AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

June 17, 2022

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–1771–P Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates

Dear Ms. Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Agency's Fiscal Year (FY) 2023 Hospital Inpatient Prospective Payment System 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 2023 IPPS proposed rule:

- Payment Updates
- Changes to the Medicare Conditions of Participation
- Hospital Quality Programs
- Requests for Information

Payment Updates

Inpatient Payment Update

The proposed rule contains a 3.2 percent payment rate increase but because of other policies included in the rule, the combined operating and capital payments under the IPPS are projected to decrease by approximately $400 million.

AHPA does not support this adjustment as we believe that it fails to account for the financial strain providers are experiencing. The COVID-19 pandemic has gravely impacted the health care industry and despite the decline in COVID-19 hospitalizations, the industry continues to face staffing shortages, rising inflation and supply chain woes. For example, between 2019 and 2021, drug prices have risen by 36.9 percent, labor costs have increased by 19.1 percent and medical supplies by 20.6 percent.[1] While COVID-19 cases have decreased across the nation, the industry is still recovering from the impact of COVID-19 surges and preparing for the potential of new variants. Recovering from the pandemic, increased inflation and continued staffing shortages make the proposed update unreasonable.

Charge Inflation Factor

CMS is also proposing to use a charge inflation factor from data prior to the COVID-19 Public Health Emergency (PHE) as they believe it provides a more reasonable approximation of the increase in costs that will occur in the next fiscal year. CMS states that the Agency does not believe that the charge inflation that occurred during the PHE will continue as the number of higher costs COVID-19 cases decline.

AHPA does not support the use of an inflation factor preceding the COVID-19 PHE as this does not accurately reflect today's environment. As mentioned earlier, providers are experiencing additional costs that are not likely to resolve within the next fiscal year. While COVID-19 hospitalizations may continue to decline, providers are also seeing higher acuity patients, many who delayed care and are now sicker and costlier to treat.[2] **Given the significant rise of inflation and the higher acuity seen in patients, we recommend that CMS reevaluate the use of a pre-COVID-19 inflation factor and instead use 2021 data.**

[1] American Hospital Association, Cost of Caring, April 2022
[2] Sg2, Impact of Change, June 2022

Wage Index

CMS proposes a 5-percent cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year. CMS believes this will mitigate the negative impact of wage index changes and significant changes to geographic delineations.

AHPA applauds this proposal as we believe this would help tamper the impact of any major wage index changes taking place within a year. Additionally, it would provide more stability for Medicare payments to hospitals.

Conditions of Participation (CoPs)

CMS is proposing two new requirements for the Medicare CoPs:

- Extend the current reporting of COVID-19 and influenza data by revising the Critical Access Hospitals (CAH) infection prevention and control and antibiotic stewardship program CoPs. Specifically, the current daily COVID-19 reporting requirement would be extended until April 30, 2024, with the scope and frequency of data collection being flexible in response to the evolving circumstances.
- Adopt new reporting requirements for future pandemics. Hospitals would be required to report data to CDC's NHSN as determined by the Secretary of HHS.

Since the beginning of the pandemic, providers have worked diligently to collect and provide data to both federal and state authorities. This has further strained limited resources, with employees having to report data both during weekends and holidays. **If CMS extends the current reporting requirements beyond the end of the PHE, we ask that the Agency explain *how* the data will be used, streamline the current requirements, and reduce the cadence for reporting.**

To reduce the reporting burden on providers, we recommend that CMS:

1) **Ensure that all the data being collected is meaningful and actionable.** For example, facilities are still required to report on therapeutics like Casirivimab, Imdevimab, Bamlanivimab, Etesevimab and Sotrovimab, which are no longer allowed to be administered by providers.

2) **Reevaluate the data proposed for collection, particularly those data elements that are not directly related to patient outcomes and leverage existing data warehouses in order to avoid any duplication.** For example, positive COVID-19 rates are already reported through CMS' Promoting Interoperability program.

3) **Allow ample time for providers to make the necessary changes to their EHRs before implementing any new data reporting requirements.** Not all health systems have robust analytical capabilities to devote to data retrieval and reporting. Additionally, many hospitals across the country are transitioning to more robust EHRs and engaged in strategies to improve interoperability. We highlight this because we view the CoP proposals as a CMS initiative to gauge the burden of the pandemic across the nation. We believe that if these recommendations are not considered, CMS might be engineering more hardships for providers.

Additionally, AHPA has reservations about the potential adoption of standard reporting requirements for future pandemics or epidemics. We request more clarity from CMS over what would trigger mass data reporting. Before adopting any new requirements, CMS should also articulate how the Agency would use that information and share it across the health care industry. Given the limited resources of health providers during pandemics and epidemics, any data collection effort should clearly lead to improvements in patient care. To avoid duplication, we also recommend that CMS work with state governments, local health departments, and the provider community to better identify how data could be shared across entities and the type of data that would be valuable in responding to PHEs.

Hospital Quality Programs

Measure Suppression Policy

CMS proposes to apply a measure of suppression policy to the Value-based Purchasing (VBP), Hospital Readmissions Reduction (HRRP) and Hospital-acquired Conditions (HAC) programs to account for public health emergency caused by the COVID-19 pandemic. Under this policy, CMS will suppress certain measure scores when calculating performance so that hospitals are not penalized.

AHPA supports this policy and commends CMS for recognizing the continued impact of COVID-19 in hospitals' performance. We ask that CMS adopt this policy in the Inpatient Quality Reporting (IQR) program as well, as it would help assess any deviation in national performance during the COVID-19 PHE compared to historical performance. While hospitals are not penalized for their performance in the IQR program, this policy would help determine if there should be any adjustment to the timeframes reported publicly for all IQR measures. For example, many patients qualify for the *PSI-04* measure due to the severity of their illness, which requires a critical procedure to be performed within two days of inpatient admission. We have seen that COVID-19 has had a significant impact in increasing the number of patients included in the *PSI-04* measure. Publicly reporting measures that have been impacted by the pandemic can result in patients erroneously concluding that the hospital offers low-quality care.

Even if there is a disclaimer acknowledging the impact from COVID-19, consumers do not have the clinical context necessary to understand how the pandemic impacted performance. Similarly, we recommend that CMS abstain from publicly reporting a hospital's performance for any of the measures suppressed through this rule. This information should be shared with hospitals as part of their Medicare feedback reports instead or give hospitals the option to opt-in for public reporting. We would like to ask that CMS also evaluates *PSI-04* performance and other IQR metrics not in a payment program for any deviation in national performance during the COVID-19 PHE compared to historical performance in preceding performance years to determine if there should be any adjustment to the timeframes reported publicly.

Additionally, as CMS resumes the use of certain quality measures and the associated payment incentives or penalties, we urge the Agency to develop an appropriate framework for baseline performance periods and data benchmarks. In thinking through the establishment of a new baseline, CMS must consider the rolling nature of COVID-19 waves both in terms of geography and temporally when the surges occur in each community. Deciding on a single year (e.g., 2023) as a benchmark or even a shorter timeframe of several months (e.g., Jan-June 2023), could have unintended consequences. At the very least, we believe CMS should use community viral load data as a correction factor for reported data. Moreover, we would be curious to discuss with CMS whether a "self-benchmark" – where each participating hospital is benchmarked against itself year over year– would be an appropriate solution until COVID-19 reaches endemic levels. A self-benchmark, adjusted by community viral load would rectify concerns about rolling waves, as organizations would not be benchmarked against other organizations in other areas of the country that experienced different surges.

Hospital Birthing-Friendly Designation

CMS proposes to establish a hospital "birthing friendly" designation to reflect the quality and safety of maternal care at a hospital. The designation would be awarded to hospitals that report "Yes" to both questions embedded in the Maternal Morbidity Structural Measure of the Hospital IQR Program. CMS is seeking feedback on additional data sources that could be used to establish more robust criteria.

AHPA supports CMS' proposal as we believe it will make it easier for consumers to shop for maternal care and further incentive hospitals to participate in perinatal quality improvement collaboratives. We recommend that CMS utilize the HHS Perinatal Improvement Collaborative to identify best practices and potential measures for future inclusion into the birthing-friendly designation.[3]

[3] HHS Maternal and Infant Care Collaborative, November 8, 2021.

CMS should also attempt to incorporate outcome measures on maternal care endorsed by the National Quality Forum (NQF).

Inpatient Quality Reporting Measures

CMS proposes to adopt 10 new quality measures in the IQR program:

- Hospital Commitment to Health Equity
- Screening for Social Drivers of Health
- Screen Positive Rate for Social Drivers of Health
- Cesarean Birth eCQM
- Severe Obstetric Complications eCQM
- Hospital-Harm—Opioid-Related Adverse Events eCQM
- Global Malnutrition Composite Score eCQM
- Medicare Spending Per Beneficiary Hospital
- Hospital-Level Risk-Standardized Complication Rate Following THA/TKA
  Risk Standardized Patient-Reported Outcomes Performance Measure Following THA/TKA

Overall, AHPA recommends that CMS seek NQF endorsement before incorporating measures into the IQR program. Adopting measures before receiving NQF endorsement could lead to the collection of information that is not evidenced-based and not beneficial to patient care. Below are our comments regarding some of the measures proposed.

Screening for Social Drivers of Health

AHPA commends CMS for recognizing the importance of the social drivers of health, also known as the Social Determinants of Health (SDOH). We strongly support the addition of this measure but recommend that CMS establish a strategy to ensure that Community-Based Organizations (CBOs) and Federally Qualified Health Centers (FQHCs) are appropriately resourced to receive referrals from hospitals and individual clinicians. If a community does not have the necessary resources to address the needs identified through the screening process, clinicians and care managers will be hesitant to inquire about social drivers of health. Integrating a community referral network into a provider's Electronic Health Record (EHR) and building the community referral networks necessary to refer patients to is a process that takes time and resources (e.g., adequate personnel, investments in new technology, IT support and staff training). We therefore recommend making this measure voluntary until CY 2025, when the measure could be made mandatory. This would give providers two years to make changes to their

EHRs, collaborate with CBOs in the creation of a seamless referral process, and train their own employees on how to collect SDOH-related information in a culturally competent manner.

Due to the different SDOH screening tools in the market, we also recommend that CMS use this time to work with stakeholders in defining best practices, standards and expectations for future data sharing and analysis. We encourage CMS to engage with the GRAVITY Project and the U.S. Core Data for Interoperability Taskforce. These groups are working across industry stakeholder organizations to understand and develop standards and best practices.

In the future, we also recommend that this measure also be adopted in the Merit-based Incentive Payment System and Outpatient Quality Reporting programs, as this is where clinicians have the capability to identify and address root causes before they lead to an inpatient admission. Alignment of SDOH measures across the continuum of care can help prevent hospitalizations, hospital readmissions and increased use of the emergency department.

Screen Positive Rate for Social Drivers of Health

AHPA supports the use of this measures as long as it is not publicly reported. We are concerned that publicly reporting this measure may unintentionally penalize hospitals serving a larger population of patients from marginalized and underserved communities. While CMS notes that this measure is not intended for hospital comparison, publicly reporting the results may encourage doing so.

AHPA also encourages CMS to explore modifying this measure. Rather than focusing on the positive screening rate, CMS should explore measures that assess how providers are closing the screening loop by addressing the needs identified in the screenings. We agree that screen positive rates would be helpful for hospitals to understand in aggregate or regionally.

Hospital Commitment to Health Equity

Beginning in CY 2023, CMS proposes adding a Structural Hospital Commitment to Health Equity measure to the IQR program. The measure is intended to assess a hospital's commitment to health equity across five domains—equity prioritization, data collection, data analysis, quality improvement and leadership engagement—with each domain having multiple elements. A point is awarded for each domain a hospital attests affirmatively, and no partial credit is granted.

AHPA commends CMS for its committed efforts to advance health equity. We believe this new health equity measure to be a step in the right direction, however, we hold reservations about the

effectiveness of the measure's application, particularly *Domain 2 – Data Collection* and *Domain 3 – Data Analysis*. As there is not yet a uniform protocol from the Agency on demographic data collection, we are concerned that this will lead to the collection of varied data across multiple health systems. To remedy this issue, we recommend that CMS require the use of a vetted and tested standardized data set. We also recommend that CMS continue to work with the NQF and the provider community to determine how best to quantify advances in health equity. While this structural measure is helpful, it may not necessarily lead to improvements in health equity.

AHPA is also concerned that all hospitals will not have capabilities within their EHR to meet the criteria set forth by this measure. Time will also be needed for hospitals to properly develop and implement a patient screening process and train their staff on how to collect any new demographic data. **We recommend that CMS extend hospitals adequate time to develop and adopt new screening processes.**

Maternity Care IQR Measures

CMS proposes adopting two maternal health Electronic Clinical Quality Measures (eCQMs), the *Cesarean Birth eCQM* and the *Severe Obstetric Complications eCQM*.

AHPA favors adopting the two maternal health measures into the IQR program. However, we ask that CMS delay their adoption until both have received endorsement by the NQF. We also recommend that CMS do *not* exclude COVID-19 patients from the *Severe Obstetric Complications eCQM* measure. While AHPA agrees that hospitals should not be penalized for COVID-19 patients, tracking obstetric complications without tracking how many of those complications were impacted by COVID-19 is a missed opportunity to measure this issue and improve patient care. Particularly during the Omicron surge, our AHPA hospitals experience an increase in maternal complications resulting from a rise of COVID-19 patients. Because this sample of the population could be large, we view it as an important data point that warrants national measurement.

Hospital-Harm Opioid-Related Adverse Events eCQM

CMS proposes adding an outcome-based *Hospital Harm—Opioid-Related Adverse Events* eCQM to the Hospital IQR Program measure set beginning with the CY 2024 reporting period. The measure uses naloxone administration as a marker for adverse events triggered by opioid administration to inpatients.

AHPA supports the adoption of this eCQM. However, we do request more information about the performance rate for this measure and what is the intended action to be taken with the collected data. We

do note that the overall number of inpatient naloxone rescue events is small, and we recommend that CMS collect and analyze several years of measure results before considering the addition of this measure into any of the IPPS pay-for-performance programs or into other clinical settings.

Global Malnutrition Composite Score eCQM

CMS proposes adding a Global Malnutrition Composite Score to the Hospital IQR Program measure set beginning with the CY 2024 reporting period. This measure would be the only one in the measure set to address malnutrition of hospitalized patients directly. The four measure components correspond to the four elements of recommended optimal nutritional care:

- Screening
- Complete assessment of patients screening positive
- Documentation of degree of malnutrition
- Nutritional care plan development

AHPA is supportive of the inclusion of an eCQM that addresses malnutrition in hospitalized patients.

Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Total Knee Arthroplasty (TKA) or Total Hip Arthroplasty

CMS proposes to adopt the Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) into the IQR program. This is a patient-reported outcome measure that includes standardized functional status data that is collected preoperatively and for one year postoperatively. Two sets of voluntary collection and submission periods would run from October 2022 through September 2024 and from April 2023 through September 2025, respectively. The first mandatory data collection and submission cycle would begin in April 2024 and run through September 2026. Measure results would be used for the FY 2028 payment determination year.

AHPA does not support the adoption of this measure into the IQR program at this time. Before considering adoption, CMS should first review and share the lessons learned from the use of this measure in the Comprehensive Care for Joint Replacement (CJR) payment model. Hospitals have been reporting this measure since the model began in 2016 in exchange for bonus points under the model's quality reporting program. However, CMS has not yet publicly released any results related to this measure.

Future Adoption of Digital National Healthcare Safety Network Measures

CMS requests information from stakeholders on the potential adoption of two digital National Healthcare Safety Network (NHSN) Measures:

- NHSN Hospital-Onset Bacteremia & Fungemia Outcome
- NHSN Healthcare-associated *Clostridioides difficile* Infection Outcome

Hospital-Onset Bacteremia and Fungemia Outcome Measure

CMS proposes adding this measure to capture the development of new bacteremia and fungemia among patients admitted to acute care hospitals. The measure will capture a wide range of bloodstream infections using determinations from data sources available in EHRs. CMS is considering adopting this measure in the Hospital IQR Program and the PCHQR Program as a replacement for the *Catheter-associated Urinary Tract Infections* (CAUTI) and *Central Line-associated Bloodstream Infection* (CLABSI) measures in the VBP and HAC Programs.

AHPA currently does not support the inclusion of this measure in any of Medicare's quality programs because the measure has not been fully reviewed and vetted. CMS' rational for inclusion is based off a single study where the authors acknowledged limitations. Specifically, the study states, "larger studies across a variety of hospital settings are needed to assess the generalizability of these results, understand current risk factors for HOB, and develop prevention strategies."[4] We agree with this recommendation and urge CMS to conduct a review of further scientific studies across a variety of hospital facilities to ensure that the measure is valid and reliable. As mentioned earlier, we also encourage the Agency to seek NQF endorsement of this measure.

Additionally, AHPA recommends that CMS delay implementation of this measure until a vetted surveillance definition has been released. Historically, any time a measure requires reporting to the NHSN, a surveillance definition is released prior to adoption. To date, providers have not been given the opportunity to comment on the surveillance definition and are unable to fully understand the implications of this measure.

AHPA also opposes replacing the CAUTI and CLABSI measures with this measure. Adopting this measure into pay-for-performance programs could lead to unintended consequences that have not been

[4] Dantes RB, Rock C, Milstone AM, Jacob JT, Chernetsky-Tejedor S, Harris AD, Leekha S. Preventability of hospital onset bacteremia and fungemia: A pilot study of a potential healthcare-associated infection outcome measure., 2019

fully assessed. For example, will CMS be able to account for under and over testing to determine the approximate infection date along the care continuum? How will CMS account for bacteremia/fungemia secondary diagnosis? Will EHR collection technology be able to exclude bacteremia/fungemia secondary diagnoses? Additionally, we believe that the CAUTI and CLABSI measure sets still hold value that will be lost if the measures are replaced.

Clostridioides difficile CDC NHSN Health-Associated Infection (HA-CDI) Outcome Measure

CMS seeks feedback on the future inclusion of the NHSN Healthcare-Associated *Clostridioides difficile* Infection Outcome measure (HA-CDI) as a digital quality measure. The measure would use the Adjusted Ranking Metric (ARM) adjusted for volume of exposure between facilities.

AHPA requests more information on how the volume of exposure variables will be defined. We are concerned that acute care facilities will carry the burden of high acuity patients already on a long-term regimen of antibiotics from history of long-term care treatment. These patients are at greater risk of *C. difficile* infection not because of inappropriate safety standards within the acute care facility but because of their lengthy antimicrobial treatment. **We recommend that CMS develop an exclusion for this population in partnership with the health systems, the CDC and the Infection Disease Society of America. Additionally, we recommend that CMS work to develop a more in-depth and recent baseline of data before considering adoption of this measure into the IQR program.**

HAC Reduction Program

CMS proposes to suppress all HAC Reduction program measures for FY 2023 so that no penalties will be applied and all hospitals will receive a total HAC score of zero. The *Hospital Acquired Infections (*HAI) measure will report measure results via hospital specific reports, which will be made public on the Care Compare website. The *PSI-90* measure will not be calculated, nor will it be reported publicly. CMS has stated that it plans to resume the use of the HAC measure data for scoring and payment adjustments in FY 2024.

AHPA supports the proposal to not calculate the total performance score for hospitals. We ask that CMS continue to monitor the impact of COVID-19 on hospital performance before committing to resume using data for scoring and payment adjustments.

Value Based Purchasing (VPB) Program

CMS proposes to suppress all measures in both the Person and Community Engagement and Patient Safety domains. The Efficiency and Cost Reduction domain will not be suppressed and neither will the Clinical domain, with the exception of the *MORT-30-PN* measure. CMS proposes to exclude patients with a principal or secondary COVID-19 diagnosis and adopt covariate adjustment for patients with a history of COVID-19 in the 12 months prior to the inpatient admission.

AHPA supports applying the proposed suppression policy as it will help ensure hospitals are not penalized for circumstances outside of their control. We also appreciate CMS' proposal to adopt a covariate adjustment for patients who have tested COVID-19 positive 12 months prior to an inpatient admission. Multiple studies have shown that patients can experience health problems after recovering from COVID-19 that can increase their acuity and impact a hospital's performance. While we support this policy, we are concerned that this adjustment may not fully capture all patients who have had a history of COVID-19. Currently, the adjustment depends on claims being submitted with either the U07.1 or Z86.16 ICD-10-CM codes. However, many patients may have tested positive for COVID-19 through at-home tests, which would not be captured in the claims data. Additionally, there is currently no code to identify COVID-19 long haulers. As a result, patients who are seeking care for these long-term symptoms may not be coded with either the U07.1 or Z86.16 ICD-10-CM codes since they no longer have a positive diagnosis. Due to these issues, we recommend that CMS adopt this covariate adjustment while working with a special NQF Technical Expert Panel (TEP) on this issue to ensure that any necessary refinements to this policy are made.

Promoting Interoperability

Query of the PDMP Measure

CMS proposes to convert the *Query of the Prescription Drug Monitoring Program (PDMP)* measure from optional to mandatory, maintaining its associated points within the Electronic Prescribing objective. Should this be finalized, the Agency would also include Schedules II, III, and IV drugs within this measure.

AHPA believes the PDMP plays an important role in patient safety by assisting in the identification of patients who have multiple prescriptions for controlled substances or who may be misusing these prescriptions. As the Office of the National Coordinator (ONC) for Health IT stated, all 50 states now can participate in querying a PDMP, which will increase patient safety and potentially reduce the abuse of

prescription drugs over time. Due to the low potential of abuse of schedule III/IV medications, CMS could consider making the querying of these specific prescriptions optional.

New Optional Measure: Enabling Exchange Under TEFCA

Under the Health Information Exchange (HIE) objective, CMS proposes to add an optional attestation measure on hospital participation in the Trusted Exchange Framework and Common Agreement (TEFCA). Hospitals would be able to earn full credit for the HIE objective by fulfillment of this measure. **AHPA agrees with this additional measure option as we believe it will promote timely and connected patient care.**

Public Health and Clinical Data Exchange

CMS proposes to continue requiring four public health measures and adopt one new measure, the *Antimicrobial Use and Resistance (AUR) Surveillance.* Should this measure be added, the points possible in this objective would increase from 10 to 25 points.

AHPA asks that this new AUR Surveillance measure be made optional. This would allow hospitals to fully adjust to reporting this measure in their EHR alongside the other four public health measures. We highly recommend that CMS work with EHR vendors before its final inclusion in the PI program because not all EHR technologies may facilitate seamless reporting of this measure.

CMS also proposes to consolidate the "active engagement" parameter within this objective to return eligible hospitals to reporting their level of active engagement through two options, instead of three.

1. Proposed Option 1: Pre-production and Validation (a combination of current option 1, completed registration to submit data, and current option 2, testing and validation);
2. Proposed Option 2: Validated Data Production (current option 3, production).

Currently, eligible hospitals and critical access hospitals are not required to do such reporting for any measures associated with this objective. **AHPA opposes the addition of this requirement as this data is already being reported to state and local health authorities.**

Finally, CMS proposes to only allow PI participants to remain in the validation stage of engagement for one reporting period before moving to production. **AHPA supports a continued attestation process but cautions that some state and regional agencies are currently unable to accept data on public health measures.** Since the onus of moving to production lies with public health agencies, CMS should collaborate with local agencies before adopting this policy.

Social Determinants of Health (SDOH) Diagnosis Codes

CMS is seeking comment on how the reporting of SDOH diagnosis codes in categories Z55 - Z65 might improve hospitals' ability to recognize severity of illness, complexity of illness, and utilization of resources. The Agency also asks whether to require reporting of select Z-codes and what additional burdens and benefits may be added should this be adopted in future rulemaking.

AHPA commends CMS for its work to evaluate appropriate initiatives and incentives within quality programs to foster a more equitable health care system. While we believe that SDOH information will improve the ability to recognize complexity and severity in the MS-DRGs, more foundational work is needed. AHPA supports the use of incentives to increase reporting of SDOH data, however, comprehensive standardization is needed first. Many health systems currently capture such data but standardization is needed to allow for true sharing of best practices between providers and delivery systems.

Health systems are currently capturing sociodemographic data but this information is not easily translatable for CMS purposes. For example, despite an available framework for mapping the more than 900 race ethnicity codes provided by the Centers for Disease Control and Prevention to the Office of Management and Budget, race and ethnicity codes captured in the EHR cannot be consistently mapped.[5] This is a result of lack of use of standard taxonomies—in part by the EHRs and in part by the providers to allow the category selections to align with how their populations would like to report information. Similarly, there are an abundance of tools to screen for SDOH with underlying definitions for certain social risk factors (e.g., food insecurity) significantly varying even when the same tool is used by different providers.

We recommend that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of socio-demographic factors. We believe a coordinated approach to be best for numerous purposes, including payment and quality. This coordinated approach requires significant input from providers across the continuum, vendors, payers and suppliers.

Requests for Information (RFI):

Please find below our responses to the different RFIs included in this rule.

[5] HL7 STANDARDS: FHIR. V4 0.1

Health Equity Principles for Pay-for-Performance

CMS seeks feedback on five specific areas of focus for overarching principles on measuring health care disparities across quality programs:

1. Identification of Goals and Approaches for Measuring Disparities.
2. Prioritization of Measures for Disparity Reporting.
3. Principles for Social Risk Factor and Demographic Data.
4. Identification of Meaningful Performance Differences.
5. Reporting Disparities Results.

AHPA commends the Agency for its continued steps to advance health equity within pay-for-performance programs. As we seek to not just collect data but also make quantifiable improvements in health equity, we support disparities-reduction strategies that:

- Emphasize relevant measures and accurate data collection.
- Quantify opportunity gaps to inform meaningful change.
- Are iterative, continually working for future improvement.

We also believe that any policy to advance health equity should align with the following five principles:

1. **Support policies that affirm health equity as a right of all people but prioritize it as an emergent issue for Black, Hispanic/Latinx, Indigenous and Asian communities.** These communities are disproportionately impacted by health inequities and are often the target of racially motivated violence.
2. **Oppose policies that exacerbate or perpetuate economic and social inequities.** Instead, AHPA strategically seeks to improve the social determinants of health for marginalized groups. Equity initiatives are most effective when they target the root causes of disparities in health outcomes.
3. **Support evidence-based research and public policy solutions that include diverse populations** (diversity in race, ethnicity, class, income level, prayer/religion, sexual orientation, disability status and gender). Biases in research undermine quality scientific decision-making; biases in public policies deepen inequities. By including diverse populations in research and policy decision-making, we are best positioned to address the unique needs of those populations.
4. **Support policies that promote equitable access to quality health care and opportunities for economic success.** This includes policies that promote a diverse workforce and remove barriers to accessing comprehensive health care services.
5. **Support policies that incentivize and promote the use of standardized demographic data and data on SDOH**. Such data empower health providers and policymakers, elevating the ability to make evidence-based decisions that support the goal of achieving health equity.

Maternity Care

CMS is requesting information on potential policy approaches for advancing maternal health care. These approaches could involve new Medicare CoPs on maternal care.

AHPA applauds CMS for increasing its focus on improving maternal care in the U.S. According to the CDC, our nation experiences higher rates of maternal morbidity and mortality than most other developed countries, rates that have continued to trend upward in recent decades.[6] As a result of these findings and our continued commitment to improve patient care, our health systems engage with clinical experts to accomplish our goal of improving maternity care.

We welcome the opportunity to further collaborate with CMS in efforts to improve maternal care and urge the Agency to consider the following recommendations:

- **As opposed to codifying a specific best practice within the Medicare CoPs, we recommend that CMS facilitate the sharing of information among providers and elaborate a framework for the improvement of maternal care.** For example, CMS should leverage the Center for Medicare and Medicaid Innovation (CMMI) to compare different discharge scenarios and share best practices. Initiatives such as the Strong Start for Mothers and Newborns Initiative should be restarted, with findings shared across the health care industry. We also recommend that CMS work with the different state perinatal collaboratives so that any strategies designed to improve maternal care are shared and further reviewed as opposed to all states working in silos. Some of those strategies could also be tested nationally through models designed by CMMI. As different state and national collaborations take place, hospitals are in the process of identifying best practices and adopting new protocols to improve maternal care. We find it premature to change the Medicare CoPs to reflect practices that are still being explored.

- **Work with Congress to promote greater access to postpartum care and support funding for navigator programs.** It is imperative to connect patients (expecting and new mothers) with appropriate resources throughout the birthing process; from conception through postpartum. Studies show that 52 percent of pregnancy-related deaths occur within a year postpartum and 40 percent of those deaths occur in the first 42 days postpartum.[7] Additionally, the U.S. is one of the only industrialized nations that does not fully cover postpartum home visits by a nurse or

[6] Centers for Disease Control and Prevention, Severe Maternal Morbidity in the United States. January 31, 2020

[7] Roosa Tikkanen et al, Maternal Mortality and Maternity Care in the United States, Commonwealth Fund, November 2020.

midwife.[8] Some Medicaid programs cover at-home visits but this varies by state. Increasing access to health care during the postpartum period is vital to improving better outcomes for mothers and children. Additionally, while the use of navigators and Community Health Workers have been found to improve patient outcomes, not many hospitals have the resources to invest in these services. Grant programs for hospitals to develop or expand existing navigator programs would help improve care coordination and potentially reduce health disparities.[9]

- **Develop a comprehensive strategy across all agencies within the Department of Health and Human Services (HHS) to improve maternal care.** This strategy should leverage the work of agencies such as the Agency for Healthcare Research and Quality (AHRQ) and expand existing programs led by the Health Resources and Services Administration (HRSA) such as Healthy Start. Increased support for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will also be essential to reduce health disparities.

- **Align financial incentives in order to reduce c-section rates and promote more vaginal births.** Currently, regardless of a patient's comorbidities, c-sections are reimbursed at a higher rate than vaginal deliveries. While we support this payment differentiation for emergency c-sections or those that are clinically recommended due to complications during pregnancy, we do not believe that the increased payment rate should apply to all c-sections.

- **Adopt quality measures that collect data on obstetric deaths and "near misses" where the patient survived despite severe complications.** This will allow CMS to better understand where to focus future efforts to address maternal morbidity and mortality. To fully address the nation's maternity problems, the federal government needs to utilize all executive branches for a comprehensive approach.

Payment Adjustments for Domestically Made N95 Respirator Masks

CMS seeks comment on a potential future payment adjustment for National Institute for Occupation Safety and Health (NIOSH) approved N95 masks that are domestically produced.

[8] Roosa Tikkanen et al., Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries, Commonwealth Fund, Nov. 2020

[9] Yee, L. M., Martinez, N. G., Nguyen, A. T., Hajjar, N., Chen, M. J., & Simon, M. A. (2017). Using a Patient Navigator to Improve Postpartum Care in an Urban Women's Health Clinic. Obstetrics and gynecology, 129(5), 925–933.

AHPA strongly supports this proposal for both inpatient and outpatient Medicare payments. We also recommend that CMS expand this adjustment to include other critical medical supplies and pharmaceuticals that played a crucial role in combating COVID-19.

Climate Change

CMS is seeking input on how climate change is impacting health care, outcomes and equity. Specifically, CMS is looking for information about how climate change affects patient populations with a focus on underserved groups. The Agency is also interested on how hospitals and the health care sector can effectively prepare for climate threats and approaches hospitals are using to reduce their greenhouse gas emissions.

AHPA applauds CMS for exploring this issue and we are committed to evaluating different strategies that could improve the environment of our patients and the communities we serve. Similar to the efforts related to health equity, hospitals across the nation find themselves in different parts of the journey to create and implement environmental sustainability plans. As a result, it would be helpful for CMS to serve as a convener and encourage the exchange of best practices in this area. This could be done through an annual report that gathers those best practices and the formation of a technical expert panel tasked with developing policy recommendations. Addressing climate change's impacts on health care and searching for approaches hospitals can take to reduce their emissions will be a significant undertaking. We believe that sharing these best practices will help create a blueprint that could guide providers in their efforts.

For the adoption of any future policies, we also recommend that CMS adopt a gradual implementation approach that takes into consideration the limited resources of health providers. The health care industry continues to deal with the impact of the COVID-19 pandemic, staffing shortages and inflationary costs. We therefore caution CMS from implementing policies that could further add to the current financial strain on hospitals.

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 Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,

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