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By Electronic Delivery

June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: ***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: Proposed Rule (CMS-1771-P; RIN 0938-AU84)***

Dear Administrator Brooks-LaSure:

The Florida Hospital Association (FHA), on behalf of its more than 200-member hospital and health systems appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services' (CMS) *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: Proposed Rule (CMS-1771-P; RIN 0938-AU84).*

For two years hospitals have led their communities through the COVID-19 public health emergency (PHE). As the country continues to experience surges in COVID, and congressional allocations of financial aid for providers run dry, hospitals continue to respond to their mission to care. However, despite their resilience in the face of the pandemic hospitals are not immune to the economic factors facing the country.

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A May 2022 Kaufman Hall report[1] on data from more than 900 hospitals paints a concerning picture of hospital finances:

- Total expenses have grown 8.3% year over year (YOY) and are 9.6% higher year to date.
- Inpatient revenue is down 1.3% (though outpatient revenue has increased 3.5% over the same period)
- Revenue is beginning to trend negative – from March to April gross operating revenue is down 7%.
- Year to date hospital margins are down 3.09% through April.
- The negative margins represent a year long trend – **April represents the fourth consecutive month of negative hospital margins.**
- In 2022 hospitals are treating fewer patients with a higher acuity - Kaufman Hall also notes that hospital patients in 2022 are likely sicker, harder to discharge and more expensive to treat than hospital patients in 2021.

The PHE has required and continues to require hospitals to increase labor costs due to labor shortages that require increased compensation for full-time employees and increased use of more costly contract labor. These labor shortages are attributable to a number of factors, including quarantines, vaccine mandates, and apprehension and stress of healthcare staff resulting in their non-participation in the healthcare workforce (whether temporarily or permanently). Additionally, hospitals and other healthcare providers have incurred abnormally high costs associated with substantial additional paid time off for nurses and therapists suffering from COVID-19 or being quarantined due to potential exposure to this disease; increased operating costs related to purchases of additional PPE; increases in purchases of other supply costs; and increased costs of cleaning supplies, among other cost increases.

The health care sector is not unique in its experience with inflation; however, providers are unable to adjust their rates to account for rising costs. Research commissioned by the American Hospital Association (AHA), show an increase in hospital costs by more than 20% from 2019-2021. This includes a 36.9% increase in drug costs and a 19.1% increase in labor costs. These inflated cost drivers have remained stubbornly high throughout the PHE regardless of actual rates of hospitalization for COVID-19.

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[1] https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022?utm_source=agcy&utm_campaign=nhfr-report&utm_medium=pr&utm_term=may-nhfr-220531 (Last accessed June 17, 2022)

Adding to these incredible stressors to hospital operations is a volatile stock market. A hospital's investment portfolio provides a financial cushion to absorb unforeseen operating challenges that may lead to potential shortfalls in operating margins. However, a confluence of world events, including inflation, have resulted in a stock market decline of more than 20% this year and the so-called bear market is not likely to end soon. As expenses climb, revenue decreases and margins are negative, hospitals will need to use their investment reserves to cover costs. Strong investment reserves have contributed to Florida's hospital's ability to weather health crises like the PHE. Reduced operating income resulting in depleted hospital investment reserves will create future vulnerabilities for hospitals.

Workforce challenges, inflated labor, drug, and supply costs, and a low volume high acuity patient population are ballooning hospital expenses. Those factors, coupled with a bleak U.S. economic outlook, are signposts of a looming crisis for hospitals. **As you consider these policies and finalize the proposed rule FHA urges you to not lose sight of the important role hospitals play in their communities and the importance of health margins to a hospital mission.**

This comment letter will provide input on the following sections of the Proposed Rules:

- III.D "Method for Computing the Proposed FY 2022 Unadjusted Wage Index"
- III.G "…Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment"
- IV.A "General Discussion" (Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2023)
- IV. F "Counting Days Associated With Section 1115 Demonstrations in the Medicaid Fraction"
- V.H "Hospital Readmissions Reduction Program: Proposed Updates & Changes"
- V.I "Hospital Value-Based Purchasing Program: Proposed Policy Changes"
- V.J "Hospital-Acquired Condition (HAC) Reduction Program: Proposed Updates and Changes"
- IX.B. "Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs – Request for Information"
- IX.E "Hospital Inpatient Quality Reporting (IQR) Program"
    - b. "Proposed Adoption of Two Social Drivers of Health Measures"

III.D. "Method for Computing the Proposed FY 2022 Unadjusted Wage Index"

CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%.

As noted above, the current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on hospitals. We remain on the front lines fighting this powerful virus—our doctors and nurses continue to care for COVID-19 patients even if other industries have moved on from the pandemic. At the same time, we continue to struggle with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic.

This update, as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the unprecedented inflationary environment we discussed above. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. **When historical data is no longer a good predictor of future changes, the market basket becomes inadequate. Yet, this is essentially what has been done when forecasting the FY 2022 and 2023 market basket and productivity adjustments.** Indeed, with more recent data, the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year. Additionally, the latest data also indicate *decreases* in productivity, not gains. We urge CMS to consider the changing health care system dynamics and their effects on hospitals.

The market basket updates for FY 2022 and FY 2023 have and will result in woefully inadequate reimbursements for our hospital. We ask CMS to implement, for FY 2023, a retrospective adjustment to account for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022

Additionally, we ask that CMS eliminate the productivity cut for FY 2023. The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes the hospital field can mirror productivity gains across the private nonfarm business sector. This has not been our hospital's experience, particularly during the pandemic. For example, national data has shown that hospitals across the country have experienced four straight months of negative margins, driven by staffing increases,

higher energy costs and inflation of costs for supplies. Moreover, the ability for hospitals to hire staff has become more difficult as the labor market has tightened. **Therefore, we have strong concerns about the proposed productivity cut given the extreme and uncertain circumstances in which our hospital is currently operating. We urge CMS to eliminate the cut for FY 2023.**

> *III.G "…Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment"*

CMS proposes to continue its policy to increase wage index values for low-wage hospitals, which was finalized in FY 2020. Specifically, for hospitals with a wage index value below the 25th percentile, the agency would increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals.

In 2020, CMS finalized that this policy would be effective for at least four years, beginning in FY 2020, in order to "allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation." The agency proposes to continue to make this policy budget neutral by adjusting the national standardized amount for all hospitals. A policy of budget neutrality will result in reductions to hospitals in the top quartiles of the wage index in order to improve the index for low-wage hospitals. Hospitals are currently reimbursed below the cost of care by Medicare, and due to the PHE are experiencing extreme revenue shortfalls. FHA supports continuing to improve the wage index values for low wage hospitals. However, we do not believe that budget neutrality is a requirement of the statute which provides CMS the authority to increase the wage index for hospitals in the lowest wage index quartile. Therefore, we support increasing the wage index values of low-wage hospitals, but continue to urge the agency to use its existing authority to do so in a non-budget-neutral manner.

> *IV.A "General Discussion"(Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2023)*

CMS Proposes to decrease DSH payments by ~$800 million.

We are concerned with CMS' proposal to decrease DSH payments—by approximately 5% or $800 million—to hospitals for FY 2023. In Florida, the DSH cuts are an estimated total of $44.5 million in the proposed rule and would reduce funding provided to those who qualify for

uncompensated care. We ask for more clarity on the agency's calculations for DSH payments. Specifically, we ask CMS to provide more details on the agency's assumption of small increases in discharge volume for FY 2022 and FY 2023. Although it appears likely that volumes will remain lower than historic, pre-pandemic levels, the trends we are seeing now indicate that FY 2022 and 2023 volumes will continue to increase substantially as individuals began to seek care.

Additionally, we question the agency's estimate that the uninsured rate will decrease from 9.6% to 9.2% from FY 2022 to FY 2023 when determining DSH payments. In our communities, it is clear that a large increase in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions begin to unwind. In Florida the Medicaid population has increased by over 1.5 million recipients and this group will be significantly impacted by the PHE expiration.

FHA cannot support a proposal with such a significant impact on funding for uncompensated care.

> *IV. F. "Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction"*

The Proposed Rule announces CMS's intent to revise its regulations to exclude inpatient days for persons who receive "medical assistance" by means of an uncompensated care pool approved by CMS under a section 1115 demonstration project from the Medicaid fraction of the disproportionate share hospital ("DSH") calculation.

The Proposed Rule is specifically designed to foreclose hospitals from claiming patient days in the Medicaid fraction numerator attributable to patients whom CMS "regarded as" Medicaid eligible when the agency exercised its authority under section 1115 of the Social Security Act to match State funds appropriated to uncompensated care pools to pay for the cost of their inpatient care.

The state of Florida operates a CMS-approved section 1115 demonstration that implements an uncompensated care pool that covers the cost of inpatient care furnished to uninsured and underinsured individuals. The Proposed Rule, if adopted, would arbitrarily and unlawfully deprive Hospitals of reimbursement for the substantial costs that they incur in treating these lower-income individuals. **We respectfully urge you to refrain from adopting this aspect of your Proposed Rule.**

In its FY 2022 IPPS proposed rule, CMS promulgated a similar proposal, attempting to limit hospitals from claiming patient days in the Medicaid fraction numerator only if the demonstration project extended inpatient hospital insurance coverage benefits directly to that patient for that day. In response, FHA, along with other major stakeholders, urged CMS not to adopt its proposed policy **based on fundamental flaws in CMS's interpretation of the governing statute and instructive case law.** While CMS did not finalize its proposal in the FY 2022 rulemaking cycle, it has now turned a deaf ear to commentors' concerns and has proposed a similarly unlawful proposal for FY 2023.

The text of the DSH Provision unambiguously requires the inclusion of patient days attributable to beneficiaries of Section 1115 demonstration projects in the numerator of the Medicaid fraction. The DSH provision (42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)) clarifies that, in determining the number of patient days for patients who were eligible for medical assistance under a State plan, "the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI." The "regarded as" language that the proposed rule seeks to change would have the effect of prohibiting reimbursement for patients that receive treatment through an 1115 waiver, which is clearly incompatible with the language in the statute.

The CMS proposal, which seeks to justify itself by claiming that uncompensated care pool payments do not count because they go to a hospital rather than directly to a recipient is contrary to standing case law. CMS's interpretation of the statute has been ruled inadequate by multiple courts, which have consistently stated that "if the Secretary approves a demonstration project, then we regard patient days involving patients who 'receive benefits under a demonstration project' as if they were patient days attributable to Medicaid-eligible patients. Once the Secretary approves a demonstration project, the statute affords the Secretary no additional authority to limit inclusion of days in the Medicaid fraction based on the Secretary's own notions of the degree or directness of the benefit to patients under the demonstration project.

CMS seeks to avoid prior court rulings by stating that the caselaw only applies to current regs, however, as noted, the proposed rule is still inadequate when reviewed against the plain text of the statutory scheme regarding DSH and Medicaid payments. The Medicare DSH statute allows the Secretary to exercise 1115 matching authority to "regard" a medical assistance" payments to hospitals for providing inpatient care to an individual. Thus, when CMS states in the Proposed

Rule that it is inappropriate to regard uncompensated care pool payments as "medical assistance," and the individuals whose care is paid for as "eligible" for "medical assistance," the agency ignores the fact that it necessarily did regard them as such when CMS agreed to match those payments using its section 1115 authority.

Further, the Medicaid statute does not dictate how States must make "payment" for care and services in order for the payment to be considered "medical assistance." Therefore, any form of payment that is intended to cover the categories of "care and services" identified in the Medicaid statute constitutes "medical assistance" and a payment method to cover that care is consistent with the statute.

Finally, the proposed rule runs directly counter to Congress's purposes in enacting the DSH provision. That provision reflects Congress's recognition that ''[h]ospitals that serve a disproportionate numbers of low-income patients have higher [M]edicare costs per case[,]'' and that those higher costs would not otherwise be compensated by the IPPS payment formula. The proposed rule would only serve to injure hospitals that provide medical assistance to low-income patients. **Hospitals should receive appropriate compensation for these costs because they are the costs associated with furnishing medical assistance to eligible individuals.**

CMS should not implement its proposal to exclude inpatient days for persons who receive "medical assistance" by means of an uncompensated care pool approved by CMS under a section 1115 demonstration project from the Medicaid fraction of the DSH calculation. However, in the event it chooses to do so, it should, at the very least, specify that its policy applies only to future demonstration projects and not those that are currently approved by the Secretary. For beneficiaries under existing Medicaid demonstration projects, as noted, the agency has already necessarily made the finding, as the time that it approved the project, that these beneficiaries are "regarded" as eligible for medical assistance. Hospitals in States with demonstration projects that incorporate uncompensated care pools have acted in reliance on the statute's promise of DSH funding to pay for the treatment of these beneficiaries.

V.H. "Hospital Readmissions Reduction Program: Proposed Updates & Changes"

The HRRP imposes penalties of up to 3% of base IPPS payments for having "excess" readmission rates for selected conditions when compared to expected rates. CMS uses six Medicare claims-based readmission measures to assess performance in the program. As required by the 21st Century Cures Act, CMS implemented a sociodemographic adjustment

approach beginning with the FY 2019 HRRP in which CMS places hospitals into one of five peer groups based on the proportion of patients dually eligible for Medicare and Medicaid that they treat. In this rule, CMS proposes several changes to account for the impact of the COVID-19 PHE

- **FHA urges CMS not to finalize its proposal to reintroduce the pneumonia readmission measure for FY 2024.** Instead, we urge CMS to conduct further analysis to ensure it has minimized the overlap between this measure and COVID-19-related pneumonia.

  In last year's inpatient PPS final rule, CMS adopted a COVID-19 measure suppression policy across its quality measure programs that permits the agency to not use quality measure data the agency believes have been affected by the pandemic and would result in distorted hospital performance. CMS used this policy to suppress the use of the PN readmissions measure from the FY 2023 HRRP because of data showing a substantial proportion of the measure cohort included admissions with a COVID-19 diagnosis. As a result, the measure's "clinical proximity" to COVID-19 was close enough to affect performance.

  CMS now believes its proposed technical changes to the measure are sufficient to minimize the overlap with COVID-19-related pneumonia. Specifically, CMS would remove patients with COVID-19 as a principle or secondary diagnosis from both index admissions and readmissions. CMS also believes the ICD-10-CM code it adopted in January 2021 that captures pneumonia due to COVID-19 as a secondary diagnosis (J12.82) is now sufficiently well-known and used by hospitals that patients with a COVID-19 diagnosis now make up a small portion of PN admissions. FHA agrees that these specification changes are directionally appropriate, and we appreciate that the proposed rule includes data showing the impact of these changes. Indeed, the percentage of pneumonia patients with COVID-19 present on admission dropped from 9.8% in January 2021 to 0.7% in July 2021. However, it is notable that there were upticks in these percentages in August and September 2021, rising to 3.5% of patients. We recommend CMS run the same data for the entirety of 2021 to ensure these increases are anomalies — rather than trends — before re-introducing the PN readmission measure into the HRRP. This would enable agencies and the hospitals to determine whether additional education on the new codes is necessary, or if further measure specification tweaks may be required.

- **FHA supports the concept of CMS's proposal to include patient history of COVID-19 diagnosis in the 12 months prior to the index hospitalization as a co-variate in the**

HRRP measures' risk adjustment models. However, we urge CMS to conduct further analysis before finalizing this proposal to ensure prior COVID-19 is captured across hospitals in a complete, consistent and equitable way. We greatly appreciate CMS's recognition of the potentially long-lasting impacts of a COVID-19 diagnosis on patient risk for readmission. To ensure a level playing field in the HRRP over the long run, CMS must improve measure methodologies to recognize COVID-19's potential impacts.

However, we would advise CMS consider the following: CMS should examine and share publicly any data on variation in how prior COVID-19 is being captured in claims data. Location of diagnosis – was the test at home and if so how was it captured in records? What about inpatient v. outpatient settings? Was the test self-reported? Are there variations in reporting by hospital type or geography? The variability associated with COVID testing and reporting must be accounted for to ensure the equity of the report.

- The proposed rule includes a request for information on how CMS could encourage hospitals to improve health equity and reduce health care disparities through the HRRP. CMS is considering approaches that go beyond providing hospitals with confidential reports of their performance stratified by particular demographic or social risk data and that could potentially impact hospitals performance — and therefore, financial penalties — in the program. For example, CMS is considering approaches that "would account for a hospital's performance on readmissions for socially at-risk beneficiaries compared to other beneficiaries within the hospital, or its performance in treating socially at-risk beneficiaries compared to other beneficiaries, or a combination of these approaches."

  FHA shares CMS's strong commitment to advancing health equity. Hospitals and health systems are working hard to identify and address health disparities, and to close remaining gaps in quality performance across patient populations. We appreciate that CMS has provided hospitals with HRRP feedback reports that could help hospitals identify potential variation in readmission performance across demographic and social risk categories. These reports can help inform hospital efforts to remove any inappropriate variation in their own care and target any supportive resources that can help reduce readmissions risk to patients that could benefit from them.

  However, we strongly urge CMS not to tie HRRP penalties to either within or between provider disparities in readmission rates. Over a decade's worth of peer-reviewed research has repeatedly underscored that 30-day hospital readmissions rates are significantly affected

by social needs that hospitals alone do not control. These social needs include access to primary care, home health and rehabilitation services in the community, transportation options that enable patients to go to follow up appointments and adequate access to nutritious foods. Many other studies have also underscored the wide variation in the availability of such resources across communities. In response to this evidence, Congress appropriately amended the HRRP statute to require CMS to account for social risk factors in calculating readmissions performance and penalties.

V.I. "Hospital Value-Based Purchasing Program (HVBP): Proposed Policy Changes"

The ACA mandated that CMS implement the HVBP program, which ties a portion of hospital payment to selected measures of the quality, safety and cost of hospital care. CMS funds the program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance. Hospitals may earn back some, all or more than the 2% withhold based on their measure performance. By statute, the program must be budget neutral — that is, the entire pool of dollars must be paid back to hospitals, and CMS may not hold back any portion of it to achieve savings to the Medicare program. CMS proposes several significant changes to the HVBP program for FY 2023 and beyond to account for the continued impact of the COVID-19 PHE.

- **FHA supports CMS's proposals to suppress most of the HVBP program's measures for FY 2023, and to apply neutral payment adjustments to all hospitals for FY 2023.** We appreciate the agency engaging with hospitals to gauge the impact of COVID-19 on individual measures and programs, and using a data-driven approach to inform its proposals. We agree that hospital performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and healthcare associated infection (HAI) measures are likely non-representative because of the pandemic.
  Furthermore, we believe it is both appropriate and well within CMS's statutory discretion to apply neutral HVBP payment adjustments for FY 2023. Indeed, it would have been problematic to apply any positive or negative HVBP payment adjustments because CMS would only have sufficient data for only two of the HVBP's performance domains. Furthermore, the HVBP program's budget neutral design means that the program does not result in costs or savings to the Medicare program.

We urge CMS to continue analyzing data from both 2021 and 2022 to determine whether further suppressions — and even neutral HVBP payment adjustments — may be necessary in future fiscal years.

- In this proposed suppression, we understand that CMS intends to suppress the use of the data in its value based payment programs, such as the readmissions reduction program, but not to withhold the data from publication. While we support this approach, we also believe it is important for transparency that the agency include information on its Care Compare website explaining this decision so that others, who might intend to use the data for other purposes also can consider whether their intended use needs to be adjusted or suppressed for a time period due to COVID-19 impacts.

- **FHA urges CMS not to finalize its proposal to re-introduce the pneumonia mortality measure for FY 2024.** Instead, we urge CMS to conduct further analysis to ensure it has minimized the overlap between this measure and COVID-19-related pneumonia.

V.J. "Hospital-Acquired Condition (HAC) Reduction Program: Proposed Updates and Changes"

The HAC Reduction Program imposes a 1% reduction on all Medicare inpatient payments for hospitals in the top (lowest-performing) quartile of certain risk-adjusted national HAC rates. The HAC Reduction Program's basic scoring methodology and measure set are unchanged. However, CMS proposes to apply several COVID-19 measure suppressions to the program in FYs 2023 and 2024.

FHA supports CMS's proposal to suppress all six HAC reduction Program measures for FY 2023, thereby resulting in no penalties for hospitals for FY 2023. As the agency appropriately notes, the COVID-19 PHE has continued to have a profound impact on hospital performance on the measures included in the program. Factors such as sicker patients, longer hospital stays, higher volumes, staffing challenges, supply constraints and other factors have all impacted hospitals at various times during the pandemic, including during the performance period for the FY 2023 HAC Reduction Program. Importantly, these impacts were not all felt at the same time, and were not uniform with respect to geography or intensity. Given that CMS cannot account for these factors in the risk adjustment models for the measures in the program, we agree that suppressing their use in determining HAC penalties is the fairest approach to hospitals.

We also support no publicly reporting PSI 90 data for FY 2023. Several vital components of the measure — including individual measure weights and parts of the risk and reliability adjustment models — were set using prepandemic data that do not account for the pandemic's impact. As a result, any reported measure results likely would be unfairly biased against hospitals highly impacted by the pandemic and would result in misleading data for the public.

FHA supports the concept of applying further measure suppressions to the FY 2024 HAC Reduction Program. However, we are concerned by the potential for the program's performance to be based solely on the PSI 90 measure. PSI 90 measure have long faced questionable levels of reliability and disconnects between performance captured in the claims data and clinical reality. Furthermore, analyses have shown that the inclusion of the PSI measure in the HAC Reduction Program likely biases the program against large hospitals and teaching hospitals that care for more complex patients. We support CMS making changes to the PSI 90 measure to better account for the impact of COVID-19 on measure performance. However, the rule did not include data demonstrating how these changes impacted measure reliability and validity, nor did it analyze how overall hospital performance may shift. We believe more data are needed to determine the appropriateness of basing HAC Reduction Program penalties on only the PSI 90 measure, and for the reasons described above, we are skeptical of that approach. **Finally, FHA supports CMS's increase to the PSI 90 minimum volume thresholds.**

However, as noted above, we continue to have significant misgivings about the ongoing use of PSI 90 in federal programs, and are not confident these changes are sufficient to solve for the measure's fundamental shortcomings. **We again urge CMS to develop a plan to phase out the use of the PSI 90 measure from federal programs.**

IX.E. "Hospital Inpatient Quality Reporting (IQR) Program"

CMS proposes to add 10 new measures to the IQR program, three of which are focused on health equity and two of which are focused on maternal health. CMS also proposes a new maternal health designation for hospitals, and solicits input on approaches it could take to advance maternal health in its quality programs. In addition, CMS proposes changes to the IQR's eCQM reporting requirements that are aligned with the requirements of the Promoting Interoperability Program.

<u>Hospital Commitment to Health Equity</u>

CMS proposes to adopt an attestation-based structural measure beginning with the CY 2023 reporting/FY 2025 payment periods that assesses hospital leadership's commitment to health equity. Hospitals would be asked to attest to implementing a series of practices the agency believes would demonstrate an organization's commitment to advancing health equity across five domains — equity as a strategic priority, data collection, data analysis, quality improvement and leadership engagement.

Reducing disparities and improving health equity is a major priority of Florida hospitals, driven by the disparities coming to light during the COVID-19 pandemic. We applaud CMS's focus and initiatives to FHA, and our member hospitals, support initiatives to highlight the importance of developing strategic initiatives, collecting data and incorporating learnings in to care delivery and quality improvement initiatives. **We support the Hospital Commitment to Health Equity measure with several recommendations for improvement.**

1. We recommend that each element within the individual domains be scored individually. While our hospitals are working in each of these areas, many who are just starting on this journey, have not implemented all of the elements**. Scoring each domain as an all or nothing is unfair and will not correctly reflect hospital efforts to address health equity.**

2. **Collection of demographic data should be scored separately from the social determinants of health information.** Hospitals have been collecting demographic data for decades. While work needed to improve the accuracy and reliability of the data, SDOH data is relatively new and hospitals are still working on strategies to improve the collection of these data, given the opportunities at various times during the patient stay or visit it can be captured. We believe separating it will highlight the importance of collecting both data elements.

3. CMS needs to develop standards and guidance on the collection of SDOH data given the significant variation depending on who is gathering the data, whether it is self-reported and/or what setting. There needs to be standards to ensure the data are gathered and reported consistently. Further, CMS should provide any additional clarifying guidance to hospitals – including additional definitions of key terms and examples – so that hospitals can answer the attestations in as accurate, complete and consistent a manner as possible.

4. The measure should include the collection of sexual orientation and gender identity data for it to capture everything that could impact health equity and disparities.

5. Whatever is adopted in the IPPS program should be consistent in all the other programs to ensure it is all aligned and to reduce reporting burdens due to different standards

Quality and Safety of Maternity Care

CMS is proposing to establish a hospital quality designation to be publicly reported on a CMS website beginning Fall of 2023. Initially, the designation would be awarded to hospitals based on their attestation of submission on the Maternal Morbidity Structural measure.

We applaud using the whole-of-government approach for improving maternal health and advancing maternal health equity that reduces maternal mortality and morbidity, reduces persistent disparities and CMS's focus on improving maternal health outcomes and increases hospital participation in HHS-sponsored and state sponsored maternal health quality improvement initiatives. Florida is fortunate to have an extremely effective and active perinatal quality collaborative, which leads at least three initiatives each year to improve maternal care. FHA is a strong partner with the Florida Perinatal Quality Collaborative, participating on their advisory groups, workgroups for each project and strongly encourages our member hospitals to participate in their initiatives.

While we appreciate CMS's intent to provide consumers information on maternal quality to help with their selection of a birthing hospital, as stated in our comments last year, we have concerns about the value of the Maternal Morbidity Structural measure for use in this first designation. Among those concerns is confusion about the measure components, specifically when the current quality initiatives may or may not include the work on the safety bundles described in the measure definition. Additionally, there are concerns about using a measure that is based on an attestation, in that interpretation of participation can vary among hospitals, from listening to eduction programs to data reporting and full implementation of the safety bundles promoted by the collaborative. **As noted in last year's comments, we recommend that CMS used outcome measures that provide actionable data to drive improvement in maternal morbidity.**

CMS has stated they will use those attesting "yes" to the Maternal Morbidity Structural Measure as the criteria for the first birthing hospital designation. We recommend CMS look at more robust outcomes measures such as the CMS maternity measures along with patient experience.

and patient experience. Those being proposed in the IQR program, such as OB complications and cesarean rate, could be considered in the future as issues with these measures are resolved.

Based on feedback from our members, patient experience would be an important component of a maternity hospital designation. However, given the lack of a standardize patient experience survey designed for maternity patients, we recommend the creation of a survey specific to maternity like the Agency for Healthcare Research and Quality's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

CMS requests information on additional activities to advance maternal health equity through various programs and policies, such as Conditions of Participation, education and outreach to undeserved areas, engaging patients and their families along with community groups, monitoring aggregate data on maternal health risks, use of community health needs assessments to identify specific maternity care needs and social determinants of health, reporting relationships among primary care physicians, OB-GYNs and other health care providers and readily available referral relationships.

As hospitals are beginning their journey on improving health equity, the initiatives need to be phased into the improvement process to allow opportunities for to learn and validate. Adopting it in the Conditions of Participation

Recommendations to advance maternal health equity and reduce maternal morbidity and mortality include:

1. Encourage the adoption of maternity medical homes to improve care integration, coordination and outcomes.
2. Involvement of the pediatrician in post-partum care model
3. Require the creation of a health information exchange which would allow health care providers access to patient history, including whether they were pregnant in the past 12 months.
4. Require training regarding maternal mortality and morbidity issues for non-maternity hospital emergency departments, freestanding emergency departments and urgent care centers.
5. Adopt public education campaigns on the importance of sharing whether they recently had a baby when being treated by other health care providers.

IX.E.b. "Proposed Adoption of Two Social Drivers of Health Measures"

CMS proposes a measure reflecting the extent to which hospitals conduct screenings for certain health-related social needs (HRSNs) that would be voluntary for the CY 2023 reporting/FY 2025 payment period and required starting for the CY 2024 reporting/FY 2026 payment period. The measure assesses the percentage of patients admitted to the hospital who are 18 years or older at the time of admission and are screened for five domains of HRSNs: food insecurity, housing instability, transportation problems, utility difficulties and interpersonal safety. CMS also proposes a second measure that reflects the percentages of patients that screen positive for each HRSN. CMS proposes flexibilities in how hospitals would implement the measures. That is, hospitals would be allowed to choose the screening tool and mode of data collection.

FHA supports inclusion of the HRSN screening measures in the IQR program **but strongly believe a longer period for voluntary reporting is warranted as hospitals improve their processes for collecting these data and reporting span beyond the inpatient setting so all those involved in the care can document and share data on HRSNs.** We believe these data are instrumental to ensuring patients have the needed resources once they leave the hospital, but it should be a component tracked by everyone on the care team including the community organizations. We also recommend that CMS support a mechanism for these data to be shared among caregivers, including guidance on how to update the data based on subsequent visits among health care providers.

IX.B. "Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs – Request for Information"

CMS has solicited feedback on overarching guiding principles to measure health disparities, including the use of existing clinical quality measures that have evidence of disparities in treatment and outcomes.

Hospitals and health systems share CMS's deep commitment to advancing health equity within their organizations and in the communities they serve. Our members are eager to engage with CMS as it considers health equity policy approaches across its programs. Given that one of the primary aims of health equity efforts is to eliminate disparities in quality performance and outcomes, FHA believes that there is a role for health equity-related measures in CMS's quality measurement programs and urge CMS to consider the following:

1. Patient population types vary in different parts of the state and in different parts of the country. Given some areas have very low volumes of some categories of patients, we recommend CMS develop a methodology to address low volumes for certain races and ethnic groups including minimum thresholds for use in quality measurement.
2. CMS should start with two existing measure areas where disparities have the greatest impact – mortality and readmissions—before analyzing disparities in other measures.
3. Given the resources required to address health equity and disparities, recommend that CMS provide incentives instead of penalties to encourage hospitals to do more in this area.
4. CMS should use patient level data and not imputed data on the service area of a hospital
5. There needs to be a statistically valid minimum threshold for using the data for quality improvement and public reporting.
6. Given the current validity and reliability of the disparities data, we recommend starting with confidential data reports to provide hospitals insights to the gaps, explore processes to improve the data reporting then move to public report.
7. These data should not be used in any type of value based payment program unless there are extremely well developed risk adjustments.

Thank you for your consideration of our comments. We urge CMS to implement the changes outlined above in the FY 2023 final rule in order to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care. If you have any questions please do not hesitate to contact Michael Williams at michaelw@fha.org.

Sincerely,

Mary C. Mayhew
President & CEO
Florida Hospital Association