June 25, 2021

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

Administrator

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

File Code: CMS–1752-P

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

Dear Ms. Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) long term acute care hospital (LTCH) prospective payment system (PPS) for fiscal year (FY) 2022. ***Please note that MHA submitted a separate comment letter regarding the proposed changes to update the inpatient PPS.***

The proposed rule is estimated to provide a $2.7 million, or 2.1%, increase to Michigan LTCHs in FY 2022, which is significantly less than the projected 6.5% increase in healthcare costs projected for 2022 based on a recent study by the PwC Health Research Institute.

The absence of adequate Medicare payments continues to challenge the financial viability of Michigan hospitals and their ability to provide care to Medicare and other patients especially given the additional challenges all hospitals have faced due to the COVID-19 pandemic. Our comments on the FY 2022 LTCH proposed rule focus specifically on:

* Opposing the addition of the COVID-19 Healthcare Personnel (HCP) vaccine in the LTCH quality reporting program
* Closing the health equity gap
* Using fast healthcare interoperative resources (FHIR)

**LTCH QUALITY REPORTING PROGRAM**

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

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

* ***Vaccine hesitancy***

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

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

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

* ***Timeliness***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**LTCH QUALITY REPORTING PROGRAM (QRP)**

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

Sincerely,

Vickie R. Kunz

Senior Director, Health Finance