The Hospital + Healthsystem
Association of Pennsylvania

Leading for Better Health

June 17, 2022

The Honorable 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: ***RE: CMS-1771-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation: Proposed Rule (Vol. 87, No. 90), May 10, 2022.***

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 235 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) 2023.

HAP is extremely concerned with CMS' proposed payment update of only 3.2 percent, given the extraordinary inflationary environment and continued labor and supply cost pressures hospitals and health systems face. **Even worse, hospitals would actually see a net decrease in payments from 2022 to 2023 under this proposal because of proposed cuts to Disproportionate Share Hospital and other payments. This is simply unacceptable for hospitals and health systems, and their caregivers that have been on the front lines of the COVID-19 pandemic for more than two years now.** While we have made great progress in the fight against this virus, our members continue to face a range of challenges that threaten their ability to continue caring for patients and providing essential services for their communities.

Separately, CMS proposes to use more than one year of data to determine uncompensated care costs. We have long stated that utilizing a single year of S-10 data may increase the potential for anomalies and undue fluctuations in uncompensated care payments, especially when hospitals experience unforeseen circumstances such as a pandemic.

Finally, we thank CMS for recognizing that the COVID-19 pandemic continues to affect hospital performance in its quality measurement and value programs, and appreciate its proposal not to

penalize hospitals for non-representative performance under the Hospital-Acquired Condition Reduction and Value-Based Purchasing Programs for fiscal year 2023. Hospitals and health systems share CMS' deep commitment to advancing health equity. We look forward to reviewing the details of CMS' proposed health equity-related quality measures and further engaging on how to advance this vital work.
The following comments provide areas of emphasis that HAP otherwise incorporates by referencing all comprehensive comments submitted 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

HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Fiscal Year 2023

Payment Update

For fiscal year (FY) 2023, CMS proposes a market basket update of 3.1 percent, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2 percent. This update, as well as the FY 2022 payment update of 2.7 percent, are woefully inadequate and do not capture the unprecedented inflationary environment. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. **When historical data is no longer a good predictor of future changes, the market basket becomes inadequate. Yet, this is essentially what has been done when forecasting the FY 2022 and 2023 market basket and productivity adjustments.** With more recent data[1], the market basket for FY 2022 is trending toward 4.0 percent, well above the 2.7 percent CMS actually implemented last year. Additionally, the latest data also indicate *decreases* in productivity, not gains.[2] We urge CMS to consider the changing health care system dynamics and their effects on hospitals.

Specifically, HAP urges CMS to: 1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023.

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

Historic inflation has continued and heightened the severe economic instability that the pandemic has wrought on hospitals; the financial pressures we are experiencing are massive. Because this high rate of inflation is not projected to abate in the near term, and inflationary pressures are likely to continue to work their way into wage expectations, it is critical to account for these challenges when considering hospital and health system financial stability in FY 2023 and beyond. ***As such, the market basket updates for FY 2022 and FY 2023 are resulting in woefully inadequate reimbursements for Pennsylvania hospitals. HAP asks CMS to implement, for FY 2023, a retrospective adjustment to account for the***

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[1] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast.
[2] U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary—2022 Q01 Results. https://www.bls.gov/news.release/pdf/prod2.pdf.

difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022.

Additionally, HAP asks that CMS eliminate the productivity cut for FY 2023. The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes that the hospital field can mirror productivity gains across the private nonfarm business sector. That has not been the experience of Pennsylvania hospitals, particularly during the pandemic. Hospitals continue to face unprecedented and unsustainable costs to fill critical positions, and even with the higher wages, there are still essential positions that remain vacant. ***Therefore, we have strong concerns about the proposed productivity cut given the extreme and uncertain circumstances in which our hospitals are currently operating. HAP urges CMS to eliminate the cut for FY 2023.***

FY 2023 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.

HAP is concerned with CMS' proposal to decrease DSH payments to hospitals—by approximately $800 million—for FY 2023. These payments are extremely important to Pennsylvania hospitals caring for the state's most vulnerable populations. We also need greater clarity on the agency's calculations for DSH payments. Specifically, we ask CMS to provide more details about the agency's assumption of small increases in discharge volume for FY 2022 and FY 2023. Although it appears likely that volumes will remain lower than historic, pre-pandemic levels, trends now indicate that FY 2022 and 2023 volumes will continue to increase substantially.

Additionally, we question the agency's estimate that the uninsured rate will decrease from 9.6 percent to 9.2 percent from FY 2022 to FY 2023 when determining DSH payments. In our communities, it is clear that a large **increase** in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions begin to unwind. ***HAP asks that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.***

For FY 2023, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $13.27 billion. Accordingly, CMS proposes that

hospitals would receive 25 percent of these funds, or $3.32 billion, as empirically justified DSH payments.

The remaining $9.95 billion would flow into the 75 percent pool, which is then adjusted to reflect changes in the percentage of uninsured. Based on the latest projections of the percent of individuals without insurance, CMS proposed Factor 2 would be 65.71 percent resulting in $6.54 billion—of the 75 percent pool during FY 2023. **However, this results in a decrease of about $654 million in the national pool for uncompensated care payments during FY 2023 as compared to FY 2022.**

For Pennsylvania, this represents a loss of $13.8 million.

HAP supports the agency's proposal to use the two most recent years of audited data from Worksheet S-10 to determine the distribution of DSH uncompensated care payments for FY 2023. Additionally, for FY 2024 and beyond, CMS proposes to use a three-year average of the three most recent fiscal years for which audited data is available. HAP also supports the three-year average because, as previously stated, utilizing a single year of S-10 data increases the potential for anomalies and undue fluctuations in uncompensated care payments. It is important to caution that CMS will need to work with stakeholders in upcoming years to ensure data from years where the COVID-19 pandemic has so dramatically affected the utilization of hospital services is properly understood and applied.

Area Wage Index Modifications

CMS previously finalized a policy to increase wage index values for low-wage hospitals, and is proposing to continue that policy during FY 2023. 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. We are disappointed that this policy has been applied in a budget-neutral manner—adjusting the standardized amount for all hospitals.

Also, CMS proposes to permanently apply a 5 percent cap on any decrease to a hospital's wage index from the prior fiscal year. This also would be applied in a budget-neutral manner.

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 appreciates that CMS recognizes 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.***

As we have previously argued, CMS is not bound by statute to make such increases budget neutral, and should adopt the position of providing relief to low-wage areas by allocating additional funds. Reducing the standardized amount for all prospective payment system (PPS) hospitals intensifies historical Medicare underpayment. We strongly reiterate that CMS should not impose budget neutrality on the low-wage hospital policy or wage decrease cap.

Graduate Medical Education Program

CMS provides payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Generally, Medicare direct GME payments are based on the hospital's per resident amount, a weighted number of full-time equivalent (FTE) residents, and the hospital's Medicare share of total inpatient days. Additionally, CMS also provides payment adjustments for hospitals for indirect medical education (IME) to account for higher indirect patient care costs of teaching hospitals.

For FY 2023, CMS is proposing to make several changes to GME that would affect Medicare direct GME and IME payments to teaching hospitals.

Due to a U.S. District Court ruling related to the agency's method of calculating direct GME payments to teaching hospitals when the weighted FTE counts exceed the cap, CMS proposes to modify its policy related to FTE caps. Specifically, the proposed policy would address situations for applying the FTE cap when a hospital's weighted FTE count is greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their initial residency period to an amount less than 0.5.

CMS also proposes to allow an urban and a rural hospital participating in the same Rural Training Program (RTP) to enter into an RTP Medicare GME affiliation agreement, which would allow some flexibility to teaching hospitals that cross-train residents.

HAP supports these proposed changes as they provide greater financial support and increased flexibility to Pennsylvania's teaching hospitals.

Medicare-Dependent Hospital and Low-Volume Adjustment Programs

Legislative action is required to address impending policy changes to two important rural payment policies—the Medicare Dependent Hospital (MDH) program and low-volume adjustment. The proposed rule reflects the policy that will be in effect if Congress does not act. HAP has worked with the Pennsylvania Congressional Delegation and is thankful for the leadership of U.S. Senator Bob Casey in leading S. 4009, the Rural Hospital Support Act. The legislation would make permanent the enhanced low-volume adjustment and MDH payments, and make other important rural payment policy changes. HAP strongly supports the bill and is encouraging action by Congress.

The MDH program is set to expire at the end of FY 2022. As such, absent Congressional action, hospitals that previously qualified for the MDH status will no longer have MDH status and will be paid based on IPPS federal rates beginning in FY 2023.

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. To support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program during 1987, allowing eligible hospitals to receive the sum of their PPS payment rate, plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. ***HAP supports Senator Casey's Rural Hospital Support Act that would make this important program permanent and add an additional base year MDHs could choose when calculating their payments.***

Additionally, under statute, the low-volume hospital policy is set to revert to requirements that were in effect prior to FY 2011. Therefore, beginning in FY 2023, CMS proposes to revert and modify the definition of a low-volume hospital and the methodology for calculating the payment adjustment to statutory requirements.

Although a low-volume adjustment existed in the inpatient PPS prior to fiscal year 2011, CMS had defined the eligibility criteria so narrowly that only two or three hospitals qualified each year. The current, improved low-volume adjustment better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers and improves access to care in rural areas. ***HAP supports Senator Casey's Rural Hospital Support Act that permanently extends the low-volume adjustment to ensure that these providers will not again be at a disadvantage and have severe challenges serving their communities.***

High-Cost Outlier Threshold

HAP is concerned about the dramatic scale of the proposed increase in the high-cost outlier threshold—a 39 percent increase from the FY 2022 threshold—that would significantly decrease the number of cases that qualify for an outlier payment. We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven the increase, but which will likely not continue fully in FY 2023. However, we urge the agency to explain in more detail the factors driving this significant increase in the IPPS high-cost outlier threshold—the largest by far in the past decade. ***Specifically, HAP asks CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.***

Modifications to the Promoting Interoperability Program

The Promoting Interoperability Program is comprised of four objectives:

- Electronic Prescribing
- Health Information Exchange
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

CMS is proposing multiple changes to the promoting Interoperability Program including:

- Requiring the reporting of the Electronic Prescribing objective's Prescription Drug Monitoring Program (PDMP) measure
- Adding a new Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) as an optional alternative
- Adding a new required Antimicrobial Use and Resistance Measure
- Consolidating the current options for "active engagement" from three to two levels
- Several changes to the scoring methodology including increasing the Electronic Prescribing objective form 10 to 20 points, and increasing the Public Health and Clinical Data Exchange objective from 10 to 25 points. The Health Information Exchange objective would be reduced from 40 to 30 points, and the Provider to Patient Exchange objective would be reduced from 40 to 25 points.
- Aligning the electronic clinical quality measures (eCQM) measure set with the Hospital Inpatient Quality Reporting Program
- Publicly reporting hospital performance in the Medicare Promoting Interoperability Program by fall 2024

HAP urges CMS to take a holistic view and approach to the future of the Promoting Interoperability Program in light of the ongoing Public Health Emergency (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 2023.***

Hospital Quality Reporting and Value Programs

CMS continues to make policy proposals to ensure that the COVID-19 PHE impact is taken into account in its hospital quality reporting and value programs.

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 ensure its impact is minimized on performance to the extent possible.

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 $400 million in readmission penalties across all eligible hospitals during FY 2023.

CMS is proposing three policy updates including:

- Resumption of the HRRP's pneumonia readmissions measure in FY 2024 that was suppressed in calculating FY 2023 performance and payment adjustments due to its "clinical proximity" of pneumonia to COVID-19
- Including patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models starting in FY 2023
- A request for information on how CMS could encourage hospitals to improve health equity and reduce health care disparities through the HRRP

In January 2021, CMS adopted an ICD-10-CM code that captures pneumonia due to COVID-19 as a secondary diagnosis and believes it to be used widely enough by hospitals to neutralize the impact of the PHE on the HRRP's pneumonia readmission measure as CMS removes patients with COVID-19 as a primary or secondary diagnosis when scoring. ***While HAP understands that a new ICD-10-CM code is in existence, HAP encourages CMS to table the resumption of this measure until additional data can be obtained detailing the appropriate use of this code in FY 2023. While considerable achievements have been made in combating COVID-19, the current PHE is still in place and should be considered annually in considering the need for suppression in subsequent years pending the PHE reach.***

HAP supports including a history of COVID-19 as a co-variate in the measures' risk adjustment models. We appreciate CMS' acknowledgement that there may be long-lasting risks for patients from COVID-19 that may affect their risk of readmission but urge CMS to conduct further analysis before finalizing his proposal to ensure prior COVID-19 is captured across hospitals in a complete, consistent, and equitable way.

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. We also

strongly urge CMS to resist tying HRRP penalties to either within or between provider disparities in readmission rates.

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:

- Continue to suppress most of the HVBP program measures for FY 2023 including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Healthcare-Associated Infections (HAI) due to the impact of the COVID-19 PHE
- Resume the HVBP pneumonia mortality measure in FY 2024 with similar caveats for removing patients with COVID-19 as a principle or secondary diagnosis as proposed for the HRRP pneumonia readmission measure
- Including patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models starting in FY 2023
- Revise the baseline period for FY 2024 for the HCAHPS and HAI measures to calendar year (CY) 2019 instead of CY 2021 to minimize the impact of COVID-19

HAP supports the proposal to continue to suppress most of the HVBP measures 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 stated in the HRRP comments, HAP encourages CMS to table the resumption of the pneumonia mortality measure until additional data can be obtained detailing the appropriate use of this code in FY 2023 and supports including a history of COVID-19 as a co-variate in the measures' risk adjustment models after CMS conducts further analysis to ensure proper data capture as noted above.

HAP also supports the revised baseline time period to isolate the impact of COVID-19.

Hospital-Acquired Conditions Reduction Program

The Hospital-Acquired Conditions (HAC) Reduction 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 other changes to the program including:

- Suppressing all six measures of the HAC Reduction Program for FY 2023 resulting in no penalties for any hospitals under this program for FY 2023

- Suppressing the HAI measure for FY 2024 but retain the PSI measure with technical changes intended to risk-adjust for COVID-19
- Increasing the minimum volume threshold for PSI 90 from three or more eligible discharges for at least one component indicator in PSI 90 to meeting both of the following criteria to receive a PSI 90 score
    - Have one or more component PSI measures with at least 25 eligible discharges; and;
    - Seven or more component PSI measures with at least three eligible discharges

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

HAP supports the concept of applying further measure suppressions to the FY 2024 HAC Reduction program but are concerned about the continuation of the PSI 90 measure. As noted in many of HAP's comment letters in the past, HAP strongly supports the removal of PSI 90 and encourages its removal across all CMS quality programs.

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 several changes to the program. The changes proposed include:

- The adoption of an attestation-based structural measure beginning with the CY 2023 reporting period that assess hospital leadership's commitment to health equity
- A new measure that assess the percentage of patients admitted to the hospital who are 18 years or older and are screened for five domains of health-related social needs (HRSN): food security, housing instability, transportation problems, utility difficulties, and interpersonal safety
- A new measure assessing the proportion of patients who screened positive on the date of hospital admission for one or more of the five HRSNs
- A new measure assessing patient-reported outcomes following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
- An updated version of the Medicare Spending per Beneficiary (MSPB)
- Updated methodology for its THA/TKA complications measure
- Increasing the number of eCQMs required for reporting from four to six measures starting with the CY 2024 reporting period
- A new measures intended to assess whether hospitals are screening for, documenting and developing plans to address malnutrition identified among elderly patients

- Voluntary reporting in CY 2023 and mandatory reporting in CY 2024 of a measure assessing the rate of nulliparous, term, singleton, vertex live born deliveries via C-section at greater than 37 weeks gestation
- Voluntary reporting in CY 2023 and mandatory reporting in CY 2024 of a measure to assess the proportion of patients with severe obstetric complications that occur during the inpatient delivery hospitalization
- A self-selected measure beginning in CY 2024 assessing the proportion of inpatient hospital encounters were adult patient have been given an opioid medication and are administered naloxone within twelve hours of receiving that medication
- Updates to two of its existing IQR measures—excess day in acute care after hospitalization for AMI and elective THA/TKA payment measure
- A new publically reported hospital quality designation focused on maternal health

As Pennsylvania hospitals remain committed to advancing health equity, HAP supports CMS' proposal for the hospital Commitment to Health Equity structural measure, however, urge we urge CMS to implement the following changes before finalizing the proposal and prior to publishing any results:

- ***Provide additional clarifying guidance to hospitals to ensure attestations are as accurate, complete, and consistent as possible***
- ***Revise the proposed "all or nothing" approach to scoring the measure and instead award one point for each individual attestation a hospital is able to complete***

HAP supports the inclusion of the HRSN screening measures in the IQR program. However, we recommend that CMS adopt the measures for voluntary reporting for now, and revisit a date for mandatory reporting after the first year of voluntary reporting to allow both CMS and hospitals to build experience and further evaluate the value of the measure. HAP also urges CMS to ensure the users of the data do not interpret the measure results of positive screens for HRSN.

HAP understands the value or patient-reported outcomes and supports the voluntary reporting of this information for THA/TKA but urges CMS to refrain from mandating the reporting at this time. HAP also supports the methodology updates to the THA/TKA complications measure.

HAP also supports the including of opioid-related adverse event eCQM and the global malnutrition composite eCQM in the menu of available eCQMs in the IQR and supports the proposed refinements to the existing IQR measures.

HAP urges CMS to obtain NQF endorsement of the Severe Obstetric Complication eCQM prior to finalizing its proposal.

HAP does not support CMS's proposals to:

- ***Update the MSPB measure***
- ***Increase the number of eCQMs required for reporting from four to six***
- ***Adopt the Cesarean Birth eCQM for voluntary reporting***

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.

Many Pennsylvania hospitals are well on their way to addressing health equity in their communities. 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.

Considerations for Policy on Health Equity

Reducing disparities in health outcomes and improving diversity, inclusion, and equity within our organizations is a top priority for Pennsylvania hospitals. The hospital community has moved beyond simply acknowledging the need for action and is now investing time, resources, and money into achieving quantifiable goals for patients, employees, and the greater community. We urge CMS to consider the following policy considerations:

Data Collection

Data are vitally important for identifying disparities and tracking improvement. However, across the numerous government programs and entities, there are inconsistent, conflicting, and potentially burdensome data collection methods, as well as a lack of standardization in the definitions, methodologies, and analyses used to decipher the data. ***HAP urges the agency to consider how its data collection plans align with other government efforts to collect health equity and social need data, as well as those already undertaken in the field.***

Meaningful Quality Measures

Given that one of the primary aims of health equity efforts is to eliminate disparities in quality performance and outcomes, HAP believes there is a role for health equity-related measures in CMS' quality measurement programs. ***At the same time, HAP urges CMS to ensure the design of the measures balances a number of practical and conceptual considerations including the relevance and ease of data collection of the measures and prioritize the most impactful measures.***

Balancing Engagement and Accountability

Pennsylvania hospitals and health systems are working within their own organizations and with their communities to meaningfully advance health equity. To date, CMS' proposed measures and several of its policy ideas are intended to reflect hospital-level practices and hospital-level data. ***However, as new policy ideas emerge, HAP believes policymakers will need to thoughtfully consider the span of accountability of such policies, and ensure hospitals and other entities are being held accountable for that which they can reasonably control and influence.***