June 25, 2021

Ms. Chiquita Brooks-LaSure **D R A F T**

Administrator

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

File Code: CMS–1752-P

***RE: CMS-1752-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2022 Rates; Proposed Rule***

Dear Ms. Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2022. The proposed rule is estimated to provide a $66 million, or 1.5%, increase to Michigan hospitals in FY 2022, which is significantly less than the projected 6.5% increase in healthcare costs projected for 2022 based on a recent study by the PwC Health Research Institute.

The absence of adequate Medicare payments continues to challenge the financial viability of Michigan hospitals and their ability to provide care to Medicare and other patients especially given the additional challenges hospitals have faced due to the COVID-19 pandemic. The latest Medicare margins data (pre-pandemic) reflects that Medicare FFS pays Michigan PPS hospitals approximately 5.5% less than the cost of providing care to Medicare beneficiaries, resulting in a shortfall of over $300 million annually. We continue to urge the CMS to close this gap to ensure long-term financial sustainability of hospitals. Our comments on the FY 2022 IPPS proposed rule focus specifically on:

* Repealing the requirement for hospitals to report median charges and negotiated payment rates for Medicare Advantage (MA) plans by Medicare-Severity Diagnosis Related Group (MS-DRG)
* Extending the Medicare wage index stop loss transition policy
* Requesting additional funding to reduce disparities in the Medicare wage index
* Opposing the $600 million decrease in the uncompensated care (UCC) pool
* Improving the allocation of additional medical residency slots
* Objecting to the proposed changes for organ acquisition costs
* Restoring the American Taxpayer Relief Act (ATRA) Documentation and Coding Offset
* Opposing the addition of the COVID-19 Healthcare Personnel (HCP) vaccine measure in the inpatient quality reporting program
* Closing the health equity gap
* Using fast healthcare interoperative resources (FHIR)
* Releasing the final program factors for the three Medicare quality-based programs prior to Oct. 1

**REPORTING MEDIAN PAYOR SPECIFIC RATES FOR MEDICARE ADVANTAGE PLANS**

The MHA appreciates and applauds the CMS’ proposal to repeal the requirement that hospitals report median payer-specific negotiated rates for inpatient services, by Medicare-Severity-Diagnosis Related Group (MS-DRG), for Medicare Advantage (MA) plans on the Medicare cost report. The MHA opposed the provision included in the FY 2021 IPPS proposed rule that would require hospitals to disclose privately negotiated contractual terms on the Medicare cost report. **We continue to urge the CMS to focus on transparency efforts that help patients access their specific financial information based on their individual coverage and care.**

**WAGE INDEX**

***Stop Loss Transition Policy***

In the FY 2021 IPPS final rule, the CMS adopted a policy to cap at 5% any decrease in a hospital’s final FY 2021 wage index compared to its FY 2020 wage index. This policy was set to expire Sept. 30, 2021, but in light of the public health emergency (PHE), the CMS seeks comments on continuing this policy in FY 2022. **The MHA objects to the CMS implementing this policy in a budget-neutral manner through a reduction to the standardized operating rate which reduces payments to hospitals. We urge the CMS to fund this policy initiative using separate and additional funds.**

***Low Wage Areas***

The area wage index (AWI) is used to adjust Medicare operating and capital payments for geographic variations in labor costs. For FY 2020 and at least three additional years, FY 2021-2023, the CMS proposes to reduce disparities in the Medicare AWI among hospitals that have a low AWI value by increasing the AWI for hospitals in the bottom quartile funded by a decrease in the national standardized operating rate for all hospitals. The MHA appreciates the CMS’ recognition of hospitals with low wage rates. In the past this was recognized for the frontier states with an increase in the AWI to 1.0 and funded by new funds. We believe that the CMS could implement a similar solution for low wage hospitals funded by additional funds.

**The MHA ardently supports improving the wage index for hospitals with low wage rates, especially in our rural areas.** **The MHA opposes the CMS’ proposed improvement of AWI values for some hospitals funded by a reduction to the standardized operating rate for all hospitals, especially when Medicare pays less than the cost of providing care.**

**UNCOMPENSATED CARE (UCC) POOL PAYMENTS**

Medicare makes disproportionate share hospital (DSH) and uncompensated care (UCC) payments to IPPS hospitals that serve more than a certain percentage of low-income patients, defined as Medicare eligible patients who also receive supplemental security income (SSI) and Medicaid-eligible patients who are not eligible for Medicare.

The CMS projects total DSH payments annually, with 25% of funds distributed using the traditional method (inpatient days for SSI and Medicaid patients as a % of total inpatient days) and 75% dedicated to the UCC pool, known as Factor 1. The CMS then reduces the UCC pool based on the percentage of the population insured in 2013, the base year prior to implementation of the Affordable Care Act (ACA), Factor 2. The CMS then distributes the UCC pool based on each hospital’s UCC costs for a given time period relative to that of all DSH eligible hospitals, Factor 3.

***Calculation of FY 2022 UCC Factor 2***

Factor 2 adjusts the amount of the UCC pool annually based on the change in the number of uninsured individuals by comparing the latest estimates to the 2013 uninsured rate of 14%. The CMS claims that the impact of the COVID-19 pandemic was taken into account in the data used to calculate the latest percentage of uninsured individuals. The CMS determined a 10.1% uninsured rate for FY 2022 based on the statutorily mandated formula resulting in the estimated uninsured population to be 72.14% of the 2013 baseline uninsured population. This results in a decrease of $600 million in the FY 2022 UCC pool compared to FY 2021. **The MHA urges the CMS to maintain the UCC pool at the current level due to the PHE.**

***Calculation of FY 2022 UCC Factor 3***

The CMS proposes to use audited S-10 UCC costs from FY 2018. The FY 2018 data also reflects revisions to worksheet S-10 cost report instructions that were effective as of Oct. 1, 2017, which should increase consistency in data reporting by hospitals compared to earlier years. **The MHA is appreciative that the CMS audits worksheet S-10 data for all DSH-eligible hospitals rather than only a portion of hospitals.** We believe this is vital to ensure consistency across hospitals since the data is used to allocate the $7.6 billion UCC pool.

**GRADUATE MEDICAL EDUCATION**

***Limit on Residency Slots***

Section 126 of the Consolidated Appropriations Act (CAA) authorizes the Secretary to distribute 1,000 new residency full time equivalent (FTE) slots over 5 years, limited to 200 per year, to applicant hospitals beginning in FY 2023. The Secretary is required to notify hospitals of the number of new positions awarded to them by Jan. 31 of the FY of the increase. For example, by Jan. 31, 2022, the CMS will notify hospitals how many new medical resident positions they will have beginning July 1, 2022.

The Secretary is required to distribute at least 10% of the aggregate number of total residency positions to four categories of hospitals that are:

* + Located in rural areas or treated as rural for Medicare IPPS purposes
  + Training more residents than their FTE cap
  + Located in states with new medical schools or additional locations and branches of existing medical schools; and
  + Serve areas designated as Health Professional Shortage Areas (HPSAs)

Based on the CAA, hospitals are limited to receiving no more than 25 additional FTE residency positions and must agree to use all of the slots made available to them. **The MHA is supportive of efforts to increase the number of Medicare-funded medical residency slots to address current and anticipated physician shortages particularly with Michigan’s aging population.**

We recognize that Medicare funding for medical residency programs is vital for ensuring training for future physicians. While the CAA allows hospitals to receive up to 25 additional FTE residency slots per hospital over 5 years, in the FY 2022 IPPS proposed rule, the CMS proposes a stricter cap of up to 1.0 FTE per year. **The MHA opposes the CMS proposal to limit new residency slots to 1.0 FTE per hospital per year when the statute allows up to 25 per hospital over 5 years. The MHA aligns our comments with those of the AAMC and urges the CMS to allow hospitals to apply for up to 15 residency slots to allow programs, depending upon specialty, a reasonable expansion over 5 years.** With the assurance of funding for up to 15 slots, hospitals could expand one or more training programs in a meaningful manner. However, if the CMS decides that slots should be distributed to as many teaching hospitals as possible, then at a minimum each hospital should receive 3 to 5 slots. Depending on the specialty length, this will allow for an increase of one resident for each year of training, though it may be insufficient to provide an opportunity to start a new program.

**The MHA also recommends that the CMS take into consideration the significant impact of the COVID-19 pandemic on the healthcare workforce as the pandemic has exacerbated physician retention, burnout, and shortage issues while also creating delays in establishing new medical residency programs. We request that the CMS extend the 5-year cap-building window by the length of the PHE plus the additional time needed to reach July 1, to align with the start date of the academic year when residency programs begin.**

***Category 4 – Hospitals that Serve Designated HPSAs***

Per the CAA, one of the 4 statutory eligibility criteria is hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs). Since the CAA did not specify how HPSAs for different medical specialties should be used to determine which hospitals meet the criteria, the CMS proposes that hospitals located in a geographic primary care or mental health (limited to psychiatry residents) HPSA be considered. The CMS based its proposal on the requirements set forth under the HPSA Physician Bonus Program. However, the HPSA Physician Bonus Program was designed as “an incentive to attract new physicians to medically underserved communities and to encourage physicians in those areas to remain there” while the purpose of the new 1,000 residency slots is to help ease the national physician shortage.

In addition, the CMS proposes that at least 50% of the resident’s training over the duration of the program must occur at the location in the HPSA. The CMS proceeds to propose further prioritization using the 4 statutory criteria based on residency programs that provide services to medically underserved populations in a population-based HPSA and would use higher HPSA scores indicating a more severe HPSA.

***Revise the HPSA Definition***

If the CMS opts to move forward with the proposed prioritization policy, the MHA urges the agency to provide clarification regarding whether there is any difference in prioritization between a primary care or mental health ***geographic HPSA*** and a ***population-based HPSA***. The process is unclear and confusing and assumes that a hospital qualifies under a geographic OR population-based HPSA for primary care and mental health. If this is not the intent, the MHA urges the CMS to revise its definition to not limit HPSAs to only geographic but to include both geographic and population-based HPSAs for eligibility.

The MHA believes that the intention of the CAA was to prioritize hospitals that serve HPSAs even if they are not located within the geographic boundaries of the HPSA. Patients who live in a HPSA may choose a nearby teaching hospital that is not located in a HPSA, due to availability of services, convenience, and proximity to their home. **The MHA opposes the requirement that the hospital or provider-based department be physically located in a HPSA and recommends that the CMS revise its definition to allow hospitals outside of a HPSA to also be eligible for the new slots if located within a specified distance of the HPSA.**

***HPSA Score***

**The MHA opposes the use of HPSA score as the primary determining factor in distributing the additional awarded slots.**  While the CAA recognizes the need for underserved populations by creating Category 4 “hospitals that serve areas designated as HPSAs” it not does not prioritize this group over the other 3 statutory categories (i.e., rural, FTEs over the cap, states with new medical schools). HPSA scores were developed to determine priorities for the assignment of clinicians in a state rather than determining the ability of the hospitals in those states to train more residents or to provide care for patients who live in HPSAs. If the CMS opts to narrow considerations, the agency can do so using the population-based HPSAs instead of HPSA scores to capture medically underserved areas that have too few primary care physicians, high poverty rates and a high elderly population.

***Requirement that at least 50% training occur at location in HPSA***

**The MHA opposes the CMS requirement that at least 50% of the resident’s training time be in the HPSA.** Unlike the rural training track program, the CAA does not include a training location requirement, therefore the CMS should not limit providers by dictating where the training occurs for consideration of these new residency slots. Accreditation standards ensure that residents train in locations with a large enough population to provide them with the necessary mix of patients and conditions for their specialty. The CMS should not limit providers since teaching hospitals are best positioned to determine the locations in which to train residents and meet the required needs of their communities.

**In summary, the MHA urges the CMS to consider our recommendations regarding HPSAs:**

* **Revise the definition of the HPSA category to include both geographic and population-based primary care and mental health HPSAs;**
* **Expand the definition to allow hospitals that are not located in a HPSA but are within a specified distance of the HPSA to qualify;**
* **Do not adopt its proposal to require at least 50% of training to occur in the HPSA; and**
* **Do not adopt its proposal to prioritize new slots solely on the HPSA score.**

***Alternative methodology to award slots***

The CMS seeks comment on an alternative approach that would prioritize the slot distribution based on the 4 statutory categories giving top priority to hospitals that qualify under all 4 categories, followed by those that qualify under any 3, then 2 and then a single category. The CMS believes this approach would allow additional time for the agency to work with stakeholders for a more refined approach in future years. **The MHA supports the CMS’ alternative approach for FY 2023 to use the 4 statutory categories with the suggested modifications as stated above to:**

* Award at least the minimum number of slots (i.e., 3.0 to 5.0 FTEs) to allow for the training of 1.0 additional resident per year according to the required duration of the specialty and consider awarding up to 15 slots, depending on the specialty to provide for existing program expansion or a new program;
* Expand the HPSA category to include both the primary care or mental health geographic **and** population-based HPSAs;
* Expand the definition to allow hospitals that are not located in a HPSA but within a specified distance of the HPSA to qualify; and
* Remove the requirement that at least 50% of the training occur in the HPSA.

The MHA appreciates the new residency slots but believe these will only provide a fraction of slots needed to ensure an adequate number of Medicare-funded residency slots for all medical school graduates and address the physician shortage. If the CMS does not consider our modifications for eligibility and distribution, we are concerned that many Michigan teaching hospitals will not qualify for the additional slots. **The MHA urges the CMS to consider our recommendations for the FY 2023 residency slot distribution as outlined above.**

***Intern and Resident Information System (IRIS) Data***

Beginning with cost reporting periods on or after Oct. 1, 2021, the Intern and Resident Information System (IRIS) data collection will be done using the new extensible markup language (XML) IRIS file, instead of the current diskette format. While the MHA is supportive of using new technology to collect the IRIS data, **we oppose the CMS’ proposal to reject a cost report that lacks supporting documentation unless the IRIS data contains the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts on the cost report.**

We are concerned that hospitals may experience software issues with the new IRIS data collection system since it has not been used before. As a result, **the MHA requests that the CMS consider these transition issues and not penalize hospitals for inadvertent errors that commonly arise due to the complications of recording resident rotations and that ultimately are corrected to ensure accurate Medicare payment.**

**ORGAN ACQUISITION COSTS**

Hospitals that perform vital life-saving organ transplantation face devastating losses due to a fundamental change included in the proposed rule that would decrease Medicare reimbursement to transplant hospitals (THs) and organ procurement organizations (OPOs). This would replace the existing reimbursement methodology that has been in place for three decades as an incentive to increase access to organ transplantation. Medicare currently shares in the organ acquisition cost for some organs that are transplanted into non-Medicare beneficiaries. The rule indicates that the existing Medicare policy was put into place due to the lack of organ-tracking capabilities and the CMS now believes that organ tracking capabilities allow THs and OPOs to discern organ recipients’ health insurance payor information so that organ acquisition costs can be more appropriately assigned to the Medicare program for organs transplanted into Medicare beneficiaries.

Medicare reimburses for organ acquisition costs outside of the IPPS and pays based on cost. Currently, Medicare calculates its share of organ acquisition costs for THs and OPOs by multiplying the total allowable organ acquisition costs by the ratio of Medicare usable organs (the numerator) to total usable organs (the denominator) reported on the hospital’s Medicare cost report. The CMS proposal would restrict the number of donated organs factored into a TH’s Medicare ratio. Currently **all** donated organs are factored into this ratio but under the proposal only those deceased donor organs that ultimately are transplanted into Medicare beneficiaries will have the care and procurement costs covered by Medicare. This ratio determines Medicare reimbursement to the TH to cover their organ acquisition cost for staffing resources, pre-transplant testing and evaluations, space and other items needed to provide care for potential cadaveric and living donors and candidates for transplant.

Data provided by The Organ Donation and Transplantation Alliance estimates that this proposal would reduce payments to 22 Michigan hospital organ transplant programs by **nearly $14 million.** As previously indicated, currently all donated organs are factored into the ratio used for organ acquisition cost.The existing policy was established to encourage organ transplantation and the scope of Medicare benefits to cover all reasonable preparatory, surgical, and post-surgical expenses associated with an organ donor.

The CMS now believes that organ tracking capabilities allow THs and OPOs to discern organ recipients’ health insurance coverage information so that organ acquisition costs can be more appropriately assigned to the Medicare program for only organs ultimately transplanted into Medicare patients. Tracking this information will create a significant administrative burden for hospitals. **The MHA requests that the CMS withdraw this proposal as it is unworkable given the inability of excising THs to obtain organ recipient payer information when the organ is donated via an OPO to a separate TH. If the CMS opts to move forward with this proposal, we request that the agency delay implementation for a minimum of 5 years. In the meantime, we urge the CMS to conduct an in-depth review of the potential impact of the proposed transplant-related provisions.**

**The MHA is also concerned about the proposed changes that would require donor community hospitals to charge OPOs reasonable costs.** Currently, Medicare-certified hospitals that are not THs but collaborate with OPOs to procure organs from cadaveric donors for transplantation are referred to as “donor community hospitals”. When a donor community hospital incurs costs for services provided to the cadaveric donor, as authorized by the OPO following the death declaration and consent to organ donation, the hospital bills the OPO its customary charges.

The CMS proposes to specify that for cost reporting periods beginning on or after Oct. 1, 2021, when a donor community hospital incurs costs for services provided to a cadaveric donor, the donor community hospitals must bill the OPO its customary charges that are reduced to cost by applying its most recently available hospital-specific cost-to-charge ratio for the period in which the service is provided. We believe that community donor hospitals typically have negotiated rates with the OPO and therefore reimbursement for excised organs is not based on charges. We also note that there is opportunity cost incurred when a community donor hospital uses its operating room to excise cadaveric organs which often requires a scheduled procedure to be canceled or delayed since hospitals infrequently have idle operating rooms. If the CMS opts to finalize its proposal to cap community donor hospital payment from OPOs for excised organs to the procedure’s cost, we are concerned that it will decrease the number of viable recovered organs and ultimately reduce access to organ transplantation for all patients who need this lifesaving procedure and are often on waiting lists for years. **The MHA opposes the CMS’ proposal to limit payment to the community donor hospitals to costs rather than charges or their negotiated rate and request that the agency withdraw this proposal.**

**FULL RESTORATION OF ATRA DOCUMENTATION AND CODING OFFSET**

The CMS implemented a 0.8% cut to the annual marketbasket update in FYs 2014-2016 to recoup the effect of documentation and coding changes that it believed do not reflect real changes in patient acuity. For FY 2017, the CMS increased this cut from 0.8 percentage points to 1.5 percentage points to achieve the $11 billion targeted by the American Taxpayer Relief Act (ATRA). In total, these cuts reduced hospital inpatient payments by 3.9%. The CMS mandated a positive 0.5% adjustment for each year from FY 2018 through FY 2023 to offset the previous recoupment. The 21st Century Cures Act subsequently reduced the FY 2018 “add-back” from 0.5% to 0.4588%. Cumulatively after all negative and positive adjustments, hospitals will have a permanent payment reduction of approximately 1%.

**The MHA believes that the CMS should restore the full 3.9% that was withheld from hospitals. We recommend that the CMS use its authority and adjust hospital payment amounts to return the payments previously withheld from hospitals.**

**INPATIENT QUALITY REPORTING PROGRAM**

***Adoption of COVID-19 Vaccination among Healthcare Personnel (HCP) Measure***

The MHA appreciates that this proposed measure represents an effort by the CMS to advance measurement to address the public health emergency and provide consumers with data to make an informed decision when choosing a hospital. **However, we believe that advancing this measure prior to full approval by the Food and Drug Administration (FDA) is premature. As such, we oppose the adoption of this measure at the current time for reasons highlighted below.**

* ***Vaccine hesitancy***

The COVID-19 vaccines are currently approved through an emergency use authorization and a significant number of Americans have chosen not to be vaccinated because of concerns regarding serious adverse events, the compressed timeline for development and approval, and general mistrust of the government and public health community. Vaccine hesitancy has created challenges among both the general public and among HCP.

* ***Unintended consequences and legal risk***

If this measure were adopted and publicly reported, hospitals would be held accountable for HCP vaccinations. The MHA is concerned that some hospitals may choose to mandate that HCP receive the vaccine as a strategy to achieve high performance, creating ethical and legal issues. Mandating the vaccine may also result in HCP leaving their positions, putting an additional strain on an already challenged workforce with many vacant positions in not only hospitals but across all healthcare settings. MHA members have also expressed concern about the legal risk to their organization if HCP experience an adverse event related to the vaccine. We also believe publicly reporting HCP vaccination rates may inappropriately pit hospitals against one another based on public opinion regarding the vaccine.

* ***Timeliness***

Given the time-sensitive nature of this measure, the CMS proposed to use a shortened reporting period (October-December 2021) for the FY 2023 program year, followed by quarterly reporting deadlines starting with the FY 2024 program. The MHA questions whether this information will be of value in 2023 and beyond for quality improvement or consumer-decision making given the time associated with data collection, submission, and validation.

We support and encourage that consumers have access to real-time meaningful data to help inform healthcare decision-making but believe that the use of a single, dated measure is not a true reflection of the safety or quality of care delivered at the hospital.

* ***Duplicative reporting is administratively burdensome***

The MHA recognizes that COVID-19 vaccination reporting is already required by the Michigan Department of Health and Human Services via the Michigan Care Improvement Registry (MCIR) system. We believe that requiring additional HCP vaccination data to be reported into the NHSN is redundant and burdensome particularly as hospitals struggle to meet current COVID-19 data reporting requirements at the state and national level.

**While the MHA opposes the adoption of the COVID-19 HCP vaccination measure in any of the quality reporting programs at the current time, we understand the intent of the measure and urge the CMS to consider the following:**

* **Delay the measure adoption until the vaccine has been given full approval by the FDA and the measure specifications are complete and have been endorsed by the National Quality Forum (NQF). We also encourage the CMS to seek comment on the addition of this measure in a future proposal.**
* **Utilize HHS TeleTracking COVID-19 vaccination data to track vaccination rates at the facility level.**
* **Direct consumers to use the HHS TeleTracking site as the data is reflective of current HCP vaccination rates.**

**REQUEST FOR INFORMATION: CLOSING THE HEALTH EQUITY GAP**

The COVID-19 pandemic shed new light on inequities in healthcare as certain populations were impacted much more significantly by the virus. **The MHA strongly supports efforts by the CMS to close this gap.** The MHA and member hospitals are committed to addressing racism and health inequities and worked with the Michigan Department of Licensing and Regulatory Affairs (LARA) to ensure that any new licensing rules related to implicit bias training are consistent with the MHA membership’s vision and efforts. As part of these efforts, the MHA worked with LARA on implicit bias training for all healthcare personnel, providing workgroup input and public comment and testimony on the draft rules. The MHA continues to seek member support and engagement on a statewide pledge to advance health equity and address social determinants of health. To date, 134 hospitals and health systems have signed the MHA Pledge to Address Racism and Health Inequities indicating a unified commitment to addressing disparities, dismantling racism and achieving health equity. In addition, over 90% of members have completed the Health Equity Organizational Assessment (HEOA), designed to provide custom around key strategies that support the organization’s ability to identify and address disparities.

Upon the 2017 launch of the “Patients over Paperwork” Initiative, the CMS’ goal was to reduce unnecessary regulatory burden and enable providers to concentrate on their primary mission of improving patient health outcomes which is supported by the MHA and other stakeholders.

The CMS outlines several areas within this RFI of potential expansions of the CMS Disparity Methods. The MHA has concerns in expanding even more ways to calculate differences in outcomes among patient groups within and across hospitals as this may ultimately increase burden and negatively impact the patient experience. The idea of including a statistical modeling technique using indirection estimation to make hospital and population-level estimates on patient rate and ethnicity could unintentionally introduce measurement bias, especially if the source data used to infer population-level race and ethnicity are inaccurate.

As the CMS considers additional measurement to address health equity, **the MHA urges the CMS to honor its “Patients Over Paperwork” initiative and streamline, align, and focus on those measures that matter most for patient care and outcomes**. **We recommend leveraging existing solutions and datasets, while standardizing and streamlining data collection processes and ensuring consistency of definitions, categories and variables such as race and ethnicity across all federal programs to reduce administrative burden and enable clinicians to focus on patient care.**

The CMS must also develop support for providers for capturing, using and exchanging information within and across service lines. The current system is siloed, fragmented and uncoordinated, which limits transparency and the ability to share and use information as patients move across the healthcare continuum.

A final challenge worth noting is that there are inadequate healthcare-based solutions for addressing social determinants of health. Platforms are available for purchase but some of these systems are too costly for hospitals and remain out of reach.

**The MHA urges the CMS to consider the following recommendations and looks forward to providing additional input when a future proposed rule is released:**

* **Choose, adopt, and adequately incentivize the use of a single standard data set** that captures necessary and sufficient information on non-clinical patient characteristics. **This should be minimally burdensome to providers** and we recommend the adoption of standardized screening tools such as [PRAPARE](https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/), [AAFP’s EveryONE project](https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html), or the CMS ACH [Health-Related Social Needs screening tool](https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf), or [the use of z-codes](https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf).
* **Distribute resources into community safety net programs to properly address social needs identified in data collection**. We urge the CMS to continue expanding the portfolio of programs and resources to support data analyses and quality improvement activities to bridge hospital-level efforts with post-acute and community-based programs and models to close health equity gaps due to lack of resources and accessibility to help strengthen the standardized collection of social needs data.
* **Expand disparity methods to include stratified results beyond current dual eligibility stratification since stratifying by dual eligibility status alone is not sufficient**. This is an easily accessible proxy measure that in no way captures the breadth of social determinants. We urge the CMS to include race and ethnicity, language preference, veteran status, health literacy, sexual orientation, and disability status which will enable a more comprehensive assessment of health equity to further identify and develop actionable strategies to promote health equity.
* **Reconsider creation of a facility equity score**: Although this is modeled from the Health Equity Summary Score (HESS) developed for the Medicare Advantage plans, the development of this score was virtually conceptual and not currently being utilized. By combining multiple measures and risk factors using output from the CMS disparity methods there would be a resulting “composite like” score. **The MHA believes a vague “composite-like” measure is not actionable or useful and cannot be feasibly and accurately calculated.**
* Consider a potential future measure regarding **organizational commitment to health equity.** We believe that consideration should be given to an attestation-based structural measure of a disparities impact statement (DIS) or organizational pledge that outlines how infrastructure supports the delivery of care that is equitable for all patient populations.

**REQUEST FOR INFORMATION: Fast Healthcare Interoperative Resources**

The CMS acknowledges that providers within the various care and practice settings covered by Medicare quality programs may be at different stages of readiness and therefore the timeline for achieving full digital quality measurement across all quality reporting programs may vary. The CMS also recognizes that reporting data for quality measurement via electronic health records remains burdensome, and their current approach to quality measurement does not readily incorporate emerging data sources such as patient-reported outcomes (PRO) and patient-generated health data. The agency also acknowledges a need to streamline the approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement and learning.

Aligning technology requirements for payers, health care providers and health information technology (IT) developers can advance an interoperable health IT infrastructure that ensures providers and patient have access to health data when and where it is needed. **The MHA supports the use and adoption of Fast Healthcare Interoperative Resources (FHIR) Application Programming Interfaces (APIs) across the healthcare system**. We agree that FHIR will be a vital part of streamlining reporting and reducing the associated burden, but we encourage the CMS to work with HIT vendors to reduce the cost and complexity of providers having to implement any new interoperability standards. The MHA looks forward to providing additional input when a future proposed rule is issued.

**TIMING FOR RELEASE OF QUALITY-PROGRAM FACTORS**

Historically, the CMS has finalized factors for the value-based purchasing, readmissions reduction and hospital-acquired conditions reduction programs several months after the beginning of the FY, which has meant that hospitals do not know their final payment adjustment for these programs until several months into the new FY. For the FY 2021 programs, the CMS did not release final factors until February. This delay is problematic for hospitals since these factors impact Medicare payments back to Oct. 1. Hospitals are subject to CMS deadlines for data submission related to the quality-based programs. If the deadlines are too close to the beginning of the FY, we recommend that the CMS revise these deadlines or the timeframes for the quality program data elements to ensure the final factors can be released prior to Oct. 1. Late release of this data by the CMS creates an unnecessary administrative burden for the MACs and hospitals related to the reprocessing of claims. In addition, hospitals are left in limbo, not knowing their final Medicare payment rate until months after the start of the FY. This is further compounded by the Medicare Advantage plans using those factors. **The MHA recommends that the CMS release final program factors before Oct. 1, prior to the beginning of the FY consistent with our comments in previous years on the IPPS proposed rule.**

**SUMMARY**

The MHA appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule and believe that our proposed changes will have a positive impact on hospitals and all patients they serve. If you have questions regarding this comment letter, please contact me at (517) 703-8608 or via email at [vkunz@mha.org](mailto:vkunz@mha.org).

Sincerely,

Vickie R. Kunz

Senior Director, Health Finance