable to essential hospitals’ efforts to expand access for their patients.

The key role technology can play in linking patients to access and high-quality care has become increasingly evident amid COVID-19. Telehealth expands the reach of specialists and other providers, allowing hospitals to efficiently connect patients to care and improve population health. Essential hospitals, which are on the front lines of the pandemic, use technology to

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connect their providers with patients in a variety of settings. The use of telehealth has been critical, not only for screening potential COVID-19 patients but also for allowing other patients to maintain continuity of care with their primary and specialty care providers while respecting physical distancing mandates. At essential hospitals, no-show rates among low-income patients are significantly lower for telehealth visits compared with in-person visits. The ability to virtually access care helps low-income populations overcome some common barriers to care, such as lack of transportation. The importance of telehealth will expand well past the current PHE, to include responding to future outbreaks and ensuring continuity of care for patients with acute and chronic conditions.

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

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

REIMBURSEMENT FOR AUDIO-ONLY SERVICES
Through rulemaking, CMS allowed certain services to be provided using audio-only technology during the COVID-19 PHE. CMS should permanently adopt payment for audio-only services it has reimbursed for during the COVID-19 PHE. Essential hospitals and their patients have benefited from this flexibility during the pandemic. The use of audio-only capabilities is beneficial for vulnerable patients who do not have access to computers or phones with video capabilities and those who have limited access to broadband that can support synchronous video visits. When the provider can deliver care and assess the patient without seeing the patient, it is entirely appropriate to offer these services through audio-only means. We urge CMS to continue to reimburse a subset of services and ensure parity for these services conducted through audio-only technology.

REMOVING RESTRICTIONS ON TELEHEALTH AND EXPANDED ACCESS TO HIGH-QUALITY CARE VIA TELEHEALTH SERVICES
During the pandemic, CMS has used its amended Section 1135 authority to waive geographic and site-of-service restrictions on originating sites, allowing Medicare patients to receive telehealth services in a wide variety of settings, including their home. These changes have been transformative in paving the way for increased access to telehealth services, both for providers in the early stages of adoption and those with established telehealth footprints. This flexibility has been imperative to promoting equity by allowing these providers to reach patients facing barriers to care. In practice, lack of transportation and other barriers to access prohibit more than just rural patients from timely access to care. Large populations in many urban areas are in health care deserts and are classified as medically underserved. Drawing a distinction between rural and urban underserved populations artificially restricts access to health care for
some patients. Even if these patients live in heavily populated urban areas, receiving a timely telehealth service from a physician can result in the early diagnosis of a life-threatening condition and play an important role in providing cost-effective follow-up care. **To further its goals of increasing access for underserved populations and promoting equity, CMS should work with Congress to permanently eliminate the geographic and site-of-service restrictions on Medicare telehealth services.**

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

**Hospital-at-Home**

The COVID-19 PHE drastically impacted health care access and delivery. As hospitals across the nation exceeded capacity due to rising COVID-19 hospitalizations, CMS in March 2020 announced the Hospitals Without Walls program, which provides broad regulatory flexibility allowing hospitals to offer services in locations beyond their existing facilities. In November 2020, the agency expanded this effort, announcing the Acute Hospital Care at Home (AHCaH) initiative to aid hospitals reaching capacity, experiencing supply shortages, and treating infected patients.

Hospital-at-home programs can shorten lengths of stay, lower rates of readmission, improve patient experience, and reduce adverse events. Further, they are effective in a variety of settings and patient populations, and their benefits are far-reaching. For some, the hospital-at-home experience takes place in their permanent residence; for others, care might be delivered in a group home or an informal shared-living situation. Delivering care where patients live is as varied as the people and neighborhoods served by a hospital providing the care.

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Providing hospital-level care at home not only has been an essential tool to handle case surges during the COVID-19 PHE, but this type of care delivery also can improve access and equity outside of a public health crisis. Hospital-at-home programs offer a new vehicle for integrating nonmedical, social needs (e.g., internet access, nutritious food) into acute care. The ability to provide care in the home presents a unique opportunity to treat a patient’s clinical diagnosis while addressing social determinants of health that can impact outcomes.

This type of care delivery is a long-term commitment, requiring both upfront costs and ongoing infrastructure to continue growing a program’s capacity. Essential hospitals have leveraged hospital-at-home programs to immediately address capacity issues during the COVID-19 pandemic and are committed to maintaining this level of access and care quality for their patient populations beyond the PHE. The long-term benefits of hospital-at-home programs have yet to be fully realized, due in part to the uncertainty providers face in Medicare reimbursement. **We urge CMS to support a permanent version of the hospital-at-home waiver after the COVID-19 PHE ends.**

**Preparing for the Future**

The unprecedented nature of the COVID-19 PHE created unique challenges with readiness, response, and evaluation. This was especially true in the communities essential hospitals serve. Today, there is no codified definition of a safety net or essential hospital for public policy or public health purposes. Essential hospitals are critical partners to local and state public health departments. Further, they serve on the front lines of care for patients in crisis and often are the first responders to infectious disease outbreaks and natural and human-created disasters (such as hurricanes and mass shootings).

Without a codified definition, it is challenging to target necessary resources and interventions to essential hospitals and their communities during such crises, further disadvantaged already marginalized communities. We saw this during the early stages of the COVID-19 pandemic, when financial relief and critical supplies were slow to materialize for underserved communities. **We urge CMS to codify a definition of essential hospital to effectively prepare for and respond to the unique public health needs their communities likely will experience in the future.**

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We look forward to an ongoing partnership with CMS to advance health equity. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

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