1921 HAP 2021
100 YEARS TOWARD BETTER HEALTH

*Leading for Better Health*

June 28, 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

**SUBJECT: CMS-1735-P.** Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year (FY) 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program; Proposed Rule, May 10, 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 inpatient prospective payment system proposed rule for federal fiscal year (FFY) 2022.

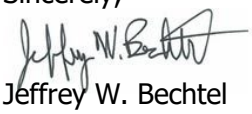
HAP recognizes many places where CMS has taken the COVID-19 public health emergency (PHE) into account in the formation and calibration of policy. The Pennsylvania hospital community has appreciated CMS' flexibility and stands ready to support CMS in using the learnings of COVID-19 to achieve shared goals.

HAP supports CMS' retraction of the problematic requirement for hospitals to report median payor-specific negotiated charges by MS-DRG and the use of FY 2019 data in rate-setting. At the same time, we have significant concerns about the proposals for dramatic changes to the long-standing organ procurement payment and reporting systems and its potential negative impact on this critical lifesaving service. We also urge CMS to modify its proposals in distributing residency slots as part of the graduate medical education program.

The following comments provide areas of emphasis, HAP otherwise incorporates by reference all comprehensive comments by the American Hospital Association.

Thank you for your consideration of HAP's following comments regarding this proposed rule. If you have any questions, contact Kate Slatt, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,



Jeffrey W. Bechtel
Senior Vice President, Health Economics and Policy

Attachment

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**HAP Comments—Inpatient Prospective Payment System**
**Proposed Rule for Fiscal Year 2022**

## Repeal of the Requirement for Hospitals to Report Median Payor-Specific Negotiated Charges by Medicare Severity-Diagnosis Related Group

In its fiscal year (FY) 2022 Inpatient Prospective Payment System (IPPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes to repeal the requirement it had finalized last year that hospitals report their median payor-specific negotiated rates for inpatient services by Medicare Severity-Diagnosis Related Group (MS-DRG) for Medicare Advantage organizations. CMS also proposes to repeal the market-based MS-DRG relative weight methodology it had planned to implement during FY 2024; instead, it would continue using its existing cost-based methodology. In addition, the agency would use FY 2019 data, rather than FY 2020 data, in approximating expected FY 2022 inpatient hospital utilization for weight-setting purposes.

***HAP strongly supports the repeal of the requirement that hospitals report their median payor-specific negotiated rates for inpatient services.*** HAP reinforces statements by the American Hospital Association (AHA): "We have long said that privately negotiated rates take into account any number of unique circumstances between a private payor and a hospital and their disclosure will not further CMS' goal of paying market rates that reflect the cost of delivering care. We once again urge the agency to focus on transparency efforts that help patients access their specific financial information based on their coverage and care."

***HAP also supports repeal of the market-based MS-DRG relative weight methodology CMS had planned to implement during FY 2024, and continued use of its existing cost-based methodology. In addition, we agree with use of FY 2019 data, rather than FY 2020 data, in approximating expected FY 2022 inpatient hospital utilization for weight-setting purposes.***

## Disproportionate Share Hospital Payment Changes

Under the Disproportionate Share Hospital (DSH) program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care that each Medicare DSH hospital provides.

## FY 2022 DSH Payments

For FY 2022, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $14.098 billion. Accordingly, CMS proposes

that hospitals would receive 25 percent of these funds, or $3.524 billion, as empirically justified DSH payments.

The remaining $10.573 billion would flow into the 75 percent pool, which is then adjusted to reflect changes in the percentage of uninsured. Based on the latest Congressional Budget Office projections of insurance expansion, which includes estimations due to the COVID-19 public health emergency (PHE), CMS proposed Factor 2 would be 27.86 percent; thus, after inputting that rate into the statutory formula, it proposed to retain 72.14 percent—or $7.628 billion—of the 75 percent pool during FY 2022. **However, this results in a decrease of about $662 million in the national pool for uncompensated care payments during FY 2022 as compared to FY 2021. For Pennsylvania, this represents a loss of $1.9 million.**

HAP requests that when CMS computes the total federal FY 2022 empirical DSH payments (as part of the "Factor 1" calculation), these estimated payments are **not** adjusted by data representative of the COVID-19 PHE (data in table "Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline"). The Discharge Factor update proposed for FFY 2022 includes uncommon data from the COVID-19 PHE, and the "other" factor assumes new Medicaid enrollees are healthier than average Medicaid recipients, and therefore use fewer hospital services during the PHE.

As stated in this proposed rule, data from the COVID-19 PHE is less suitable for FFY 2022 rate setting, and a number of measurements for value-based purchasing, readmissions, and hospital-acquired conditions adjustments have been suppressed. ***HAP requests PHE data is also omitted/suppressed from the Factor 1 calculation of empirical DSH payments used to determine FFY 2022 Uncompensated Care Funding.*** The exclusion of these estimates will provide industry leaders additional time to evaluate national funding needs, considering the ongoing impact of COVID-19 to beneficiaries and the hospitals providing care.

**Area Wage Index Modifications**

CMS previously finalized a policy to increase wage index values for low-wage hospitals. CMS proposes to continue this policy during FY 2022. For hospitals with a wage index value below the 25th percentile, the agency would continue to 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. The agency proposes to continue to make this policy budget neutral by adjusting the national standardized amount for all hospitals.

The area wage index is intended to recognize differences in resource use across types and location of hospitals. Hospitals, Congress, and Medicare officials repeatedly have expressed concern that the wage index is flawed in many respects. ***HAP applauds CMS for recognizing the need to address low-wage index values. However, improving wage index values for some hospitals—while much needed—by cutting payments to other hospitals, particularly when Medicare already pays far less than the cost of care, is***

***unacceptable. CMS has the ability to provide needed relief to low-wage areas and should do so by allocating additional funds for this purpose. CMS is not bound by statute to make such increases budget neutral. Reducing the standardized amount for all prospective payment system (PPS) hospitals intensifies historical Medicare underpayment. CMS should not impose budget neutrality on the low-wage hospital policy.***

As a result of the COVID-19 PHE, CMS is considering the appropriateness of applying a transition policy to the FY 2022 wage index for hospitals that would be negatively impacted by the adoption of updates from the Office of Management and Budget's (OMB) core-based statistical area modifications. ***We urge CMS to apply a non-budget neutral transition policy—holding hospitals harmless to wage index reductions—to all hospitals, not only those impacted by OMB's modifications.***

**New COVID-19 Treatments Add-On Payments**

In light of the COVD-19 PHE, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) for COVID-19 cases that meet certain criteria occurring on or after November 2, 2020, until the end of the PHE. The established NCTAP paid hospitals the lesser of 65 percent of the operating outlier threshold for the claim, or 65 percent of the amount by which the costs of the case exceeded the standard DRG payment.

CMS proposes to extend NCTAP for cases involving eligible treatments for the remainder of the fiscal year in which the PHE ends. In addition, CMS also proposes to extend NCTAP for eligible products that are not approved for New Technology Add-On Payments (NTAP) through the end of the fiscal year in which the PHE ends, and to discontinue NCTAP for discharges on or after October 1, 2021, for a product that is approved for NTAPs beginning during FY 2022.

***HAP supports the extension of these NCTAP payments through the end of the fiscal year in which the PHE ends and urges CMS to maintain flexibility to be able to continue these payments beyond the proposed timeframe if necessary.***

**Chimeric Antigen Receptor T-Cell Therapy**

Chimeric Antigen Receptor T-Cell (CAR T) therapy is a cell-based gene therapy in which a patient's own T-cells are genetically engineered in a laboratory and administered to the patient by infusion to assist in the patient's treatment to attack certain cancerous cells.

CMS identifies clinical trial CAR T cases in order to exclude them from CAR T weight setting and adjusts the CAR T MS-DRG payment by a multiplier calculated by dividing the costs associated with clinical trials by costs associated with non-clinical trial cases. This is to account for the fact that resources used for clinical trial cases do not include the costs of the therapy. Using FY

2019 data, CMS proposes a payment adjustment of 0.17 when calculating payment for clinical trial cases and expanded access cases assigned to MS-DRG 018 for FY 2022.

Recently, a fast-growing number of CAR T clinical trials have actively explored and expanded their potential application scenarios, increasing the number of diseases currently being studied. Understanding the full extent of resources used across different diseases and cases are still unknown and may fluctuate greatly. Indeed, the number of clinical trial cases continue to increase substantially year to year. Thus, it is uniquely important to use the latest data available to ensure an accurate reflection of the resources used in these new and evolving clinical trial cases. ***As such, HAP urges CMS to use FY 2020 data to calculate the multiplier that is used to adjust for CAR T clinical trial cases.***

**Modifications to the Promoting Interoperability Program**

***HAP urges CMS to take a holistic view and approach to the future of the Promoting Interoperability Program in light of the ongoing PHE and range of other regulatory requirements, including HIPAA, that rely on information technology (IT) infrastructure and support.*** Hospitals and critical access hospitals (CAH) urgently and appropriately redirected resources to support technology and data needs specific to the COVID-19 emergency including COVID-19 response, vaccine distribution, data reporting, and telehealth. While the PHE remains in effect, much of this work continues, while, at the same time, many hospitals are attempting to advance outstanding IT projects delayed during the height of the pandemic. ***In this period of recovery and rebuilding, we strongly urge CMS to utilize a carefully measured approach to finalizing changes to the Promoting Interoperability Program for CY 2022.***

**Graduate Medical Education Program**

Current funding is insufficient and limitations to caps on the number of residents for which each teaching hospital is eligible to receive Graduate Medical Education (GME) reimbursement are a major barrier to reducing the nation's significant physician shortage—an estimated shortage of between 37,800 to 124,000 doctors by 2034.

CMS proposes to implement provisions of the Consolidated Appropriations Act, 2021 (CAA) that affect Medicare direct GME and indirect medical education (IME) payments to teaching hospitals. The CAA provided 1,000 new Medicare-supported GME positions—the first such increase in nearly 25 years.

Under the law, CMS is tasked with distributing 200 slots per year for five years, with slot awards effective July 1, 2023. The law also states that at least 10 percent of the slots must be distributed to each of the following categories: hospitals that are located in a rural area or treated as being located in a rural area; hospitals training over their Medicare cap; hospitals in a

state with a new medical school or branch campus; and hospitals that serve areas designated as health professional shortage areas (HPSA).

**It is crucial that CMS distribute the positions in a way that ensures teaching hospitals are able to make meaningful increases in residency programs to produce more physicians.**

The IPPS proposed rule seeks feedback on two proposed methodologies for distributing the new slots. Alternative 1 would distribute slots based on a hospital's HPSA score only and would apply for all five years of the distribution process. Alternative 2 would award slots to hospitals that meet all four categories delineated by the CAA, with subsequent distribution for hospitals that meet three categories, two categories, and then one category until all 200 slots are allocated. This methodology would be for FY 2023 only, and the proposed rule states that it would allow "additional time to work with stakeholders to develop a more refined approach for future years." Both proposals only allow for a maximum of 1.0 full-time-equivalent (FTE) to be awarded per hospital per year.

*Our key recommendations are as follows:*

- *The number of FTEs per hospital should be increased to allow for meaningful program expansion.* While we recognize that the need for additional GME support far outpaces the 1,000 new GME slots, 1.0 FTE per hospital is simply not practical. Limiting each individual hospital to no more than one FTE each year effectively makes the additional slots unworkable. Such a limitation would make recruitment difficult and would not advance toward building sustainable training programs. **CMS should provide, *at the very least*, one FTE slot times the length of the relevant residency program**

- *We urge CMS to finalize the Alternative 2 methodology in the FY 2022 IPPS proposed rule, subject to modifications outlined in both the AHA's and the Association of American Medical College'scomment letters. Using the four categories of hospitals to determine the slot distribution priority is consistent with statutory intent. We also urge CMS to use additional time and solicit stakeholder feedback to develop "a more refined approach" to the distribution for future years*

- *Finally, we continue to urge CMS to support additional legislative efforts to lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities across the country*

We are grateful for action by Congress to provide 1,000 new Medicare-supported GME positions. This was a much-needed step to begin addressing the growing physician shortage.

We look forward to additional work with both Congress and the Administration to address workforce challenges.

**Organ Acquisition Payment**

The rule proposes several changes to organ acquisition payment policies with the expressed goal of making Medicare's share of organ acquisition costs more accurate. These proposals affect organ acquisition payment policies for transplant hospitals, donor hospitals, and organ procurement organizations (OPO). CMS is proposing to only pay reasonable costs when solid organs are transplanted into Medicare beneficiaries and is expected to save Medicare an estimated $230 million during FY 2022, $1.74 billion during five years, and $4.15 billion during 10 years.

The current Medicare policy for organ acquisition mirrors the kidney acquisition policy set forth in Section 1881 of the Social Security Act. The expressed purpose for this policy was to encourage kidney transplants by covering all the reasonable expenses from preparation to post-operation recovery.

The current methodology for Medicare's share of organ acquisition costs for transplant hospitals/hospital-based OPOs is calculated by multiplying the total allowable organ acquisition costs by the ratio of Medicare usable organs to total usable organs reported on the hospital's Medicare cost report. The proposed rule requires accounting and reporting of Medicare usable organs by considering organs that are shipped overseas or transplanted into non-Medicare beneficiaries; additional organ recipient tracking abilities are intended to result in more expeditious identification of Medicare patients.

The most significant proposed change would eliminate a long-standing feature of the payment system under which organs that are procured at a transplant center hospital and transplanted at another transplant center are "counted" as Medicare organs for the purpose of determining Medicare's portion of organ acquisition costs. This feature of the cost accounting system functions as a strong incentive for transplant center hospitals to establish effective programs for the identification of potential deceased organ donors and engage in other organ acquisition-related activities.

In addition, the proposed rule would appear to impose an unreasonable burden on donor transplant centers, which would be required to obtain from recipient transplant centers information regarding the recipient centers' non-Medicare third-party payor contracts (to confirm Medicare as secondary payor liability) and to track recipients' Medicare eligibility determinations, many of which are made retroactively.

These changes to the payment system and other significantly burdensome administrative requirements have the potential to significantly reduce the deceased donor organs available for transplantation, reduce access to transplantation, and may have serious repercussions for

individuals waiting for transplants. They also severely underestimate transplant hospitals' and OPOs' ability to obtain the necessary data, such as the ultimate payor of the transplant once the organ leaves their facilities.

***HAP encourages CMS to retract all of the organ acquisition proposals included in the calendar year (CY) 2022 IPPS and convene a stakeholder group inclusive of transplant hospitals, OPOs, insurers, patient groups, and others tasked with completing a comprehensive analysis of the impact of these actions on patient access to transplantation before proceeding.***

**Medicare Shared Savings Program**

Continuing its recognition of the impact the COVID-19 PHE, CMS is proposing to again offer the opportunity for participants in the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) to freeze their level of risk for CY 2022 at the current level.

The MSSP was redesigned during December 2018, through the "Pathways to Success" rule. This rule created a glide path that automatically advanced participating MSSP ACOs along the path to increasing risk from level A to level E during a five-year period unless the ACO selects a faster path.

When the COVID-19 PHE began, CMS acknowledged that modifications to the automatic advancement program design would be required and in a May 8, 2020, Interim Final Rule with Comment made this change for CY 2021. Under the new policy, ACOs could elect to remain at their CY 2020 risk level for CY 2021, however, during CY 2022, they would advance directly to the level that they otherwise should have been. For example, CY 2020 level A ACOs that elected to remain at level A for CY 2021, would advance directly to level C during CY 2022.

The extension of this policy for CY 2022 will operate in the same manner. ACOs may elect to remain at their current level of risk but will advance to their original targeted risk during CY 2023.

***HAP appreciates CMS' acknowledgement that the COVID-19 PHE has caused unprecedented levels of uncertainty and disruption in health care and is taking steps to provide additional protections for participating providers in ACOs; however, HAP encourages CMS to revise its proposal to automatically advance participants by multiple levels. HAP recommends allowing the automatic advancement to begin for paused hospitals by advancing one level only until reaching level E unless the ACO requests a faster glide path.***

**Hospital Quality Reporting and Value Programs**

In an attempt to ensure that hospitals are neither penalized or rewarded for their performance in CMS quality programs due to complications or non-representative quality data, CMS is proposing an extension to the suppression policy initially implemented in a September 2020, IFR.

The original policy noted that CMS would not use data from the first and second quarters of 2020 to calculate performance or make payment adjustments in any of its quality and value programs. The new proposal extends this suppression policy for the duration of the PHE for data it believes have been affected by the COVID-19 PHE.

In determining whether to suppress data, CMS proposes considering the following:

- Significant deviation in national performance on the measure
- Clinical proximity of the measure's focus to the relevant disease, pathogen or health impacts of the COVID-19 PHE
- Rapid or unprecedented changes in: (1) clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or (2) the generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin
- Significant national shortages or rapid or unprecedented changes in: (1) health care personnel; (2) medical supplies, equipment, or diagnostic tools or materials; or (3) patient case volumes of facility-level case mix

***HAP supports CMS' efforts to proactively address the impact the COVID-19 PHE has likely had on hospital performance in its quality programs and applauds strategies to suppress measurement across its programs.***

**Hospital Readmissions Reduction Program**

The Hospital Readmissions Reduction Program (HRRP) seeks to reduce readmissions in six clinical areas including acute myocardial infarction, heart failure, pneumonia, total hip arthroplasty/total knee arthroplasty, chronic obstructive pulmonary disease, and coronary artery bypass surgery by imposing a penalty of up to 3 percent of base IPPS payment for having readmissions exceeding an expected level. The proposed rule estimates $553 million in readmission penalties across all eligible hospitals during FY 2022.

CMS is proposing three policy updates and a request for input including:

- Aligning the Medicare Provider Analysis and Review data used to determine aggregate payment and payment adjustments with modified performance periods identified in the September 2020, IFR

- Suppression of the HRRP's pneumonia readmissions measure in calculating FY 2023 performance and payment adjustments due to its "clinical proximity" of pneumonia to COVID-19
- Excluding COVID-19 patients from performance calculations for the remaining five readmission measures
- Requesting input on its interest in expanding the confidential, hospital-specific HRRP performance stratified by dual-eligible status to the public as well as stratifying the data by race/ethnicity

***HAP supports the suppression of the pneumonia readmissions measure and encourages CMS to continue its consideration for suppression in subsequent years pending the PHE reach. While HAP appreciates and understands the need to continue to use data in efforts to make forward motion in addressing health equity, we have concern that significant improvements must be made in the collection and reporting of race/ethnicity data prior to implementing any new reporting mechanisms.***

**Hospital Value-Based Purchasing**

The Hospital Value-Based Purchasing (HVBP) program is funded by reducing participating hospitals' base rates by 2 percent. Hospitals have the opportunity to earn back some, all, or more than the 2 percent based on their performance in the HVBP program. This year, CMS proposes to:

- Suppress most of the HVBP program measures for FY 2022 including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the Medicare Spending per Beneficiary (MSPB), and the Healthcare-Associated Infections (HAI) due to the impact of the COVID-19 PHE
- Apply neutral payment adjustments for FY 2022 because there is not sufficient data to calculate performance on three of the HVBP's four measure domains
- Suppress the pneumonia mortality measure for the FY 2023 HVBP program
- Exclude COVID-19 patients from mortality measures beginning during FY 2023
- Remove Patient Safety Indicator (PSI) 90 beginning during FY 2023
- Revise the baseline periods for FY 2024 specifically for the HCAHPS, HAI, and MSPB to use CY 2019 as the baseline period instead of CY 2020, which was impacted by the COVID-19 PHE

***HAP supports the proposal to move forward with neutral payment adjustments for FY 2022 due to the unknown impact of the COVID-19 PHE and highly recommends continued analysis and action on the impact of the PHE in future years of the program. As noted in many of HAP's comment letters in the past, HAP strongly supports the removal of PSI 90 at the beginning of FY 2023 and encourages its removal across all CMS quality programs.***

**Hospital-Acquired Conditions Reduction Program**

The Hospital-Acquired Conditions (HAC) program reduces payment to hospitals who are in the worst performing quartile as measured by the HAC measure set by 1 percent.

While the HAC measure set and scoring methodology remain unchanged with the proposed rule, CMS does propose suppressing performance data from the third and fourth quarters of 2020 in calculating performance for FYs 2022 and 2023. This policy builds off of the September 2020, IFR announcement that CMS would not use data from Q1 and Q2 of 2020 to calculate performance or payment adjustments for this program.

***HAP supports the proposal to suppress additional periods of performance for the HAC program and respectfully requests continued analysis of the impact of COVID-19 on future years of the program.***

**Inpatient Quality Reporting and Electronic Clinical Quality Measure Reporting**

The Inpatient Quality Reporting (IQR) Program is a pay-for-reporting program. Failure of hospitals to meet the required program requirements reduces payment to hospitals equal to one-quarter of the annual market basket update.

This year's rule proposes to add five new IQR measures and to delete five existing IQR measures from the program. The new measures proposed include:

- COVID-19 Vaccination Among Health Care Personnel measure: If finalized, hospitals would be required to begin reporting data on October 1, 2021, using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) Healthcare Personnel Safety Component submission framework
- Maternal Morbidity Structural measure: Hospitals will be asked to report if their organization participates in a statewide or national perinatal quality improvement program that addresses various aspects of maternal care. For the FY 2023 program, hospitals would have a shortened reporting period from October 1 to December 31, 2021
- Hybrid Hospital-wide All-cause Mortality Measure: Initially introduced as a voluntary measure for FY 2025 IQR program, this measure would become required with the FY 2026 IQR program and will require hospitals to submit certain "core clinical data elements" to supplement Medicare claims for measurement and scoring
- Glycemic Control Electronic Clinical Quality Measures (eCQM): Beginning with the FY 2025 IQR program, CMS will add two new eCQMs (severe hypoglycemia and hyperglycemia) to the potential eCQMs that can be chosen to fulfill eCQM reporting requirements

***HAP generally supports the inclusion of the new maternal morbidity structural measures as a positive first step in addressing the maternal health crisis in the***

*United States; however, believes that a more appropriate measure that directly assesses the quality of maternal care may be better time spent. HAP also supports the inclusion of the severe hypoglycemia and hyperglycemia eCQMs as options for reporting as part of the IQR measure set.*

*While HAP understands the importance of wide adoption of the COVID-19 vaccine and Pennsylvania hospitals have been working tirelessly toward that end, we believe inclusion of this measure is premature. Pennsylvania hospitals and health systems have made remarkable progress in vaccinating their workforce in a short time frame. Significant work is underway to identify and address remaining gaps. Still early in the deployment of this remarkable scientific breakthrough, more time is needed to craft a meaningful, accurate, and fair performance measure that will produce data that is helpful to policymakers, public health partners, and the public. As an example, the need for boosters remains unknown and likely will impact the methodology for designing this measure. We encourage CMS to delay any mandatory reporting for at least one year.*

*HAP also encourages CMS to withhold from implementing any additional required hybrid measures until the accuracy and validity of the measure specification can be verified and the electronic health record vendors necessary to support the reporting of the measure are ready. We urge CMS to allow hospitals to voluntarily report this information but refrain from adopting this as a requirement.*

The measures being proposed for removal include:

- PSI-04 (Deaths among surgical inpatients with serious treatable conditions) because it overlaps with the new all-cause mortality measure
- PC-05 (Exclusive breast milk feeding eCQM) because CMS feels the new maternal morbidity structural measure will be better aligned with improving outcomes
- ED-2 (Admit decision time to emergency department (ED) departure time eCQM) because CMS believes there is little correlation between ED waits and mortality
- STK-03 (Anticoagulation therapy for atrial fibrillation/flutter eCQM) and STK-06 (Discharged on statin medication) because the IQR includes other stroke measures and the removal could ease provider burden

*HAP supports the removal of these measures.*

In addition, CMS seeks feedback on three potential future IQR measures:

- 30-day risk-adjusted all-cause mortality for patients admitted with COVID-19 infection
- Patient-reported outcomes following elective primary total hip and/or total knee arthroplasty
- Health equity structural measure

***HAP agrees that assessing the impact of COVID-19 is very important; however, we believe adding the mortality measure to this program is premature and requires additional analysis on the long-term impact of the PHE on quality.***

***While HAP appreciates and understands the need to continue to use data in efforts to make forward motion in addressing health equity, we have concern that significant improvements must be made in the collection and reporting of race/ethnicity data prior to implementing any new reporting mechanisms.***

**Health Equity Request For Information**

CMS recently has used the IPPS 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 begin 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 CEOs 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 must also be made to evaluate and address broader community resources and needs.***