AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 17, 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-1753-P

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) Calendar Year (CY) 2022 Hospital Outpatient 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 CY 2022 OPPS proposed rule:

- Health Equity
- COVID-19 Flexibilities
- The Inpatient Only List
- The Ambulatory Surgical Center Covered Procedures List
- The Radiation Oncology Model
- The Hospital Outpatient Quality Reporting Program

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:

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]

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 and individual providers.

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

[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

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 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.

COVID-19 Flexibilities

Although CMS is not directly proposing to make any COVID-19 flexibilities in this proposed rule, the Agency is seeking feedback for future policy development. **AHPA appreciates the leadership shown by CMS throughout the COVID-19 public health emergency and recommends that the Agency continue to explore making many of the related flexibilities permanent.** These flexibilities made it

[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

possible for providers to fully embrace telehealth. Hospitals across the nation are now able to connect individuals with various specialists from the comfort of their homes; better manage the chronic conditions of patients through remote patient monitoring; and improve patient outcomes by expediting access to medical treatment. The progress made through this type of delivery of care cannot be squandered. As COVID-19 continues to challenge us, telehealth can reduce patient exposure to the virus while also increasing access to care. Below we outline some of the experiences of our member hospitals and the benefits enjoyed by patients as a result of the waivers granted.

- **Faster access to treatment and specialized care.** Telehealth has allowed hospitals to connect patients with an array of specialists who may not be locally available during a patient's hospitalization (i.e., neurology, endocrinology, rheumatology, cardiology). This has expedited access to needed medical treatment and reduced the need for patient transfers to other facilities.

- **Better management of chronic conditions.** Through telehealth, hospitals have been able to offer a variety of services such as diabetes self-management education, medical nutrition therapy and coaching. As an example, patients have been able to select food from in their home and learn how to read labels with an educator. Patient surveys have been significantly positive and highlighted patient's desire to continue to receive education in this manner.

- **Improved follow-up care, preventing lapses in care.** Some hospitals have used telehealth to monitor the health of patients discharged from the Emergency Department. At AdventHealth, headquartered in Florida, patients were discharged home with a telecommunication device to daily answer questions about symptoms and record temperature. Patients also had the ability to text with a nurse or request a video visit. This improved follow-up care has helped reduced missed appointments and avoid lapses of care.

- **Expanded hospital capacity through Hospital-at-Home model.** Adventist Health, located in California, launched a new Hospital-at-Home model that provides a flexible tool for managing waves of potential COVID-19 outbreaks in nine Adventist Health service areas. Hospital-at-Home models increase the ability of hospitals to treat more patients by freeing valuable acute care beds and allowing patients in need of less intensive care to be treated in the comfort of their home.

While there are still many barriers, such as state licensing laws, that limit the widespread use of telehealth, we believe that the permanent adoption of the COVID-19 waivers would accelerate the innovations already taking place via telehealth. Telehealth serves as an option to provide health care

services to patient populations that are more vulnerable to the virus, such as the elderly, pregnant women and those with existing chronic conditions or limited mobility. Reinstituting the telehealth restrictions that existed prior to the pandemic would be a missed opportunity to expand access to care, ensure the continuity of services currently provided through telehealth and build the needed infrastructure to prepare for future pandemics.

The Inpatient Only List

CMS proposes to halt the three-year phased elimination of the Inpatient Only (IPO) List and re-add the 298 services removed from the list in CY 2021 back onto the list, beginning in 2022. The Agency also seeks comment on whether it should maintain the longer-term objective of eliminating the IPO list or instead scale back the list to ensure that inpatient-only designations are consistent with current standards of practice.

AHPA supports a strategic and data driven approach to scaling back the Inpatient Only List instead of a bulk elimination process. We recommend that the Agency work alongside key stakeholders, including specialty physicians, to evaluate which procedures are the best candidates to be done in the outpatient setting.

The Ambulatory Surgical Center Covered Procedures List

In the CY 2021 OPPS final rule, CMS eliminated a subset of the ASC Covered Procedures List (CPL) addition criteria and added 267 surgical and "surgery-like" procedures to the CPL. In the CY 2021 OPPS final rule, CMS proposes to reinstate the ASC CPL criteria for adding procedures to the list and remove 258 of the 267 procedures added in CY 2021. CMS also proposes to adopt a new nomination process for adding surgical procedures to the ASC CPL. Under this proposal, stakeholders would be able to formally nominate procedures and provide public comment on procedures under consideration.

AHPA strongly supports the proposed addition of an initial nomination process prior to the rulemaking cycle. While health systems and individual providers may already weigh in on proposed additions to the CPL once they have been included in a proposed rule, this proposed nomination procedure will allow us to provide more comprehensive and more nuanced recommendations earlier in the process.

The Radiation Oncology Model

CMS proposes to proceed with the previously-delayed Radiation Oncology (RO) Alternative Payment Model (APM) on January 1, 2022, with brachytherapy removed as an included modality, liver cancer removed as an included indication and lowered discount factors for components.

AHPA supports the exclusion of liver cancer and brachytherapy as included indications and modalities, but recommends that CMS delay the RO model's January 1, 2022, start date. Given the significant community need for COVID-19-related care, many health systems and physician groups have not been able to dedicate the time and resources necessary to be ready for the proposed start date of January 1st.

Extreme and Uncontrollable Circumstances

CMS also proposes to adopt an "extreme and uncontrollable circumstances" policy, which would allow CMS to grant exceptions to model requirements, revise payment methodologies, and shift model performance periods to account for public health emergencies and other extraordinary events. Participants would be notified of any changes no later than 30 days prior to the original start date.

AHPA supports the adoption of an extreme and uncontrollable circumstances" policy but recommends that CMS increase the notification window for RO model participants. We recommend that the Agency notify participants at least 90 days in advance of the exception to allow for a robust level of planning.

Additional Clarity Requested

As CMS considers the best way to incorporate Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey results, AHPA requests clarification on how technical scoring under the RO model will account for less-than-optimal patient response rates. Should the response rates to surveys be less than anticipated, this will likely impact participating providers' ability to be successful in the RO model.

The Hospital Outpatient Quality Reporting Program

Measure Additions and Removals

CMS proposes to remove the following two chart-abstracted measures, beginning with CY 2023 reporting:

- *Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (OP-2)*

- *Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3)*

AHPA supports the remove of these two chart abstracted measures, as there are other measures available to support assessing confirmed myocardial infarction patients and those presenting with a potential heart attack.

CMS also proposes to add or reinstate four measures, including:

- *Cataracts: Improvement in Patient's Visual Function within 90 days* and
- *Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems Survey-Based Measures*

AHPA recommends that CMS consider whether the value of the cataract-related measure will outweigh the additional administrative burden of its collection. Cataract operations already have a high success rate within the first 90 days. The Agency may want to consider adopting another measure that would better assess outpatient quality. **AHPA also recommends that the OAS-CAHPS measure be made voluntary instead of mandatory, as there is little variation in hospitals' performance scores for this measure.**

Future Adoption of THA and TKA-related Measures

CMS seeks comment on whether to adopt specific measures on patient-reported outcomes for elective primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA), two procedures that recently transitioned into the outpatient setting.

AHPA recommends that CMS assess these measures at the provider level, as the provider has a much stronger influence on these procedures' outcomes and a more direct relationship with the patient. Hospitals often find it difficult to get patients to respond to either pre- or post-class surveys, making the patient-reported outcomes difficult to attain. We also recommend engaging with patients or patient-advocacy groups directly to uncover potential barriers to high levels of patient engagement with post-operative surveys.

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,

Carlyle Walton, FACHE

President
Adventist Health Policy Association