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September 17, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P. O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1753-P, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals; Proposed Rule, August 4, 2021

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) hospital outpatient prospective payment system proposed rule for calendar year (CY) 2022.

HAP applauds two significant policy reversals included in this year's proposed rule. Specifically, the proposed reversal of the elimination of the inpatient-only list and the reinstatement patient safety criteria for adding procedures to the ambulatory surgical center covered procedures list. HAP also supports proposals to maintain important telehealth flexibilities granted during the Public Health Emergency (PHE).

However, HAP adamantly opposes the proposed significant increases to the civil monetary penalty for non-compliance related to the mandated disclosure of negotiated rates as well as continued payment cuts for 340B drugs.

We also reiterate our position against continuing site-neutral payment reductions. CMS should reverse its unlawful and harmful policy reducing payment for outpatient clinic visits in excepted provider-based hospital outpatient departments.

The following comment letter also addresses changes to:

- Radiation Oncology Model
- Hospital Outpatient Quality Reporting Program
- Payment for Non-Opioid Alternatives

In addition, we incorporate, by reference, all of the comments provided in the American Hospital Association's response to the proposed rule.

Thank you for your consideration of HAP's comments about this proposed rule regarding outpatient payment and other provisions related to hospitals and the patients they serve in Pennsylvania.

If you have any questions, contact Kate Slatt, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,

Jeffrey Bechtel
Senior Vice President, Health Economics and Policy

Attachment

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HAP Comments—Outpatient Prospective Payment System
Proposed Rule for Calendar Year 2022

Payments to 340B Hospitals

The Centers for Medicare & Medicaid Services (CMS) proposes to continue the deep cuts to Outpatient Prospective Payment System (OPPS) payments to 340B hospitals. These cuts directly harm 340B hospitals and their ability to care for their patients, contravening Congress' intent in establishing the 340B program. These cuts are the crux of the legal issue the U.S. Supreme Court will review during its upcoming term. For more than 25 years, the 340B program has helped participating hospitals stretch scarce federal resources to reach more patients and provide more comprehensive services. The continuation of this harmful policy, especially as the COVID-19 pandemic continues, will undoubtedly result in the continued loss of resources for 340B hospitals and only exacerbate the strain on these hospitals and the patients they serve. ***HAP continues to oppose the agency's deep OPPS payment cuts to 340B hospitals.***

Use of CY 2019 Claims Data for CY 2022 OPPS and ASC Rate-setting

Typically, CMS uses the most recently available claims data for rate-setting, which for calendar year (CY) 2022, rate-setting purposes would be CY 2020 claims data. Similarly, under ordinary circumstances, CMS would use cost report data from the most recent release, which for CY 2022 would be cost report data extracted from the Healthcare Cost Report Information System (HCRIS) in December 2020. However, because the CY 2020 claims data and cost report data include services furnished during the COVID-19 pandemic, which significantly decreased outpatient service utilization, CMS determined that CY 2019 data would better approximate expected CY 2022 outpatient service utilization than CY 2020 data. As a result, the agency proposes to set CY 2022 OPPS and ambulatory surgical center (ASC) payment rates using the most recent complete data available prior to the COVID-19 Public Health Emergency (PHE). This is the CY 2019 claims data and the same set of cost reports used for 2021 OPPS rate-setting. ***HAP strongly supports CMS' proposal to use CY 2019 claims and FY 2018 HCRIS cost report data for CY 2022 rate-setting and appreciates its recognition of the unusual nature of the CY 2020 data.*** That said, our support of this methodology only pertains to the proposed CY 2022 rates and weights. The data used in future years' rulemaking should be revisited on a year-by-year basis.

Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

CMS proposes changes to the hospital price transparency rule and requests comments to potentially inform policymaking in the future. ***HAP strongly urges CMS to work in conjunction with the American Hospital Association (AHA) and others to improve the hospital price transparency rule, especially as it relates to better aligning these requirements with those in the transparency in coverage final rule and No Surprises Act.***

HAP fully supports policies that help patients access the information they need when making decisions about their care, including information about their potential costs. Hospitals have long been committed to providing patients access to this information, though some earlier solutions were more cumbersome, manual processes with significant technical barriers, such as those related to obtaining cost-sharing information from insurers. However, many hospitals have overcome these barriers during the last several years, with patient price estimator tools now commonly available on both hospitals' and insurers' websites. Patients soon will have access to even more financial information prior to care through the implementation of the other federal price transparency policies. To avoid patient confusion and duplication of efforts, alignment across these policies is critical. Any changes to the hospital price transparency rule should be focused on achieving this goal.

Our specific comments about the agency's proposals and requests for comment follow.

Increase in Civil Monetary Penalties for Noncompliance

CMS proposes to increase the civil monetary penalties (CMP) for noncompliance with the hospital price transparency rule on a sliding scale based on hospital bed count as follows:

Proposed Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed during CY 2022 and Subsequent Years (Table 63)

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	$330/hospital	$109,500/hospital
31–550	$310–$5,500/hospital (equal to $10/bed)	$113,150–$2,007,500/hospital
Over 550	$5,500/hospital	$2,007,500/hospital

HAP strongly opposes increasing these penalties and urges CMS not to finalize this proposal. CMS argues that higher penalties will encourage greater compliance, citing findings from its initial reviews and a number of external studies. However, there is no evidence that the current penalty amount impacted early compliance with this rule. In fact, to date, CMS has not actually issued any penalties. Hospital noncompliance is more likely due to competing priorities primarily related to the ongoing COVID-19 pandemic, something the AHA raised prior to the implementation start date of January 1, 2021.

Compliance with this rule requires hospital human resources—it is not simply a compilation of existing spreadsheets. Many personnel across multiple departments working alongside a number of hospital technology vendors must build and populate the machine-readable files from scratch. Because the negotiated rate information required by CMS does not actually exist for many services, hospitals must make decisions about how to populate these sheets with the

most meaningful information available. This is a significant body of work, and the personnel required to comply with this rule have been overwhelmed with more pressing assignments, such as bringing hospital surge capacity online and assisting with the monitoring and tracking of vaccine distribution.

As CMS notes in the proposed rule, "noncompliance [with the Hospital Price Transparency rule] is less serious than noncompliance that poses or results in harm to the public." Hospitals made the same calculation in prioritizing COVID-19 preparation and care over preparing for compliance with this rule. CMS showed support for hospitals needing to prioritize COVID-19 over other federal requirements during this period, offering enforcement discretion for a number of federal requirements. Hospitals believe such flexibilities should be granted for these policies as well. In lieu of these flexibilities, hospitals have been forced to make those resource allocation decisions on their own.

Given hospitals' need to continue focusing their efforts on caring for their communities in the midst of COVID-19, as well as the ongoing uncertainty about how CMS defines "compliance," CMS should not impose such high fees for noncompliance. HAP strongly encourages CMS to use this initial implementation period to learn more in order to inform any future changes.

It is crucial for CMS to assess what changes are needed to better align these requirements with the other federal price transparency policies. The U. S. Departments of Health and Human Services, Labor, and Treasury began the work of reducing duplication and aligning price transparency policies in their recent frequently asked questions (FAQ), which addressed overlaps in the No Surprises Act and transparency in coverage requirements. More is needed though to further align those requirements with the hospital price transparency rule requirements. As noted, patients now have multiple avenues for accessing information about their health care costs as a result of technological advances and federal and state policies. Depending on the source of the estimates and the inputs included (e.g. common ancillary services, other providers) these estimates will assuredly vary, and hospitals are concerned about how this misalignment could actually hinder, not help, patients' understanding of their cost obligations. ***HAP strongly urges the agency to take steps to align all of the federal price transparency requirements in order to minimize any confusing or conflicting information for patients.*** Doing so also will help mitigate the substantial costs to the health care system of implementing each of these distinct policies.

This work may be part of the notice and comment rulemaking process related to the good faith estimates for insured patients and advanced explanation of benefits discussed in the FAQ. We urge the agency to ensure hospital price transparency rule alignment during that process. ***In preparation for those rules, HAP recommends that CMS convene a multi-stakeholder group, including hospital, insurer, and vendor technical experts, to determine:***

- ***The best source(s) for patient cost estimates, such as the good faith estimates/advanced explanation of benefits, the machine-readable files,***

and/or the various online patient price estimator tools. If the group agrees that multiple sources are warranted, it also should plan for how to ensure consistency across the various platforms so that patients do not receive conflicting estimates

- *What, if any, value is created for the patient through the publication of the machine-readable files and whether the hospital and insurer files are both necessary*

Patient Price Estimator Tools

CMS also offers clarification regarding the use of a patient price estimator to fulfill the shoppable service requirement, noting that for a tool to be compliant it must provide the patient a single amount, tailored to their circumstances, and based on benefit information received directly from the patient's insurer (if applicable). The patient-specific cost estimates generated by these tools provide the information that patients most often request when preparing for the financial aspects of their care. Many hospitals were already implementing these types of online search tools prior to publication of the hospital price transparency rule, or were considering doing so in the near future. ***HAP supports the use of patient price estimator tools and commends CMS for permitting hospitals to use these tools to comply with a portion of the rule.***

As discussed previously, a critical next step for the field is ensuring alignment across the various options for patients receiving cost estimates prior to care. Hospitals are committed to working with CMS and other stakeholders to determine appropriate standards for developing pre-service patient cost estimates, whether they be done through online price estimator tools or as a good faith estimate as required by the No Surprises Act. ***HAP again urges CMS to work with stakeholders on the many technical considerations for these estimates and apply the same standards across all types of patient cost estimates.***

Exemplar Hospitals

CMS requests comment about ways to identify and highlight hospitals that are "embracing and exemplifying the spirit of consumer price transparency," and offers a number of possible options that CMS is considering. Hospitals have taken many steps to improve their patients' access to cost information. However, the hospital price transparency rule in current form does not provide the best pathway for patients to get accurate cost estimates, therefore HAP does not believe that a designation based on these regulations is appropriate. ***HAP supports the use of patient price estimator tools and commends CMS for permitting hospitals to use these tools to comply with a portion of the rule.***

In addition, we are particularly concerned by CMS' suggestion that price transparency could be incorporated into the hospital quality measures. It is essential that quality measures focus solely on issues that directly impact patient quality. ***HAP recommends that CMS not move***

forward with this, or other, options being considered to highlight exemplar hospitals.

"Plain Language" Definition

CMS finalized requirements for the shoppable service requirement in the CY 2020 hospital price transparency final rule, including a "plain language" description of each shoppable service. At the time, CMS did not establish plain language standards and instead left it up to each individual hospital to develop their own plain language descriptions. In this proposed rule, CMS seeks comment about whether it should require specific plain language standards and, if so, what those standards should be.

Significant work already has been done by hospitals to implement the shoppable service requirements as currently stated in regulation. ***Prior to introducing new standards, HAP encourages CMS to convene a multi-stakeholder group consisting of hospitals, insurers, and patient representatives to identify what is working and determine whether any further standardization is necessary.*** As discussed previously, such standards should then be used across the various price transparency policies, including those in the transparency in coverage final rule and the No Surprises Act, to ensure patients are seeing consistent language across all platforms. ***HAP urges the agency to allow more time with the hospital price transparency rule in effect before implementing any new type of standardization.***

Machine-Readable File Standardization

Hospitals, often in partnership with vendors, developed their machine-readable files based on their interpretation of the available guidance and to accommodate the hospitals' different types of privately negotiated contracts with insurers. CMS now is seeking comment about whether it should impose additional standardization on these files.

Hospitals already have dedicated significant resources toward complying with the machine-readable file requirements. They have done so despite continued skepticism of these data's usefulness to the patient and in spite of the immense strain to the health care system caused by the COVID-19 pandemic. Standardization at this point could negate much of the upfront work, requiring hospitals to start again in order to recreate their files in the new format. This would create excess administrative burden, once again drawing resources away from more important hospital needs. Moreover, these regulations have not been in effect long enough to determine what attributes of existing files are most useful, if any. Finally, as discussed in the previous sections, more work is needed to align these requirements with those in the transparency in coverage and No Surprises Act. ***HAP urges CMS not to impose additional standardization until the work to align the three price transparency policies is complete.***

Medicare's Site-Neutral Payment Policies

In the CY 2021 OPPS proposed rule, CMS proposed to continue its payment policy for clinic visits furnished in excepted off-campus provider-based departments (PBD) at an amount that equals 40 percent of the OPPS rate.

Despite the many concerns and objections raised by HAP, the AHA, and other commenters, CMS's CY 2021 OPPS final rule adopted the proposal to continue cuts to payments to excepted PBDs and make the cuts in a non-budget-neutral manner.

The AHA, three of its member hospitals, and the Association of American Medical Colleges (AAMC) filed suit during January 2019 to challenge the new clinic visit payment policy, arguing hospitals with excepted off-campus PBD faced imminent injury as a result of CMS' unlawful decision to reduce clinic visit payment rates and to do so in a non-budget-neutral manner.

While the court originally found that the agency exceeded its statutory authority when it cut the payment rate for clinic services at excepted off-campus provider based clinics, that decision has been overturned. Efforts to have the ruling reviewed were declined by the Supreme Court on June 28, 2021.

In this rule, CMS proposes to continue its payment cuts to grandfathered (excepted) off-campus PBDs hospital outpatient clinic visit services. Payment will continue to be set at 40 percent of the OPPS payment amount. CMS also proposes to continue the payment cut for non-grandfathered (non-excepted) off-campus PBD during CY 2022 identifying payment at 40 percent of the OPPS rate.

By continuing the cut, we believe CMS has undermined clear congressional intent and exceeded its legal authority, despite the U.S. Supreme Court, on June 28, declining to review the unfavorable ruling by the appeals court that deferred to the government's inaccurate interpretation of the law.

HAP reiterates its comments from the previous year's proposed rule and incorporates, by reference, all of the comments provided in the AHA's response to the proposed rule. We continue to urge CMS to:

1. ***Immediately restore the higher payment rates for clinic visits furnished by excepted off-campus PBDs that existed before CMS adopted the unlawful payment cuts***
2. ***Promptly repay hospitals the difference between the amounts they would have received under those higher rates and the amounts they were paid under the unlawful payment rates***
3. ***Abandon the proposed continuation of the payment cut in 2022***

Changes to Inpatient-Only List

CMS designates certain procedures that can only be performed in an inpatient setting for various reasons such as the acuity of the procedure, history of the patient, or postoperative recovery time. The list is typically reviewed by CMS annually.

Last year, CMS proposed to eliminate the inpatient only (IPO) list during a three-year period, from 2021 through 2024, and proposed to begin this process with the elimination of 266 musculoskeletal services from the IPO list. As part of its explanation, CMS stated that clinicians should ultimately use their clinical judgement based on the needs of the beneficiary in selecting a site of service.

In commenting about last year's rule, HAP urged CMS to refrain from eliminating the IPO in its entirety to ensure the safety of its beneficiaries. Many procedures included on the list are high risk, invasive, complex procedures and warrant the inpatient care setting.

In this rule, CMS has reversed course and is proposing to halt the elimination of the IPO list to ensure more analysis related to beneficiary safety as well as acknowledging the impact of the PHE on providers' readiness for such a significant change. CMS is also proposing to add 298 services that were removed in last year's rule beginning in CY 2022.

Additionally, CMS is proposing five criteria for determining whether a service or procedure should be removed from the IPO list:

1) Most outpatient departments are equipped to provide the services to the Medicare population
2) The simplest procedure described by the code may be furnished in most outpatient departments
3) The procedure is related to codes that CMS already has removed from the IPO list
4) A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis
5) A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been prosed by CMS for addition to the ASC list

Finally, CMS is soliciting comment about whether the IPO list should eventually be eliminated or if it should continue a systemic scale of the list to maintain current standards of practice.

HAP applauds CMS' acknowledgement of the problems that the total elimination of the IPO would cause and fully supports its reversal of last year's proposals. HAP further advocates for appropriate criteria to assess systemically what procedures should be taken off the list as current standards of practice continue to change.
It is important to note, however, that hospitals have been well on their way to implementing the finalized provisions from the CY 2021 OPPS. Many hospitals have already scheduled non-

emergent surgeries after the first of the year utilizing the current rules. ***HAP urges CMS to implement a glide path for the first 60 days of CY 2022 as it relates to enforcement of the IPO as hospitals are operating in good faith under the current rules.***

Telehealth Flexibilities

Telehealth Mental Health Services: Undoubtedly, the COVID-19 pandemic has created a world of uncertainty for patients and their health care providers. While a grim reality, the pandemic has also been the impetus for advancing access to health care through technology tenfold. Beneficiaries have been able to continue to see their health care provider and do so safely in the comfort of their own home and will continue to demand access to telehealth when clinically appropriate.

CMS is seeking comment about whether it should make permanent flexibilities that allowed hospital outpatient clinical staff to furnish mental health services, education, and training to Medicare beneficiaries in their homes. In the rule, CMS acknowledged that this flexibility is tied to the PHE and is concerned that access could be impacted if the policy is rescinded at the conclusion of the PHE.

Direct Supervision: During the PHE, CMS allowed the direct supervision of pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services to be provided via audio/video technology subject to the judgement of the supervising practitioner through the end of the PHE or December 31, 2021, whichever is later. CMS is seeking comment about whether it should temporarily continue beyond the timeline above.

HAP urges CMS to make broad, permanent adoption of any telehealth services that were acceptable during the pandemic and fully supports the continuation of flexibilities that allow hospital outpatient clinicians to provide telehealth mental health services to beneficiaries in their homes. HAP urges CMS to continue to be flexible in considering additional services as we continue in this emergency, and manage increased care needs stemming from the disruption in access to care during 2020.

While we appreciate the importance telehealth has had in caring for patients with mental health needs and appreciate the attention CMS has given to these services, HAP urges CMS to make similar flexibilities available to non-mental health services.

HAP also urges CMS to allow permanently direct supervision of pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services via audio/video technology. We also urge CMS to allow the supervising physician to be "immediately available," rather than requiring "real-time presence" to furnish assistance and direction throughout the service using audio/video real-time communications technology.

Radiation Oncology Model

As included in the Patient Access and Medicare Protection Act (PAMPA) of 2015, CMS developed the radiation oncology (RO) model to test whether site-neutral, modality agnostic, bundled payments for radiotherapy could reduce Medicare costs while preserving or enhancing the quality of care. The model was slated to begin on January 1, 2021 but was delayed by CMS for six months and then an additional six months by Congress.

In this rule, CMS is proposing to start the RO model for physician group practices, hospital outpatient departments (HOPD), and freestanding radiation therapy centers that deliver radiotherapy services in randomly selected areas of the country on January 1, 2022, contrary to the urging of the AHA and others to delay implementation in light of the current PHE.

Additionally, the rule proposes significant additional proposals related to the RO model including but not limited to:

- Changes to RO model participant exclusions—CMS is proposing to only exclude those HOPDs actually participating in the Pennsylvania Rural Health Model (PARHM) instead of those who have been identified as eligible to participate because they would receive overlapping payments between their global budget payments and those as part of the RO model. They also propose to exclude participants in the Community Transformation track of the Community Health Access and Rural Transformation (CHART) model
- Changes to included cancer types and radiotherapy modalities—CMS proposes to remove liver cancer from the list of 16 cancer types included in the model. It also proposes to remove brachytherapy from the list of radiotherapy services
- Quality reporting requirements for professional and dual participants—CMS proposes to override their delay of quality measure requirement finalized last year and requires professional and dual participants to submit quality data starting January 1, 2022

HAP is disappointed that CMS is implementing a complex, poorly understood, mandatory, new payment model as hospitals nationwide are again consumed with fighting a new COVID-19 wave and continue to support our nation's public health mission.

HAP urges CMS to refrain from finalizing the implementation of the RO model at this time and to evaluate further the downstream implications of the model on beneficiary access and provider sustainability. HAP also opposes the mandatory nature of the implementation and urges CMS to allow for voluntary participation when implemented.

Additionally, HAP would like to share the following core concerns recommendations about the model design in general:

The timeline and requirements for data capture and reporting are too ambitious; as a result, participants will fail to report usable data, and CMS will be unable to meaningfully assess the model's impact on practice patterns and quality of care.

HAP suggests creating a "glide path" to successful reporting by phasing in the requirements and associated penalties over time rather than starting with an "all-or-none" structure. We would recommend that CMS delay the clinical data element reporting timeline for the RO Model to align more closely with registry reporting, thereby allowing institutions to collect data once using highly trained staff and robust validation processes, then report to multiple stakeholders including central registries and CMS at the same time.

The requirement to report data about non-Medicare patients places an undue burden on participating centers without associated benefit to CMS and may provide skewed results as authorization approvals from non-Medicare payors can dictate the course and modality patients receive.

HAP recommends limiting reporting requirements to Medicare beneficiaries.

The model creates disincentives for national investment in proton therapy which, over time, will reduce access for beneficiaries to the highest quality care in clinical scenarios common to the Medicare demographic.

HAP recommends allowing newer proton facilities to receive a reimbursement adjustment or additional modality factor.

Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting (OQR) Program is a pay-for-reporting quality program for the hospital outpatient department setting. The Hospital OQR Program requires hospitals to meet quality reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update if these requirements are not met.

In the CY 2022 OPPS/ASC proposed rule, CMS is proposing several changes:

- Adopt three new measures
    - COVID-19 Vaccination of Health Care Personnel beginning in the CY 2024 reporting period
    - Breast screening recall rate beginning with CY 2023 reporting period
    - ST-segment elevation myocardial infarction (STEMI) electronic clinical quality measure (eCQM) beginning with CY 2023 reporting period
- Make the reporting of two voluntary or suspended measures mandatory
    - Cataracts: Improvement in patient's visual function within 90 days following cataract surgery beginning CY 2023

    - Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and System (OAS CAHPS) survey-based measures
- Remove two measures
    - Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival
    - Median time to transfer to another facility for acute coronary intervention
- Update the validation policies of the Hospital OQR Program to reduce provider burden and improve processes

HAP understands the importance of wide adoption of the COVID-19 vaccine and Pennsylvania hospitals have been working tirelessly toward that end. In commenting about the Inpatient Prospective Payment System Proposed Rule, we shared concerns about adopting the measure in its current form and urged delay. There have been significant developments in the implementation of vaccination policies during recent weeks. Pennsylvania hospitals and health systems have made remarkable progress in vaccinating their workforce in a short time frame. While we understand CMS' intent in the proposal of the measure, we urge CMS to do the following to provide additional clarity:

- *Develop plans to issue guidance regarding documentation of booster doses and reporting so that hospitals and health systems can easily incorporate this information once booster doses are recommended*
- *Maintain alignment across relevant federal guidelines, CMS should allow facilities to exclude health care personnel who decline vaccinations under the provisions outlined by the Equal Employment Opportunity Commission from the measure's denominator*
- *Work with the Centers for Disease Control and Prevention and the Department of Health and Human Services to clarify and streamline the various COVID-19-vaccination-related data reporting requirements*

Additionally, the breast screening recall rate is not currently endorsed by the National Quality Forum (NQF). *HAP does not support the inclusion of any measures that have not been fully vetted and endorsed by NQF.*

HAP does not support the mandatory reporting of the cataracts measure or the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey measures as both continue to be operationally burdensome and require additional analysis.

HAP supports the removal of the fibrinolytic therapy received within 30 minutes of ED arrival and median time to transfer to another facility for acute coronary intervention measures and supports replacing the measures with the ST-segment elevation myocardial infarction (STEMI) eCQM.

Payment for Non-Opioid Products

Section 6082 of the SUPPORT Act requires the Secretary to review payments under the OPPS and ASC for opioids and evidence-based non-opioid alternatives for pain management to ensure there are not financial incentives to use opioids instead of non-opioid alternatives.

For the past three years, CMS has analyzed utilization patterns to evaluate whether its packaging of non-opioid alternatives that function as a supply was impacted. CMS did not observe any significant reduction in the HOPD setting. However, the opposite was true when CMS analyzed utilization in the ASC setting. As a result, CMS unpackaged and paid separately at the average sales price (ASP) plus 6 percent for non-opioid pain management drugs that function as surgical supplies when furnished in the ASC setting but declined to pay separately for these drugs in HOPDs.

In this rule, CMS notes that similar utilization trends were identified in HOPDs, however, significant increases in utilization were identified in ASCs (after the unpackaging of these drugs). Regardless, CMS is proposing to continue to package non-opioid pain management drugs in the HOPD setting but is requesting comment about whether to expand the ASC policy of paying separately to HOPDs.

Because of the significant importance of ensuring the best patient care, HAP urges CMS to remove any barriers that might exist in utilizing these non-opioid pain management drugs and thus fully supports expanding implementation of the policy to pay separately at ASP plus 6 percent for non-opioid pain management drugs that function as surgical supplies in the HOPD setting.

Health Equity Request For Information

CMS recently has used the Inpatient Prospective Payment System rulemaking process to expand the role of quality measurement to identify inequities. In this rule, CMS is requesting additional information relating to its work to advance health equity.

While there have long been clear signs of disparate health outcomes, this issue became glaringly apparent during our nation's efforts to combat the COVID-19 PHE. This has created a "call to action" and Pennsylvania's hospitals are responding.

HAP has been working collaboratively with members and the Pennsylvania Department of Human Services to introduce a new hospital quality incentive program aimed at addressing health inequities and racial disparities. Initially, the program will focus on implementing pathways that incentivize:

- Creating and implementing a structured race, ethnicity, and language (REaL) data collection process
- Using REaL data to identify gaps and address inequities

- Screening and identifying social needs and social risks
- Convening internal and external stakeholders to identify opportunities to close gaps

The expressed goal of the program is to improve disparate outcomes stratified by race related to preventable admissions.

In addition to working with the state to create programs for hospitals to address this issue, HAP is also embarking on the launch of a new Racial Health Equity Learning Action Network that will bring Pennsylvania hospitals together to share best practices related to the meaningful work being done on health equity in this state.

Pennsylvania hospitals also have been actively participating across other initiatives as well, including:

AHA 123 Equity Pledge

During 2015, AHA launched its #123forEquity pledge campaign, which built on the efforts of the National Call to Action to Eliminate Health Care Disparities. More than 1,650 hospitals, including 49 Pennsylvania hospitals and health systems, pledged to take action to eliminate health care disparities. In the pledge, member hospitals and chief executive officers committed to taking action to accelerate progress related to the four areas of the initiative's call to action:

- Increasing the collection and use of race, ethnicity, and language preference data
- Increasing cultural competency training
- Increasing diversity in governance and leadership
- Improving and strengthening community partnerships

Philadelphia Area Hospitals' Commitment to Anti-Racism

Thirteen of HAP's southeastern Pennsylvania hospitals and health systems recently announced a collective commitment to combat racism, inequality, and discrimination in all its forms. Stating that racism is a health care issue and explicitly acknowledging that systemic racism drives the socioeconomic factors that are barriers to health care access, cosigners committed to:

- Re-examining policies and procedures and making changes, with an equity lens, that promote equality, opportunity, and inclusion for all
- Improving access to primary and specialty care for people in underserved communities
- Building trust through community partnerships with the goal of addressing chronic conditions that impact communities of color
- Advocating for investments that create innovative solutions to improve access, and provide safe, high-quality health outcomes for all communities in Pennsylvania
- Hiring and promoting leaders of color and increasing diversity in governance
- Renewing and expanding each organization's commitment to providing anti-racism and implicit/unconscious bias training for all staff, volunteers, and physicians

- Bridging relations between law enforcement and community by offering events aimed at encouraging conversations, improving relations, and creating trust
- Increasing the collection and use of race, ethnicity, language preference, and other socio-demographic data

HAP supports CMS' efforts to improve health equity through its quality programs as one prong of a multi-prong strategy. While the delivery of health care is vitally important in health equity, significant thought and investment also must be made to evaluate and address broader community resources and needs.