AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

June 28, 2021

VIA ELECTRONIC MAIL
regulations.gov

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: CMS-1752-P Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates

Dear Ms. Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Fiscal Year (FY) 2022 Hospital Inpatient Prospective Payment System (IPPS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 94 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole. Specifically, we offer comment to CMS on the following issue areas within the FY 2022 IPPS proposed rule:

- DSH Payment Calculations
- Advancing Health Equity
- Organ Acquisition Payment Policies
- PSI-90 Removal from the Hospital Value Based Purchasing Program
- The Promoting Interoperability Program
- Price Transparency

Disproportionate Share Hospital (DSH) Payment Calculations

Uncompensated Care Payments

CMS proposes to continue to use a single year of uncompensated care costs from Worksheet S-10 of the FY 2018 cost reports in FY 2022 uncompensated care payment. CMS also proposes a revised calculation of the Medicaid fraction of the DSH calculation. Under this proposal, patient days of individuals receiving benefits under a section 1115 waiver would be counted in the numerator of the fraction. This would only be done if the patient directly receives inpatient hospital insurance coverage on that day.

AHPA does not support using a single year of cost report data to determine uncompensated care payments. The validity of using one year of data as a cost reporting period is not a reliable measure and does not provide a true representation of uncompensated care provided by hospitals. Using three years' worth of cost reporting gives a better perspective since it is looking at a larger period that averages out the patients to reflect numbers that are more accurate.

Defining Uncompensated Care

For purposes of calculating Factor 3 and uncompensated care costs, CMS defines "uncompensated care" as the amount located on line 30 of Worksheet S-10, the cost of charity care and non-Medicare bad debt. CMS continues to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for the purposes of calculating Factor 3. As we have previously commented alongside the Premier health care alliance, **AHPA believes that CMS should capture the reality faced by many states—that many states do not fully cover the costs associated with providing care to newly-insured Medicaid recipients.**

Among other reasons, CMS notes that including Medicaid shortfalls in the calculation would represent a form of cross-subsidization from Medicare to cover Medicaid costs, a general policy that CMS and the Medicare Payment Advisory Committee have not supported. However, as the policy currently stands, Medicare *will* be significantly subsidizing those states with Medicaid payment rates that do not cover the cost of care relative to those with payment rates that do not. This problem is further compounded if a state has higher Medicaid enrollment and inadequate payment rates. **AHPA encourages CMS to consider including Medicaid shortfalls it its definition of uncompensated care.**

Advancing Health Equity

AHPA applauds CMS for prioritizing the advancement of equitable and optimal health for all Americans. We are committed to health equity as a right of all people, acknowledging that it is an emergent issue for Black, Hispanic/Latinx, Indigenous and Asian communities. We support public policy solutions that consider the diversity in race, ethnicity, class, income, disability status and gender of the broader community. Therefore, we support CMS' effort to address health equity within Medicare's quality programs and welcome the opportunity to comment on the issues below:

- The use of race and ethnicity algorithms
- Future potential stratification of quality measure results by race and ethnicity
- Potential creation of a hospital equity score to synthesize results across multiple social risk factors

The Use of Race and Ethnicity Algorithms

CMS is considering how to best infuse race and ethnicity data within its quality programs, particularly within the Hospital Readmissions Reduction Program and Inpatient Quality Reporting Program. Although CMS has used some self-reported race and ethnicity data in the past, the Agency has not consistently collected such data. CMS is considering using predictive algorithms to supplement race and ethnicity data through assumptions based on surname analysis or preferred language.

We recommend that CMS reject the use of any health equity focused predictive algorithm, as these have been found to inject additional racial bias into patients' health care experiences.[1] We believe that the existing limitations in using race-estimation algorithms (e.g. limitations in surname analysis) outweigh the potential benefit of their use. Instead, we recommend empowering providers with more robust demographic data, including endorsing the use of patient self-reported race and ethnicity data. While observer-reported race and ethnicity data are still routinely used in care delivery, self-reported data have a much higher rate of validity—particularly for Indigenous, Latinx, Asian and Pacific Islander populations.[2]

[1] The Harvard T. H. Chan School of Public Health. (2019). Widely Used Health Care Algorithm Has Racial Bias.
[2] Jarrín, O., Nyandege, A., Grafova, I., Dong, X., Lin, H. (2020) Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared with Gold-standard Self-reported Race Collected During Routine Home Health Care Visits. doi: 10.1097/MLR.0000000000001216

Future Potential Stratification of Quality Measure Results by Race and Ethnicity

CMS is considering stratifying hospital-level reporting using race and ethnicity data, including using a standardized set of social, psychological and behavioral data from hospitals. CMS also seeks comments on the possible collection of a minimum set of demographic data elements, such as disability status, sex, sexual orientation and gender identity, and primary language, by hospitals at the time of admission. The Agency is interested in potential challenges facing hospitals with limited resources in collecting a standard minimum set of demographic data elements.

AHPA supports CMS' goal of measuring, collecting and analyzing quality measures and outcomes data by race and ethnicity, and believes that this information will assist our member health systems in population health and equity-specific initiatives. To narrow the scope of the data stratification, CMS could consider initially requiring such stratification for a limited number of quality measures that are known to have significant national disparities. CMS may work with the National Quality Forum and the Department of Health and Human Services' Office of Minority Health to determine which measures within Medicare's quality programs should receive focus and develop a timeframe for the stratification of such measures by race and ethnicity. This approach would allow health providers, particularly those with limited resources, sufficient time to make any needed adjustments to their Electronic Health Records (EHRs) and address potential challenges relating to data collection.

We also recommend that any standardized demographic dataset under consideration capture social risk factors that impact wholistic health, including education level,[3] language spoken at home[4] and the incarceration status of an immediate family member.[5] In creating standard definitions for these demographic fields, we urge CMS to engage with local community groups as well as national associations to align standard definitions with the actual designations that patients use in self-identification. This standardization will be invaluable for future health equity research and will ensure that the data captured can be comparable among providers.

In addition to adopting standard definitions, it will also be important for CMS to provide guidance on how to best collect the required data. To ensure data validity, we recommend requiring providers to

[3] Raghupathi, V., Raghupathi, W. (2020). The Influence of Education on Health: An Empirical Assessment of OECD Countries. https://doi.org/10.1186/s13690-020-00402-5

[4] Brodie, K., Abel, G., Burt, J. (2016). Language Spoken at Home and the Association Between Ethnicity and Doctor—Patient Communication in Primary Care: Analysis of Survey Data for South Asian and White British Patients. http://dx.doi.org/10.1136/bmjopen-2015-010042

[5] Lee, R. Fang, X, Luo, F. (2013). The Impact of Parental Incarceration on the Physical and Mental Health of Young Adults. https://doi.org/10.1542/peds.2012-0627

use evidenced-based screening tools when collecting social determinants of health data. CMS could provide a list of options for hospitals to choose from for data collection purposes. Without standardization in EHR data collection, inaccuracies can be introduced that impede rather than support more equitable care delivery. Additionally, we advise that CMS provide guidance on a recommended frequency for collecting any social determinants of health data to ensure that such data is reported adequately and in a standardized manner.

Finally, we recommend that CMS stratify payer claims datasets provided to hospitals by race and ethnicity. Without it, hospitals and individual providers must attempt to connect the payer data with their own internal EHR data to create a profile of their patient population, potentially compromising the accuracy of the data.

Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risk Factors

CMS is considering creating a Hospital Equity Score that would synthesize results for a range of measures and use multiple social risk factors to summarize hospital performance. Such data would be publicly reported on Care Compare or a successor website.

AHPA supports CMS' goal of creating an equity-based scoring or ranking system to synthesize results across multiple social risk factors and increase accountability. However, we are concerned that such a score could miss the opportunity to affect real change if it is not coupled with value-based incentives designed to give health providers the needed resources to address the health inequities found on the data. Some hospitals, particularly safety-net hospitals, may not yet have robust health equity strategies due to a lack of adequate resources. A health equity score, if not done correctly, may inadvertently hurt those hospitals serving large racial and ethnic populations. Therefore, we recommend that CMS couple demographic data collection with positive incentives within its value-based programs. While health systems alone cannot solve the broader societal issues impeding health equity, value-based health equity incentives could leverage this more robust demographic data to reward hospitals and individual providers for closing outcomes gaps in the populations they serve.

CMS should consider providing a value-based incentive or penalty reduction for hospitals that provide the Agency with meaningful information on their initiatives to address inequity in health care. This could serve as a repository of initiatives across the country, which could be leveraged to track trends and identify best practices. By providing positive incentives rather than financially punitive ones, CMS can promote hospitals' use of demographic data to make health care more equitable without unintentionally eroding safety-net hospitals' more limited financial resources. This approach recognizes

that hospitals are at disparate points on their individual health equity journeys and provides the necessary incentives to support their unique needs.

Organ Acquisition Payment Policies

CMS proposes to change, clarify and codify Medicare organ acquisition policies, including requiring that transplant centers determine the insurance status of the patient, should the organ be subsequently transplanted elsewhere, by October 1st. AHPA shares CMS' commitment to advancing equitable access to transplant care. We further support CMS' goal of assuring proper accountability for payment of transplantation services.

For this reason, we respectfully request that the Agency delay implementation of the organ donation and transplantation provisions included in this IPPS FY2022 rule. During this delayed implementation, we recommend collaborating with the Organ Procurement Transplant Network (OPTN) to develop a process and timeline that advances transparency and accountability in payment for services without burdening OPTN members with additional data reporting requirements.

For example, we support accurate collection and reporting of transplant patient payer data but suggest this information be provided by transplant centers to the OPTN at the time of transplant rather than the time of listing. This change would enable all OPTN members and CMS to obtain accurate, timely data without imposing an additional data collection burden. Within AHPA, we are fortunate to have one of the seven hospital-based OPOs in the United States; this could allow our OPO to work collaboratively with the transplant centers they serve, including our transplant institute, and our internal revenue cycle departments to fulfill the proposed request in the manner suggested by CMS. However, most other OPOs do not have hospital affiliations and would face significant difficulty in complying by October 1st. **We strongly suggest a pause for further study to ensure that patient care and equitable access to organs are preserved while this change is adopted.**

PSI-90 Removal from the Hospital VBP Program

CMS proposes to remove the Patient Safety and Adverse Events Composite (PSI-90) from the Hospital Value-Based Purchasing Program beginning in the FY 2023 performance year. The provided reason for removing the PSI-90 was stated as Factor 8, the costs associated with the measure outweigh the benefit of its use in the program. However, CMS proposes to retain the measure in the Hospital-Acquired Conditions (HAC) program. According to CMS, removing the measure from the VBP program would

reduce the reporting burden on providers because the VBP program requires that the software used to calculate measure scores between the baseline and performance period match. The HAC program does not include baseline periods and can therefore more easily implement measure scoring.

While AHPA commends the effort to remove undue reporting burdens, we believe that removing the PSI-90 measure from the VBP program while retaining it in the HAC program would not substantially reduce the reporting burden. If CMS deems it vital to remove the PSI-90 measure, consideration should be given to removing it from both programs. Doing so would greatly reduce the reporting burden on hospitals while eliminating the potential of duplicative penalties**.**

The Promoting Interoperability Program

Query of the PDMP

CMS proposes to maintain the Electronic Prescribing Objective's *Query of the PDMP* measure as optional while increasing its available bonus points from 5 points to 10 points for the reporting period in CY 2022.

AHPA agrees with the decision to maintain this measure's optional status and the continuation of bonus points, which can encourage the use of the measure while allowing health systems to continue to hone their monitoring of this metric. We believe that increasing the bonus points from 5 to 10 points would incentivize early adopters. We also concur that the use of numerator and denominator data encourages a robust way to track and trend the use of this electronic health information.

The Public Health and Clinical Data Exchange Objective

CMS proposes to require the use of four new measures associated with the *Public Health and Clinical Data Exchange* Objective beginning with the EHR reporting period in CY 2022. According to CMS, their adoption would better position public health agencies for future health threats. The four measures are Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Laboratory Result Reporting.

AHPA concurs that, in the interest of public health, the adoption of these measures would lead to the collection of valuable data for public health emergencies. However, we believe that there is not adequate time for both EHR vendors and public health agencies to develop and test four required measures by the end of the current calendar year, as currently proposed.

AHPA recommends keeping the current requirement of two self-selected public health measures to allow software vendors the necessary time to develop and test related software functionalities, as

well as to reduce the reporting burden on hospitals. We find the addition of required measures overly burdensome as it would require hospitals and their EHR vendors to allocate significant resources to satisfy. Unlike the other proposed measures, this measure would obligate providers to reconstruct or revamp existing IT systems, which involves additional financial investments. If additional measures are pursued, hospitals may find it difficult to meet the reporting deadline and provide accurate and necessary data. Because of the financial pressure placed by the COVID-19 pandemic on hospitals, we believe that it would be best to not adopt additional measures at this time. If CMS wishes to adopt this measure in the future, we recommend providing additional time for hospitals to comply.

New SAFER Guides Measure

CMS proposes to add a new Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure to the Protect Patient Health Information objective, beginning with the CY 2022 EHR reporting period. Collectively, the SAFER Guides help health care organizations to conduct self-assessments to optimize the safety and safe use of EHRs.

AHPA requests further clarification from CMS on the proposed SAFER Guides measure for organizations that govern multiple hospitals, providers and ancillary services. More specifically, AHPA seeks clarity on whether the self-assessment required by this measure needs to be conducted by individual facilities (e.g. each CMS Certified Number) or can be satisfied by the parent health system. In general, large health care systems often use the same vendors, organizational policies, configurations and interfaces across their markets. If CMS proposes to obtain self-assessment data from individual entities instead of using systemwide data, we believe there will be an undue and unintended duplicity in reporting requirements.

Reporting and Submission Requirements for eCQMs

CMS proposes requiring hospitals to use only certified technology consistent with the 2015 Edition Cures Update when submitting data for the Hospital IQR Program beginning with the CY 2023 reporting period.

AHPA recommends allowing more time for hospitals to transition to the 2015 Edition Cures Update data submission, extending the timeframe through January 1, 2025. We believe that mandating this update in the CY 2023 reporting period does not provide sufficient time for hospitals' IT developers to test and certify the proper usage of the 2015 Edition Cures Update. Extending the deadline until January 1, 2025, will allow hospitals and IT developers more time to make the necessary changes.

Clinical Quality Measures in Alignment with the Hospital IQR Program

Eligible hospitals and Critical Access Hospitals (CAHs) must report on electronic clinical quality measures (referred to as CQMs or eCQMs) selected by CMS using CEHRT, as part of being a meaningful EHR user under the Medicare Promoting Interoperability Program. CMS also proposes to adopt two new eCQMs in order to achieve better alignment with the IQR program: Hospital Harm-Severe Hypoglycemia and Hospital Harm-Severe Hyperglycemia.

AHPA agrees with the proposed removal of eCQMs that are no longer scientifically proven, relevant to the public or topped-out. AHPA also supports the adoption of new eCQMs, as they provide hospitals with further options for alignment within their high-risk, high-volume patient populations.

AHPA seeks clarification from CMS on the proposed timeline for public reporting of performance data for the newly proposed Hospital Harm-Severe Hypoglycemia and Hospital Harm-Severe Hyperglycemia additional eCQM measures.

Data Availability Requirements for Eligible Hospitals and CAHs

CMS proposes to modify the *Provide Patients Electronic Access to Their Health Information* measure to require eligible hospitals and CAHs to ensure that patient health information remains available to the patient (or patient-authorized representative) for an indefinite amount of time. This modification would allow the patient to use any application of their choice that is configured to meet the technical specifications of the API in the eligible hospital or CAH's CEHRT.

AHPA opposes requiring that hospitals provide indefinite access to patients' health information, given current technological best practices and limitations. CMS states in the proposed rule that "*The proposed requirement would apply beginning with the EHR reporting period in CY 2022, and would include all patient health information from encounters on or after January 1, 2016*," which seems to imply that hospitals will be required to keep and maintain a significant amount of data in the future. This requirement will undoubtedly impose a significant financial burden on hospitals as it would require large storage space within hospitals' EHRs.

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality

CMS is seeking public comment on the future usage of digital quality measures (dQMs) and Fast Healthcare Interoperability Resources (FHIR) in hospital quality programs. CMS is also seeking feedback on approaches to support the inclusion of Patient-Generated Health Data (PGHD) and other currently non-standardized data. Examples of PGHD include blood glucose monitoring or blood pressure readings using home health equipment, or exercise and diet tracking using a mobile app or wearable device.

AHPA supports CMS' effort to collect digital quality data and the Agency's proactive consideration for the future adoption of PGHD data. However, we are concerned about the current capability or EHR vendor readiness to make the goal of utilizing PGHD achievable. We also question the reliability of the PGHD data considering that it is gathered from patients and it may not be collected in a standardized manner.

Price Transparency

In partial fulfillment of Executive Order 13813 titled, "Promoting Healthcare Choice and Competition Across the United States," CMS implemented a new methodology to calculate MS-DRG weights. Under this methodology, hospitals were required to report their median negotiated charges by MS-DRG on their Medicare cost report for cost reporting periods ending on or after January 1, 2021. The median negotiated charges for MA plans would then be used to calculate inpatient payments beginning in FY 2024. In this rule, CMS proposes to reverse this policy after "further consideration of the many contract arrangements hospitals use to negotiate rates with MA organization payers, and the usefulness, for rate-setting purposes, of the market-based data."

AHPA supports the proposal to reverse the use of median negotiated rates for setting hospital inpatient payments. While we support efforts to better align Medicare payment rates with the market value of inpatient items and services, relying on negotiated charges does not achieve this goal. The charges paid to MA health plans are largely based on Medicare Fee-for-Service charges and are therefore reflective of traditional Medicare and not market costs. Section 1866 of the Social Security Act and its pertaining regulation (42 CFR 422.214) stipulate that providers must accept payment for MA plan members at the rate applicable under traditional Medicare. Therefore, relying on MA negotiated charges to change traditional Medicare charges would not achieve the Administration's goal. Additionally, negotiated charges consider the unique and varying circumstances between payers, providers and patients in each market. As for commercial payers, they may negotiate rates in order to market products that appeal to specific segments of the population, such as younger and healthier people, that may not be representative of the Medicare population. Therefore, using commercial charges to set inpatient rates would not accurately capture the cost of treating Medicare beneficiaries. Further, it is not clear how the averaging of negotiated rates will impact the quality of outcomes. Some health care systems may make above average investments to achieve improved results, but averaged reimbursement may not be sufficient to sustain the quality of those outcomes.

Due to the issues mentioned above, AHPA recommends that CMS explore other payment mechanisms to better capture the cost of providing care to Medicare patients. One potential

alternative would be to base Medicare inpatient rates on hospitals' cost of providing services for each MS-DRG, irrespective of negotiated charges. Under this methodology, hospitals would report the cost of providing services for each MS-DRG based on either the hospital's cost accounting system or the cost report. A similar approach has been adopted in Australia, where cost data is reported annually by hospitals to develop a National Efficient Price. This public hospital data undergoes validation, quality assurance checks and reporting to allow adequate benchmarking.[3] To explore this and other options, we recommend that CMS establish a taskforce dedicated to reviewing different payment methodologies for potential use in Medicare. The Center for Medicare and Medicaid Innovation (CMMI) could help to test some of the different options recommended by the taskforce. We believe that this approach would allow the Agency to better study and evaluate the impact of various payment methodologies while working closely with health providers.

AHPA also urges the Agency to reverse the policy requiring hospitals to publicly share their negotiated rates with payers. As mentioned in previous comments to CMS, requiring hospitals to post their negotiated charges is not effective in advancing price transparency. Patients' financial obligations are typically not a hospital's negotiated charge with an insurer. Furthermore, patients will not be able to deduce the amount they are financially responsible for from negotiated charges, which makes it difficult to shop for health care services. For example, medical supplies such as drugs and implantable devices have variable, interactive pricing based on the actual cost of the item to a hospital. The charge for a particular drug may also vary depending on the weight of the patient and the dosage needed. Therefore, displaying the negotiated charge for a drug on a website would not allow any person to appropriately estimate the drug's price. Other variables, such as a patient's deductible and whether a health provider is in-network, also affect a patient's ultimate financial responsibility. Thus, the use of negotiated charges is not meaningful to patients. A patient's copay, deductible and total out-of-pocket costs are more meaningful to patients when making health care decisions.

To truly advance price transparency and empower patients in their health care decisions, we recommend adopting the price transparency principles below:

- **Focus on the cost to the consumer.** Meaningful price information, such as co-payments and deductibles, will help patients understand the amount of money they are responsible for and enable them to better shop for services.
- **Couple price information with quality information.** Price information needs to be paired with objective and understandable quality information for consumers to make an educated decision about where to obtain high-value health care services.

- **Focus on consistency.** Provide consistent price and quality information across providers, allowing consumers to compare and contrast their options. For example, allowing hospitals to identify their own shoppable services may result in significant variation and fail to facilitate price comparisons.
- **Partner with multiple stakeholders.** We recommend working collaboratively with patient groups, providers and insurers to determine not only what information would be the most meaningful to patients, but also the most consumer-friendly way to provide such information.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Julie Zaiback-Aldinger, Executive Director of Community Advocacy and Health Equity, at Julie.Zaiback@AdventHealth.com.

Sincerely,

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