June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD, 21244
Attention: CMS–1771–P
Submitted electronically to: http://www.regulations.gov

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

Dear Administrator Brooks-LaSure:

On behalf of the Premier healthcare alliance uniting an alliance of more than 4,400 U.S. hospitals and health systems and approximately 225,000 other providers and organizations, we appreciate the opportunity to submit comments regarding the FY 2023 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). With integrated data and analytics, collaboratives, supply chain solutions, and consulting and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Additionally, Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our member hospitals and health systems which, as service providers, have a vested interest in the effective operation of the Inpatient PPS. Below, the Premier healthcare alliance provides detailed comments with suggested modifications to the policies proposed by CMS.

IPPS RATE UPDATES AND IMPACTS OF RISING LABOR COSTS

CMS proposes to update IPPS operating payments for FY 2023 based on a forecasted 3.1 percent increase to the hospital market basket. **Premier has significant concerns that the proposed payment update does not come close to sufficiently reflecting the rising cost of labor that hospitals have faced over the last couple years.**

The hospital market basket is an input price index that measures the average percentage change in the price of goods and services hospitals purchase to provide inpatient care. As a fixed-weight index, the hospital market basket measures changes in prices over time of the same mix of goods and services purchased during a base period. As a result, any changes in the mix of goods and services are not measured annually. CMS rebases the hospital market basket every four years. The current market basket, which was rebased for FY 2022, reflects hospital costs from Medicare cost reports that began on or after October 1, 2017 and before October 1, 2018. CMS updates the market basket annually by

forecasting costs using available historical data. Traditionally, CMS updates its proposed rule forecast in the IPPS final rule to reflect more recently available data.

To update the market basket for the FY 2023 proposed rule, CMS utilized the IHS Global Inc.'s (IGI's) fourth quarter 2021 forecast, which includes historical data through third quarter of CY 2021. Following past practice, we anticipate the final rule will be based on IGI's second quarter 2022 forecast of the FY 2023 market basket and include historical data through second quarter of CY 2022.

A recent PINC AI™ analysis found that labor costs have increased by more than 16 percent since the start of FY2021 and do not show signs of returning to a lower level. Labor costs have increased by more than 10 percent in FY 2022 alone. (See Figure 1 in Appendix.) To determine changes in hospital labor costs, PINC AI™ analyzed the data within its workforce optimization solutions, one of the nation's largest and most robust sources for standardized geographically diverse payroll data and benchmarks – all collected and validated by health system users daily. The data come directly from a hospital's general ledger.

Our analysis found that increased labor costs are significantly higher than what CMS is currently estimating as part its market basket update for FY2023. Based on the latest data, CMS is currently estimating a 3.8 percent increase in compensation and benefits for FY2023. Labor costs for hospital workers make up approximately 53 percent of the 2018-based IPPS market basket.[1] CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI). Specifically, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers. This compares to the Premier data that comes directly from hospital payroll.

One critical difference between Premier's analysis and the ECI data, is that the ECI survey of hospital employment costs only includes employed hospital workers, not contracted ones.[2] Driving the growth in labor expenses has been an increased reliance on contract staff, especially contract nurses, who are integral members of the clinical team. While this increase in the use of contracted staff may be temporary, it does suggest a reason why the hospital market basket for FY 2021 and FY 2022 and the forecast for FY 2023 understates hospital increases in costs. Additionally, there has been a significant increase in clinician resignations and retirements during the pandemic. A recent analysis finds that by 2025 it is expected that the United States may have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap. These factors have increased the use of contract labor and travel nurses, which have become a new reality in healthcare as well as increased competition for clinical staff that has driven up wages.

Using data provided by OACT, Premier has also compared the market basket increase provided based on a projection to the actual market basket after the fact. Hospitals received an update based on a market based of 2.4 percent for FY 2021 but the actual increase was 3.0 percent. For FY 2022, hospitals received a market basket update of 2.7 percent but CMS' projected data suggest the increase will be 4.0 percent. **Given the extraordinary circumstances and the unprecedented effect of the pandemic on hospital inflation, Premier believes that CMS should do a one-time forecast error correction to the market basket to recognize the extraordinary price increases hospitals experienced during the pandemic compared to the inflation update they actually received for FY 2021 and FY 2022**.

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[1] Wages and salaries and fringe benefits for civilian workers in hospitals account for 53 percent of the market basket. The remaining 14.6 percent of labor costs are accounted for by professional fees, administrative and facilities support, installation, maintenance and repair and all other labor costs.
[2] Per discussions with CMS Office of the Actuaries (OACT)

We are concerned that the data that CMS uses to predict real inflation and cost of labor does not reflect reality and will result in a third consecutive year where the payment update is not reflective of the actual cost increases hospitals are experiencing now and into the future. This comes at a time when many acute care providers are struggling to stay afloat after years of COVID-related financial losses. At the same time, patient acuity and length of stay have increased when compared to earlier in the pandemic. Additionally, ongoing delays in non-emergent procedures and increased costs for supplies, medicine, testing and protective equipment has placed additional strain on hospital finances.

Finally, we do not believe these increased labor costs are transitory. Long before the pandemic, many clinical staff were in short supply and growing closer to retirement age. According to pre-pandemic research published in 2018, healthcare was projected to be short more than 1 million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant talent pipeline.[3] Since that time, the pandemic has only exacerbated matters, with more than 500,0000 nurse retirements expected in 2022.[4] As talent shortages become more severe, providers are paying more to attract and retain scarce staff. These wage increases cannot be taken back and have set a new floor. However, the BLS' ECI does not appear to accurately reflect the increased labor costs resulting from these projected ongoing shortages.

Under section 1886(d)(5)(I)(i) of the Act, "the Secretary shall provide by regulation for such other exceptions and adjustments…as the Secretary deems appropriate." Premier believes the understatement of the hospital market basket for FY 2021 and FY 2022 and potentially FY 2023 as well is such an occasion for using the exceptions and adjustments authority. As noted above, PINC AI data collected directly from hospitals is showing a 10 percent increase in 2022 to date for hospital compensation (67.6 percent of the market basket) compared to the 3.8 percent being forecast by IGI. **Premier recommends doing a one-time only forecast error correction on the FY2021 and FY2022 market basket of a combined 1.9 percentage points for FY2023 using the exceptions and adjustments authority.**

Further, Premier strongly recommends that CMS use its exceptions and adjustments authority to substitute the PINC AI data for the IGI forecast to provide hospitals with an increased payment update in FY2023 to accurately reflect labor costs. Additionally, we recommend that CMS OACT reevaluate the data sources that it uses for calculating labor costs and consider adopting new or supplemental data sources in future rulemaking that more accurately reflect the cost of labor, such as more real time data from the hospital community. While Premier is unable to forecast a market basket for FY 2023, we note the substantial impact a 10 percent increase in the labor components would have on the historical market basket for FY 2021. CMS historical data shows an FY 2021 market basket of 3.0 percent based on compensation increases of between 2.7 and 3.0 percent for 67.6 percent of the index. Going outside of its normal process and using the PINC AI increase of 10 percent would raise the historical market basket index to 7.9 percent.

UNCOMPENSATED CARE PAYMENTS (UCP)

[3] Zhang, Ziaoming, et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit,"*Americna Journal of Medical Quality,* 2018, Vol. 33(3) 229–236, https://edsource.org/wp-content/uploads/2019/02/Zhang-Daniel-Pforsich-Lin-2017-United-States-Registered-Nurse-Workforce-Report-Card-and-Shortage-Forecast_-A-Revisit.pdf
[4] American Nurses Association, "Nurses in the Workforce," https://www.nursingworld.org/practice-policy/workforce/

CMS estimates that approximately $6.538 billion will be available in uncompensated care payments for qualifying IPPS hospitals in FY 2023, which is an approximately 9.1 percent decrease from FY 2022. This decrease is driven by updated assumptions regarding hospital discharges and percentage change in uninsured, which is discussed in greater detail below.

Since FY 2014, CMS has calculated uncompensated care payments as the product of three factors:

- *Factor 1:* 75 percent of the aggregate DSH payments that would be made in the absence of the Affordable Care Act (ACA)
- Factor 2: Percentage change in uninsured since implementation of ACA; and
- Factor 3: A hospital's uncompensated care costs for a given time period relative to uncompensated care costs for that same time period for all hospitals that receive Medicare DSH payments.

Below we will detail several concerns about CMS' estimates of Factors 1 and 2 that determine the aggregate pool of uncompensated care funding that will be distributed to hospitals. As the statute precludes administrative or judicial review the uncompensated care calculation, it is imperative that CMS accurately determine both Factor 1 and Factor 2 as these estimates are not subject to any further revision.

Factor 1

CMS Office of the Actuary estimates Factor 1 based on the most recently available data and adjusts this estimate to account for inflation, changes in utilization, case-mix and other factors. Since the FY 2022 IPPS Final Rule, CMS has updated several of its assumptions, which have led to a $540 million decrease (or -5.1 percent) in Factor 1 in FY 2023 as compared to FY 2022.

The primary driver of this decrease is changes in assumptions related to discharges. Specifically, CMS decreased its estimate of discharges in both FY 2021 and FY 2022 by 7 percent and 5 percent, respectively. In the rule, CMS notes that the discharge figure for 2021 is based on Medicare claims data that has been adjusted by a completion factor to account for incomplete claims data. Given ongoing staffing shortages and challenges with responding to the pandemic, a number of hospitals have reported delays in billing, which may have contributed to an even higher rate of incomplete claims in FY2021 which would not be accounted for in the completion factor. As a result, discharges may have been higher in FY 2021 than what was used in the Factor 1 calculation. **We urge CMS to recalculate its estimate of FY 2021 discharges based on more complete data and that it considers delays in billing when using claims data to estimate FY2022 discharges.**

Additionally, **we are concerned that CMS' estimates of case-mix for FY 2022 and FY 2023 may underreport the acuity of patients.** During the pandemic, many patients, particularly patients with chronic conditions, delayed or did not seek needed care out of concern of contracting COVID-19 or because they were sheltering at home. Studies have found that delayed care may contribute to higher mortality rates and comorbidities.[5] We continue to urge CMS to evaluate its case-mix predictions to account for effects from the pandemic.

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[5] Smith, M, Vaughan Sarrazin, M, Wang, X, et al. Risk from delayed or missed care and non-COVID-19 outcomes for older patients with chronic conditions during the pandemic. J Am Geriatr Soc. 2022; 70(5): 1314- 1324. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17722

Factor 2

Factor 2 is used to adjust Factor 1 based on the change in uninsured since implementation of the ACA. Since FY 2018, CMS has used uninsured estimates from the National Health Expenditures Accounts (NHEA). For FY 2023, CMS estimates that the uninsured rate will be 9.2 percent, which is 0.4 percent decrease from FY 2022. We are concerned that the proposed uninsured estimate does not fully account for the end of PHE and the expiration of two critical pieces of legislation that will likely increase the rate of uninsured.

Under the Families First Coronavirus Response Act, state Medicaid programs are prohibited from disenrolling individuals during the PHE. With the PHE expected to end in 2022, more than 14 million people could lose Medicaid coverage, according to an Urban Institute study.[6] While some of these individuals could be eligible for other coverage, such as through the Marketplace, several factors could impact whether individuals receive alternative coverage. For example, Marketplace plans or employee-sponsored insurance tends to be more expensive than Medicaid, which could be cost prohibitive for many individuals. Additionally, if the PHE ends partway through the year, individuals could enroll in Marketplace coverage through a special enrollment period. However, without coordination between state Medicaid agencies and the Marketplaces, individuals may not be aware of their coverage options through special enrollment.

The American Rescue Plan (ARP) also included two provisions that improved the affordability of obtaining coverage through the Marketplace: (1) lowered the percentage of income that consumers are expected to contribute to premiums for those who are between 100-400 percent of the federal poverty level and (2) extended premium tax credits to households above 400 percent of the FPL. Both provisions are only available through coverage year 2022 and will expire in 2023. An estimated 3 million people are expected to become uninsured when the premium tax credits expire, according to a recent study by HHS' Assistant Secretary for Planning and Evaluation (ASPE).[7]

We urge CMS to take the expiration of these provisions into account when updating its estimate of uninsured in the final rule. At a minimum, CMS should provide additional detail on how it accounted for the expiration of these policies in its analysis.

Factor 3

Factor 3 is used to determine the amount of uncompensated care payments that each hospital will receive. Beginning in FY 2018, CMS began transitioning to data from Worksheet S-10 of the Medicare hospital cost reports when calculating allocations of uncompensated care. Starting in FY 2021, CMS began using the most recently available single year of audited Worksheet S-10 data. For FY 2023, CMS is proposing to calculate Factor 3 using the average of audited FY 2018 and FY 2019 Worksheet S-10 data. Additionally, starting in FY 2024, CMS proposes to calculate Factor 3 using an average of the three most recently fiscal years for which audited Worksheet S-10 data is available.

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[6] Buettgens, Matthew and Jessica Banthin, "Estimating Health Coverage in 2023," Urban Institute, May 10, 2022, https://www.urban.org/research/publication/estimating-health-coverage-2023

[7] Branham, D. Keith et al, "Projected Coverage and Subsidy Impacts If the American Rescue Plan's Marketplace Provisions Sunset in 2023," Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, March 23, 2022, https://aspe.hhs.gov/sites/default/files/documents/1647ad29528ee85a48d6ffa9e7bfbc8f/arp-ptc-sunset-impacts-03-22-22%20Final.pdf

Premier supports moving to a three-year average of audited Worksheet S-10 data. As we have noted in prior comments, using three years of data will help to smooth out variations in uncompensated care from year-to-year.

Finally, we appreciate recent CMS efforts to clarify the Worksheet S-10 instructions over the last several years. **We urge CMS to work with its Medicare Administrative Contractors (MACs) to establish consistent auditing practices and to provide greater transparency on auditing protocols, such as making audit instructions publicly available.** Some stakeholders have expressed concern with the lack of consistency that the MACs apply to audits – both across MAC jurisdiction and across auditors within the same MAC. This has resulted in auditors requesting hospitals to resubmit information in completely different formats than what is required by their usual MAC or hospitals having to submit different information depending on the individual auditing them. Additionally, CMS should consider implementing a fatal edit to ensure the S-10 is complete and internally consistent and instruct the MACs to audit negative, missing or suspicious values.

REQUESTS FOR INFORMATION (RFI)

Payment Adjustments for Domestically Made N95 Respirator Masks

CMS acknowledges the impact of overseas production shutdowns, export restrictions, and shipping delays during the pandemic on the availability of raw materials and components that are critical to public health supplies, such as personal protective equipment (PPE). CMS highlights the availability of surgical N95 respirators in particular as being a critical type of PPE to protect health care workers and patients from future respiratory pandemics. Recognizing that domestically produced N95 respirators are more costly than foreign-produced ones, CMS seeks comment on a potential IPPS and outpatient prospective payment system (OPPS) payment adjustment for National Institute for Occupational Safety and Health (NIOSH)- approved N95 masks that are wholly domestically produced.

From the beginning of the COVID-19 pandemic, Premier has been at the forefront of response efforts working around the clock to ensure hospitals, health systems, and alternate site providers across the country have access to the necessary PPE, medical supplies and pharmaceuticals to treat COVID-19 patients. This includes:

- Acquiring a minority stake in and making purchasing commitments to Prestige Ameritech, the nation's largest domestic producer of face masks located in Texas, to produce 8 million N95s and more than 45 million other PPE products annually.
- Collaborating with Honeywell to support the expansion of the U.S. production of nitrile exam gloves in Honeywell's Fort Worth, TX-based facility. Starting in Q3 of 2022, the collaboration will produce at least 750 million U.S.-made exam gloves in the first year alone.
- Creating a joint venture partnership with DeRoyal Industries Inc. that is expected to produce more than 40 million domestically manufactured gowns annually in Knoxville, TN. The gowns are now coming off the line and deliveries have begun.
- Acquiring a minority stake and committing to product purchasing in Exela Pharma Sciences to secure vital supply of 19 pharmaceutical products, including several generic injectables that frequently appear on the FDA's drug shortage list. Exela manufactures in Lenoir, NC.
- Using our global sourcing arm, S2S Global, to identify new sourcing of manufacturing capacity, ultimately contracting with seven different PPE factories across the globe to secure 36 million masks and respirators and 16 million gowns.

- Arranging cargo carriers and major airlines to expedite transportation of products so they could be onshore in hours, rather than months.
- Coordinating and allocated 2 million donated masks.
- Adding 40+ new manufacturers of COVID-19 related supplies, including new domestic entrants of N95 masks, to our national contracts using an expedited review process to rapidly increase options.
- Working with non-traditional and adjacent industries such as distilleries, textile manufacturers, and automobile manufacturers to fill supply gaps for essentials such as hand sanitizer, face shields, isolation gowns and surgical caps.
- Creating an online exchange for health systems, Resilinc, to trade PPE supplies among one another dynamically moving specific supplies to the neediest hot spots.
- Leveraging our existing drug shortage program, ProvideGx, to secure additional safety stock and dedicated supplies, thereby avoiding shortages for many critical products.

As part of these efforts, we have spent time reflecting on the experience of the health care industry during the COVID-19 response efforts. We agree with CMS' assessment that reliance on overseas manufacturing, along with export bans and manufacturing shutdowns globally were a contributing factor to the shortages our nation witnessed in critical medical supplies, such as N95 masks. However, the cost of acquiring domestically produced products is a challenge for hospitals and health care providers as domestically-sourced PPE in general is 20-30 percent more expensive than globally-sourced PPE.

We support adoption of a payment adjustment to inpatient and outpatient Medicare payments for domestically produced N95s. We strongly recommend that CMS expand this adjustment to include other critical medical supplies and pharmaceuticals.

CMS specifically seeks comment on two potential frameworks for adjusting payments:

- *Option 1:* biweekly interim lump-sum payment that would be reconciled at cost report settlement. Hospitals would be required to report on aggregate cost and total quantity of NIOSH-approved N95s it purchased that were wholly domestically made and those that were not. CMS would use this information to calculate an estimated cost differential between domestically produced and foreign sourced masks and would adjust payments accordingly
- *Option 2:* claims-based approach that would involve CMS establishing a MS-DRG add-on payment. Under this approach, CMS would establish a unique billing code that hospitals would append to a claim attesting to meeting or exceeding a domestic sourcing threshold for the year. CMS is considering a domestic sourcing threshold of 50 percent.

In designing this payment adjustment, **we recommend that CMS adopt a method that is least burdensome to the hospital community**. CMS should limit the frequency of reporting as much as possible and seek to utilize existing reporting processes. At this time, it is unclear how CMS would operationalize a claims-based approach without significantly increasing burden on providers. For example, it is unclear how CMS would measure whether a hospital meets the sourcing threshold, the type of documentation that a hospital would need to maintain, and how CMS would audit compliance. Additionally, greater clarity is needed around at what point in time providers would need to meet threshold and what would happen if the provider found out that it no longer met the threshold. Finally, it is unclear from the proposed rule if the add-on payment would only be applicable for certain claims (e.g., if domestically sourced N95s were used for the procedure or service) or for all Medicare claims. The former scenario would be difficult, if not impossible, for providers to track and document and would significantly increase burden on providers.

As a result, **we support adoption of a lump-sum payment** that could be reconciled through an existing reporting structure, such as cost reports. We also encourage CMS to work with the hospital and supply chain communities to automate reporting in the future. For example, to help alleviate provider burden, it is possible to build infrastructure that would allow purchases made from a GPO contract to be reported directly to CMS on behalf of providers.

Under the exceptions and adjustments authority under IPPS, CMS can adjust payment without applying a budget neutrality adjustment. However, under the OPPS, CMS would be statutorily required to apply the adjustment in a budget neutral manner. CMS seeks comment on whether it should apply the adjustment in a budget neutral manner under IPPS, similar to its statutory authority under OPPS. **Premier strongly discourages CMS from applying the adjustment under IPPS in a budget neutral manner.** Doing so would significantly reduce the effectiveness of this policy, especially as more hospitals acquire domestically produced products. Such an adjustment would be counterproductive in that it would effectively take away the incentive that is being provided with the additional payment through a payment reduction elsewhere. Additionally, applying a budget neutral adjustment could have a detrimental effect on safety net or smaller hospitals, who may be less able to absorb the higher costs of acquiring domestically produced medical supplies. Additionally, we do not believe CMS should apply a budget neutrality adjustment under the OPPS at this time. We encourage CMS to work with Congress to revise statute to allow CMS to apply this policy in a non-budget neutral manner under the OPPS.

In addition to creating incentives for health care providers to purchase domestically manufactured critical supplies, **we continue to urge the Administration and Congress to establish incentives for manufacturers to ensure that domestically manufactured, critical medical products are priced competitive with globally sourced products.** To that end, Premier is urging Congress to pass tax incentives to support domestically manufactured critical medical products and drugs as well as a tax credit for income generated from the sale of domestically manufactured goods.

In summary, Premier recommends that:

- CMS expand the adjustment beyond N95 masks to include other domestically manufactured critical medical supplies and pharmaceuticals;
- CMS ensure reporting of domestically purchased thresholds is not burdensome to the hospital community and consider opportunities to automate the reporting of data;
- CMS does not apply to adjustment under IPPS in a budget neutral manner; and
- CMS work with Congress to establish incentives for manufacturers to ensure that domestically manufactured goods are priced competitive with globally sourced products in the future.

Request for Information on Social Determinant of Health Diagnosis Codes

CMS is soliciting public comment on how the reporting of diagnosis codes in categories Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances) may improve its ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs. CMS believes that reporting SDOH-related Z codes in inpatient claims data could enhance coordination within hospitals across their clinical care and discharge planning teams, including post-acute partners. CMS notes that stakeholders have identified several reasons for not reporting Z codes, including the fact that they are not required and patients are not willing to discuss these issues.

We appreciate that CMS is considering how SDOH information should impact payment through the MS-DRGs. While we believe that SDOH information will improve the ability to recognize complexity and severity in the MS-DRGs, more foundational work is needed to accomplish this goal.

Premier supports use of incentives or requirements to increase reporting of SDOH data. However, comprehensive standards are needed first. Health systems are currently capturing SDOH data, but the information is not easily translatable for CMS purposes. Standardization is vital to providers' success in driving towards health equity, as it will foster the development and sharing of best practices within and among clinical settings, health systems, and delivery system designs. In the proposed rule, CMS notes the underutilization of Z-codes. In part, this can be attributed to a lack of standardization. Many providers' EHRs include SDOH screening tools, but the tools do not align with the available ICD-10 Z codes for SDOH. There is also a lack of alignment between Z codes and ONC/HIT certification requirements.

In this rule and other payment rules, CMS has also sought comment on using SDOH data to support assessing health equity through quality measurement. As CMS focuses on moving all quality measures to a digital platform, hospitals may be required to report SDOH data from EHRs using the US Core Data for Interoperability (USCDI). Conversely, The Gravity project has been using a combination of LOINC and ICD-10 codes for SDOH information. Collecting SDOH information through multiple mechanisms will place unnecessary burden on hospitals. Moreover, in the absence of comprehensive standards it will lead to inconsistent information. **We strongly recommend that in developing standards for SDOH data, CMS consider all the use cases to make it feasible for all providers to consistently collect and report data in a standardized manner without creating undue burden**.

Measuring Healthcare Quality Disparities Across CMS Quality Programs

Reducing disparities in care and achieving health equity across communities requires a holistic approach to care, shifting the incentives in our health system from sickness-based to wellness-based**. When providers are responsible for total cost of care for their patients and have flexibility to address social determinants of health, providers will be proactive in addressing inequity and disparities.** Addressing the underlying social and economic inequities as well as systemic barriers and biases that drive disparities in care requires (1) data collection and monitoring of key outcomes and health equity measures and (2) shifting the payment system to account for a more comprehensive set of services that address disparities. We appreciate CMS' commitment to closing health equity gaps in the CMS quality programs and look forward to partnering with CMS in this area.

CMS continues to seek input on addressing disparities across the CMS quality programs. In the proposed rule, CMS seeks input on key principles the agency should consider when addressing disparities through quality measure development. These principles are stratified into five key categories.

We recommend that all efforts to stratify measures by race, ethnicity and social factors begin with confidential reporting and appropriate risk adjustment to account for factors associated with outcomes that cannot be addressed by providers. We must avoid a perverse cycle, wherein certain policies – such as public reporting of stratified quality data – discourages beneficiaries from visiting providers that care for patients in marginalized communities, subsequently leading to unequal care for those patients due to lack of equal resources to treat them. It is critical that information publicly shared on disparities in care is accurate and can be understood by consumers. Moreover, while stratification and comparing providers with similar populations helps identify opportunities for improvement, it does not provide hospitals with all the tools necessary to address any underlying factors contributing to health inequities. **These efforts must be combined with a broader set of supports to enable providers to**

respond to disparities in care, such as learning networks and data on available community support services. Finally, we must recognize the challenges of stratifying measures that do not have adequate sample size. CMS must recognize the need for increased patient-level data and the associated burden to collect and report that information. **Overall, we support the principles outlined for stratifying measure results and offer additional perspectives on each principle below.**

Goals and Approaches for Measuring Disparities using Stratification. CMS discusses the within- and between- provider methodological approaches for comparing measures results. **We support using both approaches**, which has also been recommended by the Assistant Secretary for Planning and Evaluation.

Selecting and Prioritizing Measures for Disparity Reporting. CMS discusses measures that could be prioritized including existing measures; measures with identified disparities; measures with reliable and representative comparisons; and outcome, access, and appropriateness measures. We agree with these principles and encourage CMS to be transparent about why certain measures were selected for disparity reporting. CMS should use its existing processes (e.g., NQF endorsement, Measures Applications Partnership, and Notice of Proposed Rule Making) to seek stakeholder input before measures are stratified. Additionally, as we note above, CMS should first employ confidential reporting and seek additional feedback prior to public reporting.

Social Risk Factors and Demographic Data Collection. CMS notes that patient reported data is the gold standard and discusses other potential data sources, including billing and administrative data, area-based indicators of social risk and demographics, and imputed sources of social risk and patient demographics.

Health systems are currently capturing sociodemographic data, but this information is not easily translatable for CMS purposes. For example, despite an available framework for mapping the more than 900 race ethnicity codes provided by the CDC to the OMB, race and ethnicity codes captured in the EHR cannot be consistently mapped. This is a result of lack of use of standard taxonomies—in part by the EHRs and in part by the providers to allow the category selections to align with how their populations would like to report information. Similarly, there are an abundance of tools to screen for SDOH with underlying definitions for certain social risk factors (e.g., food insecurity) significantly varying even when the same tool is used by different providers.

The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time. AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

We ask that CMS make a concerted effort to advance standards for the collection of socio-demographic information, using existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. As we note above, CMS needs a coordinated approach for using sociodemographic data for numerous purposes including payment and quality. This coordinated approach requires significant input from providers across the continuum, vendors, payers, and suppliers. **We recommend that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of socio-demographic factors.**

We do not support the use of indirect estimation techniques due to data inaccuracy. Health systems are currently collecting self-reported sociodemographic data from their populations through a

variety of methods. Inaccurate measure stratification can disrupt ongoing efforts to improve disparities in care. **Instead, we urge CMS to rapidly and meaningfully pursue efforts to improve access to directly collected race and ethnicity data from self-reported sources.**

Finally, **we support using area-based indicators of social risk as an initial step in providing hospitals confidential feedback**. As noted above, hospitals are currently working to identify disparities in their populations. Having measure rates using area indices will allow hospitals to compare their own stratified results to stratified results based on the area indices. This provides valuable information of how a hospitals population or performance may vary from the region.

Identification of Meaningful Performance Differences. CMS notes several approaches for detecting meaningful differences in stratified results. As we note above, we encourage CMS to approach stratification of measures results similar to approaches used for collection and reporting of all measure results. CMS should convene a Technical Expert Panel.

Reporting Disparity Results. CMS discusses a goal of confidential reporting to providers for new programs and measures. **We agree with this approach and reiterate that CMS should seek stakeholder input prior to public reporting.**

FHIR in Hospital Quality Programs

In the FY 2022 proposed rule, CMS articulated its goal of moving to fully digital measurement by 2025. As part of this goal, CMS aims to streamline the approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning. In this rule CMS seeks broad input on the transition to digital quality measurement. Premier appreciates CMS' commitment to advancing digital measurement. We have long been committed to advancing providers' capability to analyze data from multiple sources and to manage the health of their populations. We offer the following comments on advancing digital quality based on experience with supporting providers in advanced data analytics and quality reporting:

- *Definitions.* CMS has updated the definition of digital quality measures (dQMs) to be quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. **We support this revised definition and appreciate that CMS is considering data sources beyond EHR sources.** As part of this discussion, CMS indicated that given the ongoing challenges of reporting, the Agency is considering how eCQMs fit within the framework of dQMs. Accordingly, as we note below, we do not support CMS' proposals to expand the number of required eCQMs.

- *Data Standards and FHIR eCQM Reporting.* CMS states that standardization is necessary across implementation guides and value sets to facilitate interoperability. CMS also continues to focus on FHIR-enabled application programming interfaces (APIs). Additionally, CMS continues to test conversion of existing electronic clinical quality measures (eCQMs) for use with FHIR-based resources and indicates plans to develop a unified CMS FHIR receiving system. A holistic approach is needed for data standards whereby standards are developed and adopted for use across care settings. There are at present a limited number of common data elements across inpatient, outpatient, and post-acute care; however, these elements could serve as a starting point for cross-continuum patient assessment. While FHIR will likely make development and

maintenance of measures easier over time, measure developers are just beginning to test measures using FHIR. We will need sufficient testing and consideration by multi-stakeholder groups such as HITAC and NQF prior to wide-spread adoption. A critical component to using FHIR for eCQMs is the adoption of bulk FHIR transactions to simplify and speed transmission. In the absences of bulk FHIR transactions, providers will be unable to support FHIR implementation. Additionally, the FHIR standards are not broad enough to support all potential use cases as much of the data captured in the EHRs does not correlate to a standard. Similarly, FHIR is only used by EHRs and has limited application to other digital data sources, such as HIEs. Open APIs and rapid expansion of the FHIR standard are needed to achieve dQMs. CMS needs to work with ONC to advance the adoption and consistent implementation of data and interoperability standards so that provider data collection and reporting requirements are enabled by health information technology.

Climate Change Impacts on Outcomes, Care, and Health Equity

CMS solicits input regarding how hospitals, nursing homes, home health agencies, and other providers can better prepare for the impact of climate change and how HHS and CMS can support hospitals to effect change in this space.

Premier supports HHS' and CMS' focus and efforts in tackling climate change and reducing greenhouse gas (GHG) emissions. **Premier has been, and remains, committed to doing our part in improving the environment and will continue to work toward advancing environmentally sound and climate-related best practices within our business and in our communities.**

The scientific consensus is clear. Human-caused climate change is real and will have significant consequences for the health and wellbeing of Earth's inhabitants. The 2020s have been called a 'critical' and 'decisive' decade where action will be vital if we are to avoid the worst consequences of a changing climate. Maintaining the Earth's average temperature at, ideally, 1.5^{o}C and certainly no more than 2°C above pre-industrial levels is vital.

For its part, the healthcare sector is responsible for almost 10 percent of U.S. GHG emissions. Fortunately, over the last 20 years a new language and system for addressing GHGs has evolved. GHGs include various volatile gases, principally carbon dioxide (CO_2) and methane (natural gas), as well as nitrous oxide (N_2O) and more exotic pollutants such as hydrofluorocarbons (HFCs) and sulfur hexafluoride (SF_6).

Organizations account for their production of these gases using "scopes," and these break down as follows:

- **Scope 1:** Emissions produced directly at controlled or owned facilities. For hospitals, this would primarily be CO_2 from boilers and incinerators, as well as emissions from owned vehicles. In addition, anesthetic gases (primarily desflurane) and those lost from refrigerant systems are considered scope 1.
- **Scope 2:** Emissions attributable to purchased electricity, steam, heating and cooling. GHGs emitted by an electric utility as they produce an organization's purchased power are accounted for in scope 2 emissions.
- **Scope 3:** All other indirect emissions attributable to an entity. These include emissions from business travel, employee commuting, waste disposal and investments. **Critically for healthcare, scope 3 emissions also include those associated with purchased goods and services, and capital goods.**

In response to climate change, many healthcare organizations, including Premier members, are using the above taxonomy to account for climate change impact. Guidelines issued by organizations such as the Greenhouse Gas Protocol and the Taskforce on Climate-Related Financial Disclosures (TCFD) provide a roadmap. Publication of this accounting, either in the form of an annual report or via an independent body such as CDP — a global disclosure system to manage environmental impacts — is the next step. This is followed by setting goals for emissions reduction and eventual elimination (also known as a net-zero target, where any residual emissions are offset by GHG removal elsewhere).

Each organization may set their own targets, but a one-size-fits-all approach may not work. Flexibility is key, as a GHG reductions approach leveraged in other industries may not apply in healthcare due to the complexities in its unique needs and operations. The gold standard is to set a "science-based target," where a reduction plan has been verified by the Science Based Targets Initiative (SBTi) to align with keeping temperatures well below the 2°C threshold. An important note is that while many non-profit organizations, including many of Premier's members, can and should set science-based targets, they are currently not yet verified by the SBTi.

Premier's Decarbonization Efforts on Behalf of Healthcare

Premier aids healthcare decarbonization efforts across all three scopes. For scopes 1 and 2, our contracted suppliers help members save energy in various ways. For example:

- HVAC services suppliers can support with everything from system tune-ups to entire retrofits and replacements;
- Building services suppliers can design and implement upgrades such as LED lighting retrofits; and
- Energy services firms can assist members in a wide variety of capacities, including in the purchase of renewable energy.

Scope 3 emissions are an emerging and challenging area — and Premier is collaborating with our members to understand their primary challenges and co-develop solutions. For instance, Premier works with suppliers to ensure sustainability information is available before purchasing decisions are made. Our RFIs include questions on environmentally preferable policies and practices, and are guided by Premier's Environmentally Preferred Purchasing (EPP) Advisory Council. Comprised of sustainability specialists from a cross-section of member health systems, the EPP Advisory Council input is vital to ensuring that our efforts reflect their goals, and that supplier documentation is fit for purpose. With guidance from the Council, as well as Practice Greenhealth and the Healthcare Climate Council, we're also updating RFIs to include specific questions on our suppliers' GHG accounting — what they are measuring, how they are reporting and whether they have set emissions reduction targets. Specifically:

- Premier RFIs contain detailed product-level questions on a swathe of environmental traits, including the presence of chemicals of concern, product reuse and recyclability and packaging. RFI questions also pertain to GHG accounting, data publication, and target setting which is used to baseline performance and drive conversations with suppliers. Premier will also use the data it collects to understand how best it can support its supplier base through outreach and education during the transition to net zero.
- Health systems are now leveraging technology and analytics to easily identify sustainable suppliers and products designed to reduce environmental impact, pinpoint gaps and opportunities, and benchmark against their goals. Premier technology contains EPP information for more than 200,000 products and nearly 400 suppliers — and we expect this number to grow. As a use case, Premier members are leveraging RFI information and supply chain data to support programs aimed at the reduction and elimination of certain anesthetic gases that have significant global warming potential such as desflurane.
- Premier offers reprocessing under contract for many items so that they may be used again safely and with environmental stewardship in mind. As an example, one Premier-contracted supplier

offers a fluid cart with proprietary cleaners and a closed-system process that reduces operating room (OR) red bag waste by up to 70 percent with its reusable reservoirs — eliminating the OR's need for plastic containers. Another Premier-contracted supplier for reprocessing avoids one million pounds of landfill waste per annum on a single reprocessing contract alone.
- Member health systems are also re-evaluating their foodservice operations with an eye to using more environmentally friendly products and reducing their output of plastic waste.

Premier's Own Decarbonization Efforts

Premier is currently in the process of conducting an environmental assessment of our Scope 1 and Scope 2 carbon emissions and expects to assess our Scope 3 carbon emissions in calendar year 2023. These assessments will aid us in determining our baseline emissions footprint and developing strategies to reduce our carbon footprint. Additional information regarding Premier's environmental sustainability work is available in our inaugural 2021 Sustainability Report.

Actions HHS and CMS Can Take to Propel Decarbonization Efforts

The Administration can help create incentives to drive greener choices for the safety and health of patients, workers, and the environment by:

- Giving healthcare providers a seat at the table in setting emissions goals and other climate-related targets. It is critical that, once climate-related targets are identified, healthcare entities are given a reasonable runway to implement such targets.
- Recognizing that a one-size-fits-all approach may not work. Flexibility is key as GHG reduction approaches leveraged in other industries may not apply in healthcare due to the complexities in its unique needs and operations, including the non-profit status of many healthcare entities.
- Ensuring the availability of resources to assist healthcare entities in assessing their GHG emissions, goal setting, and reducing their emissions. Appropriate resources are a critical factor for success in this space, especially given the financial constraints healthcare entities currently face as highlighted in our comments.
- Considering incentives for healthcare providers to purchase greener medical supplies and pharmaceuticals, similar to the payment adjustment that CMS is considering in this proposed rule for domestically manufactured N95 masks.
- Creating incentives for manufacturers of critical medical supplies and pharmaceuticals to manufacture products using more environmentally sustainable processes and materials.

CONDITION OF PARTICIPATION: REPORTING COVID-19 AND INFLUENZA INFECTIONS

During the PHE, CMS has required hospitals to report daily on certain COVID-19 related information, such as number of staffed and occupied beds, information about its supplies, count of COVID-19 cases, and current inventory and usage of COVID-19-related therapeutics. These reporting requirements are currently in place for the duration of the PHE.

CMS proposes to modify its Medicare conditions of participation (CoPs) to require that, beginning at the conclusion of the PHE and continuing until April 30, 2024, a hospital must electronically report information about COVID-19 and seasonal influenza in a standardized format specified by the Secretary. Additionally, to respond to future crises more effectively, CMS proposes a framework for hospitals to report requested data in the event of a future local, state, and national PHEs specific to an infectious disease or pathogen. If finalized, hospitals would be required to report requested data through the CDC NHSN or other surveillance system, as determined by the Secretary. As part of this proposal, CMS could require

hospitals to report person-level information, including medical record identifier, race, ethnicity, age, and relevant comorbidities of infected patients.

We appreciate efforts by CMS to streamline reporting through existing reporting mechanisms, such as the CDC's NHSN or other surveillance systems. However, **we strongly urge CMS to weigh the reporting burden on providers against any potential benefit gained from data collection.** In general, there is a need for greater transparency on how data is being utilized in response to the current PHE and how it might be utilized under any future PHE. The main priority for providers in a public health emergency is ensuring patients are getting the care that they need.

Collecting and reporting patient-level data will require hospitals to invest significant human and monetary resources to ensure they have the processes in place to track this information.

CMS should consider reducing the frequency that hospitals must report data and require only essential data fields to be reported. For example, CMS should reconsider requiring hospitals to report patient-level data. While this data could be beneficial for evaluating impacts of future pandemics or epidemics across populations, for the most part data will not be actionable in responding to the infectious disease or pathogen since data is deidentified. While it is important to evaluate the impact of pandemics or epidemics, CMS should seek to collect this data through other means that do not increase burden on hospitals, especially during a time that they are actively responding to a public health emergency.

CMS should evaluate whether there are other data sources it could utilize in evaluating future public health emergencies. At a minimum, CMS must better articulate the value of collecting patient-level data, particularly how it will help the government and hospitals directly respond to patient care during the public health emergency. CMS should use a similar framework when evaluating what data to collect and the frequency in which it collects the data.

Additionally, CMS should work with state governments, local health departments, and the provider community to better identify how data could be shared across entities and the type of data that would be valuable in responding to PHEs. As part of this, CMS should work with stakeholders to align data requirements to ensure reporting is done in a consistent manner that reduces burden on providers.

Additional clarity is also needed around what exactly hospitals will be required to report following the conclusion of the COVID-19 PHE up until April 30, 2024. As the preamble and regulatory text is currently drafted, it is unclear if hospitals will continue reporting the same data elements under the existing reporting requirements or if CMS would change to the new reporting process and modify data elements. CMS should work to put out guidance as soon as feasible so that providers can better prepare for any changes.

With the requirements being tied to a CoP, we recommend that CMS use enforcement discretion and work with surveyors to ensure that there is ample time for hospitals to come into compliance. CMS must recognize that this type of reporting is resource intensive and will require hospitals to implement reporting processes and systems. At the same time, hospitals are actively responding to a public health emergency and may not have the staffing or capabilities available to compile requested data.

Finally, as the Administration explores ways to better prepare our nation's health system for future pandemics, Premier urges HHS to establish an automated, on-call system to collect near real time supply chain data. A major issue during the pandemic was the lack of visibility into the exact quantities of critical medical supplies and drugs that were on U.S. soil at any given time. As a result, there was a surplus of

products in many parts of the nation while hard-hit communities were operating in crisis mode. A lack of understanding of product availability resulted in excessive purchasing of products, the emergence of unscrupulous and fraudulent vendors, and hoarding, which created shortages for others.

To avoid this in the future, Premier encourages HHS to contract with a private entity or entities expert in this area to establish an on-call, automated supply chain tracking system to provide near real-time insight into the amount of critical medical and health supplies available in the Strategic National Stockpile (SNS) and in the medical and health inventories of private entities like hospitals, manufacturers, and distributors, and time estimates for when inventories may be replenished.

QUALITY REPORTING PROGRAMS

Establishing the Maternal Care Designation

CMS proposes to establish a hospital designation reflecting quality and safety of maternal care. This designation would be awarded based on the Maternal Morbidity Structural measure that CMS adopted into the Hospital IQR Program as part of FY 2022 rulemaking. If finalized, CMS anticipates publicly reporting this designation on a public-facing CMS website beginning in Fall 2023.

Premier applauds CMS for taking this first step in recognizing health systems that provide high quality maternal care. The proposed approach aligns with national efforts to identify the causes of maternal mortality and morbidity, reduce disparities in maternal health outcomes, and advance best practices for improving care for mothers and infants. Because reliable data has long been incomplete or unavailable, the U.S. lacks a clear understanding of the number of women who die or sustain lifelong harm as a result of pregnancy and childbirth. Maternal care improvement must start with reliable data that identifies the root causes. Using data to understand the root causes of mortality and severe maternal morbidity is critical to attacking this problem. With that information we will be able to better assess interventions that can be scaled to solve this problem for our country. **While we support this first step, we encourage CMS to continue to explore other measures that move beyond attestation and move towards measuring outcomes.**

Premier has partnered with HHS' Office of Women's Health to leverage Premier's data and proven performance improvement methodology to scale advancements in care for mothers and infants across the nation. Premier is also uniting a cohort of more than 200 hospitals across the country – particularly those that serve vulnerable populations – to reduce health disparities; scale standardized, evidence-based practices; and reliably measure associated outcomes. These efforts are generating positive outcomes and needed to be scaled nationwide**. We encourage CMS to build on the lessons learned from this effort to rapidly expand the measure set that is used to define the maternal care designation.**

Cross Program Measure Suppression Policy

As part of last year's rulemaking, CMS adopted a cross-program measure suppression policy to address the effects of the COVID-19 pandemic across its value-based programs, including the Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) program, and Hospital Acquired Condition (HAC) Reduction program. Under this policy, CMS will suppress measure rates when calculating performance under the value-based program if it determines that a measure was

significantly impacted by the ongoing public health emergency (PHE). Additionally, CMS adopted several other mitigation policies, such as excluding patients with a primary or secondary diagnosis of COVID-19 from some of the measure calculations.

As we noted last year, Premier applauds CMS for taking a proactive and thoughtful approach to addressing the impacts of the COVID-19 pandemic on quality measurement. CMS' suppression policy recognizes that ongoing pandemic has impacted quality measurement in a multitude of ways that are beyond the control of facilities. As part of this year's rulemaking, CMS proposes additional suppression policies to address impacts on performance in 2020 and 2021. This includes:

- Adopting a covariate adjustment for patient history of COVID-19 in the 12 months prior to admission
- Suppressing additional measures in payment year (PY) 2023 and PY 2024 across programs
- Not calculating scores for hospitals under both the HVBP and HAC reduction programs in performance year 2023

We continue to appreciate CMS taking steps to ensure that hospitals are not unfairly penalized because of these impacts. Below we have provided additional feedback on these proposals in each value-based program.

Hospital Readmissions Reduction Program

As part of last year's rulemaking, CMS finalized a policy to suppress for PY 2023 the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization (NQF #0506) measure based on its clinical proximity to COVID-19. CMS also updated the measure specifications for the other readmissions measures to exclude patients with a COVID-19 primary or secondary diagnosis.

As part of this year's rulemaking, CMS is proposing to resume use of the pneumonia readmissions measure in PY 2024. In doing this, CMS would exclude patients with COVID-19 primary or secondary diagnoses from all the readmission measures. Additionally, CMS proposes to adopt a covariate adjustment for patients that had COVID-19 in the 12 months prior to admissions.

In proposing to resume use of the pneumonia measure, CMS notes that it believes the availability of COVID-19-related ICD-10 codes effective January 1, 2021 will enable CMS to differentiate patients with COVID-19 from pneumonia patients without COVID-19.

While Premier is supportive of the steps CMS is taking to adjust the readmissions measures for COVID-19 impacts, **we are concerned that it is premature to resume adoption of the pneumonia measure.** In earlier rulemaking, CMS finalized a policy to exclude the use of claims data from the first half of 2020 in calculating performance across multiple quality programs, including the HRRP. As a result, for PY2024, the performance period for the pneumonia measure is from July 1, 2019 through December 1, 2019 and July 1, 2020 through June 30, 2022. This means data collection will include a 6-month period prior to the availability of the COVID-19-related ICD-10 codes. Additionally, rapidly changing guidance to providers may have impacted their ability to adjust to new coding practices. We urge CMS to assess the impacts of COVID-19 on hospital performance on the pneumonia measure and to take steps to suppress the measure if there are significant deviations in hospital performance.

We appreciate CMS' proposal to adjust performance based on whether a patient had COVID-19 in the 12 months prior to admission. Numerous studies now indicate that many patients continue to experience health problems long after they recovered from COVID-19, commonly referred to as long-haulers. Additionally, the health care community continues to learn about the long-term effects of COVID-19 on patient's overall health. However, we are concerned that the covariate adjustment may not sufficiently capture all patients who have a history of COVID-19. The adjustment depends on claims being submitted with either the U07.1 or Z86.16 ICD-10-CM codes. However, many patients may have tested positive for COVID-19 through at-home tests, which would not be captured in the claims data. Additionally, at this time there is no code to identify COVID-19 long haulers. As a result, patients who are seeking care for these long-term symptoms may not be coded with either the U07.1 or Z86.16 ICD-10-CM codes since they no longer have a positive diagnosis. Rather, visits for these patients may be billed with other codes for the chronic conditions that have resulted, such as diabetes, autoimmune disorders, or neurological issues.

We recommend that the covariate adjustment methodology be considered and reviewed by a special NQF technical expert panel (TEP) to ensure that the adjustments are comprehensive enough to capture the long-term impacts of COVID-19. As part of that we encourage CMS to evaluate whether there are additional codes or information from the claims that would help strengthen the risk adjustment model.

Hospital Value-Based Purchasing Program

As part of last year's rulemaking, CMS finalized several changes to measures and scoring under the Hospital Value-Based Purchasing Program (HVBP) for PY 2022. First, CMS suppressed all measures in three of the four program domains: Person and Community Engagement Domain, Patient Safety Domain, and the Efficiency and Cost Reduction Domain. Additionally, CMS did not calculate total performance scores for hospitals since they would be based on only measures in one domain (Clinical Domain). CMS is statutorily required to reduce operating DRG payments by 2 percent under the HVBP program. As a result, CMS reduced payments, but each hospital received a value-based incentive payment that matches the 2 percent reduction, resulting in a neutral payment adjustment for FY 2022.

For PY 2023, CMS is proposing to suppress measures across two domains: Person and Community Engagement Domain and Patient Safety Domain. As part of last year's rulemaking, CMS finalized a policy to suppress the Pneumonia (PN) 30-Day Mortality Rate (MORT-30-PN) measure due to its clinical proximity to COVID-19. For the remaining measures in the Clinical domain (other mortality measures and complications from hips and knees measure), CMS finalized a policy to exclude patients with a principal or secondary COVID-19 diagnoses. As part of this year's rulemaking, CMS is proposing to update this policy by adopting a covariate adjustment for patients with a history of COVID-19 in the 12 months prior to admission.

Additionally, CMS proposes to not calculate a total performance score for hospitals for PY 2023. Similar to PY 2022, CMS would reduce all operating payments by 2 percent, as required by statute. However, each hospital would receive a value-based incentive payment that matches the reduction, resulting in a net neutral payment adjustment. Finally, while CMS is suppressing measures and not calculating total performance scores, CMS proposes to provide all hospitals with confidential feedback reports and publicly report all measure rates, with caveats regarding COVID-19 impacts.

Premier supports CMS' decision to suppress the measures included in the Person and Community Engagement and Patient Safety and to not calculate a total performance score for PY2023. This policy will help ensure hospitals are not penalized for impacts outside of their control.

As noted above, we appreciate CMS' proposal to adjust performance based on whether a patient had COVID-19 in the 12 months prior to admission. However, we are concerned that this adjustment which relies on the U07.1 or Z86.16 ICD-10-CM codes may not fully capture all patients who have had a history of COVID-19. **We recommend that the covariate adjustment methodology be considered and reviewed by a special NQF TEP to ensure that the adjustments are comprehensive enough to capture the long-term impacts of COVID-19.** As part of that we encourage CMS to evaluate whether there are additional codes or information from the claims that would help strengthen the risk adjustment model

Additionally, we do not support CMS' proposal to publicly display rates. CMS has determined that rates were significantly impacted by the pandemic. As a result, displaying this information will have limited value and is likely to cause confusion or misinterpretation of quality. Even with a note acknowledging the impacts from COVID-19, consumers will have no reference to understand how much of an impact COVID-19 had on quality measurement for the facility. Some consumers may continue to use the information and compare data across facilities. The impacts of COVID-19 will vary depending on region and facility, as the pandemic peaked in different regions at different time. Additionally, the medical community's response to the pandemic evolved overtime, as knowledge of the virus increased and new treatments became available. As a result, depending on where a facility was located, the impacts may have varied for reasons completely out of the facility's control. **We recommend that CMS not publicly display the HVBP rates**. At a minimum, CMS should provide hospitals with the option to opt-in to public reporting as part of their confidential feedback review.

Hospital-Acquired Condition Reduction Program

Last year, CMS finalized a suppression policy that resulted in all data from CY 2020 being excluded in calculating HAC measure performance for PYs 2022, 2023, and 2024. As part of our comments, we urged CMS to continue to monitor the impact of COVID-19 on 2021 performance, as many of the issues that hospitals experienced in 2020 continued in to persist in 2021.

As part of this year's rule, CMS is proposing several updates to the HAC Reduction Program to address COVID-19 impacts. For PY 2023, CMS is proposing to suppress all HAC measures. As a result, all hospitals would receive a Total HAC score of zero for PY 2023 and no penalties would be applied. For the CDC NHSN measures, CMS proposes to provide hospitals with confidential reports and to publicly report measures on *Care Compare*. CMS does not propose to calculate nor publicly report measure results for the CMS PSI 90 measure because it is concerned results could be distorted since the reference period is prior to the pandemic and thus would not include COVID-19 data.

For PY 2024, CMS is proposing to update the measure specifications for the CMS PSI 90 measure to risk adjust for COVID-19 diagnoses. For the CDC NHSN HAI measures, CMS is proposing to suppress CY 2021 data. As a result, the measures would be calculated based only on CY 2022 performance. CMS plans to resume using measure data for scoring and payment adjustments in 2024.

We support CMS' proposal to suppress all measures for FY 2023 and to not calculate a total HAC score for hospitals. As CMS notes the pandemic had a significant impact on performance, as a result of changes in care protocol and clinical guidelines and staffing shortages.

However, similar to the HVBP Program, we are concerned about CMS' proposal to publicly report hospitals' performance on the suppressed measures. As noted above, displaying this information will have limited value and is likely to cause confusion or be misinterpreted by consumers. Even with a note acknowledging the impacts from COVID-19, consumers will have no reference to understand how much of an impact COVID-19 had on quality measurement for the facility. Additionally, depending on where a facility was located, the impacts may have varied for reasons completely out of the facility's control. **We recommend that CMS not publicly display the CDC NHSN HAI measure rates**. At a minimum, CMS should provide hospitals with the option to opt-in to public reporting as part of their confidential feedback review.

We support CMS' proposal to exclude CY2021 data in its calculation of the CDC NHSN measures for PY 2024. As we noted last year, hospitals continued to face many of the same challenges in 2021 as in 2020. However by only using one year of data (2022), some hospitals may see more variability in their performance, as compared to prior years. CMS should monitor the impact of truncated performance periods and consider taking further action if hospitals experience significant fluctuation in performance from prior performance periods.

To date, CMS has not provided additional detail on the methodology it will use to risk adjust the CMS PSI-90 measure for COVID-19 diagnoses. **We urge CMS to release additional details as soon as possible and that it work with a NQF TEP to review the risk-adjustment methodology.**

Hospital Inpatient Quality Reporting (IQR) Program

Measures proposed for adoption

CMS proposes to adopt ten measures into the Hospital IQR Program:

1. ***Adopting Hospital Commitment to Health Equity Measure.***

   CMS proposes adding a structural measure – Hospital Commitment to Health Equity – to the Hospital IQR Program measure set, beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years. The measure is intended to assess a hospital's commitment to health equity across five domains—strategic priority, data collection, data analysis, quality improvement and leadership engagement**. We support this structural measure as a first step in addressing health equity for hospitals.** Leading hospitals have long engaged in efforts to address health equity within this communities. This measure will incent providers to continue and expand these efforts.

2. ***Adopting Screening for Social Drivers of Health measure***

   CMS proposes adding a process measure – Screening for Social Drivers of Health – to the Hospital IQR Program measure set, beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years. The measure is intended to promote adoption of screening for health-related social needs (HRSNs) by hospitals across five domains: food security, housing instability, transportation needs, utility difficulties, and interpersonal safety. **We support this measure and appreciate that CMS will allow hospitals to use their existing**

screening tools to meet the measure requirements. CMS should leverage mandatory reporting of this measure to help accelerate standards for HRSN data.

3. ***Adopting Screen Positive Rate for Social Drivers of Health measure***

CMS proposes adding this measure as a companion measure to the proposed Screening for Social Drivers of Health measure, which is intended to enhance standardized data collection for identifying high-risk individuals who could benefit from connection via the hospital to community-based services relevant to their HRSNs. The measure also could allow impact estimates for the effects of the included HRSN domains on hospitalizations and be valuable during discharge planning. CMS notes that the measure is not intended for comparisons among hospitals.

We do not support publicly reporting this measure. Publicly reporting the rate of positive screening would make hospitals that serve a larger population of marginalized and underserved communities appear as though they are lower performing, without adjusting for the impact of serving patients who are affected by multiple social drivers of health. Further, if patients see a high rate of positive screenings attributed to a hospital, they may avoid going to that hospital for care, which could reduce access. There are a myriad of benefits to hospitals collecting data on the rate of positive screenings, and using those data to inform their programs and policies addressing health equity. However, we do not see the benefit of this measure as a public reporting tool. **While CMS notes that this measure is not intended for hospital comparison, publicly reporting the results will encourage doing so.** The Measure Applications Partnership Health Equity and Rural Health work groups expressed similar concerns during their December 2021 meeting.

Rather than focusing on the positive screening rate, CMS should explore measures that assess how providers are closing the screening loop by addressing the needs identified in the screening. We do believe that screen positive rates would be helpful for hospitals to understand in aggregate or regionally. **We encourage CMS to explore modifying the screening of social risk measure to be a composite that includes subcomponents for screening positive rates.** For example, CMS could structure measure collection so that “screen positive”, “screen negative” or “did not screen” is captured for each domain. The aggregate rate would be the percentage of admissions with “screen positive” or “screen negative” for each of the domains. This would effectively convey the percentage of admissions that were screened (as in the screening measure) but provide CMS will additional drill-down data that is not publicly reported. The drill-down data could be used to provide national, regional, and local information on screen positive rates to hospitals. This would support hospitals overall understanding of how their patients social risk needs may vary from their communities and support coordination across providers to address social risk needs.

4. ***Adopting Cesarean Birth eCQM***

CMS proposes to add the Cesarean Birth electronic clinical quality measure (eCQM) to the Hospital IQR measure set, starting as a voluntary eCQM that hospitals could self-select for the CY 2023 reporting period. Hospitals would be required to report the eCQM beginning with CY 2024 reporting.

Premier generally supports adoption of maternal health measures and we have partnered with HHS’ Office of Women’s Health to leverage Premier’s data and proven performance improvement methodology to scale advancements in care for mothers and infants across the nation. However,

we are concerned about the reliability of the Cesarean Birth eCQM at this time. Only 15 hospitals submitted at least one quarter of CY 2020 production data to The Joint Commission. The measure has undergone very limited feasibility and reliability testing involving just 7 hospitals and two EHR systems. This eCQM version of the Cesarean Birth measure is currently under review by the NQF. **Premier recommends that additional measure testing be conducted and NQF endorsement be awarded prior to CMS adopting this measure into the Hospital IQR program.**

5. ***Adopting Severe Obstetric Complications eCQM***

CMS proposes a second maternal health measure for adoption into the Hospital IQR Program, the Severe Obstetric Complications electronic clinical quality measure. This measure would first be available as an eCQM that hospitals could self-select for CY 2023 reporting, but would then become mandatory beginning with CY 2024 reporting. CMS views this measure as a gateway to improving maternal morbidity rates nationwide.

Premier recognizes the potential value of measures that could inform initiatives and policies to reduce maternal morbidity overall and the disparities in rates associated with multiple demographic and social risk factors. However, we are concerned about the validity and feasibility of the Severe Obstetric Complications eCQM at this time. We note that multiple concerns about validity, feasibility, risk adjustment and clinical appropriateness were raised during review by multiple Measure Applications Partnership (MAP) Workgroups. The measure is currently under review by the NQF. **Premier recommends that CMS defer adoption of the measure into the Hospital IQR Program until the MAP's concerns are resolved during the NQF review process and the measure receives NQF endorsement.**

6. ***Adopting Hospital-Harm—Opioid-Related Adverse Events eCQM***

CMS proposes adding an outcome measure – Hospital Harm—Opioid-Related Adverse Events electronic clinical quality measure – to the Hospital IQR Program measure set beginning with the CY 2024 EHR reporting period. The measure uses naloxone (opioid antagonist) administration as a proxy for adverse events following opioid administration to inpatients. This measure has had a lengthy development history involving multiple refinements. As part of FY 2020 rulemaking, CMS proposed but did not finalize adoption of the measure into the Hospital IQR Program data set. The measure has since been refined and retested.

The Premier health alliance is generally supportive of adopting measures targeting the nation's opioid epidemic. In the past we did not support adoption of this measure due to concerns that some naloxone use captured by this measure was in fact not an unplanned response to impending harm to inpatients. However, we believe that subsequent measure specification refinements have substantially improved the specificity of the measure as a means to identify actual "recue use" of naloxone when patient harm is imminent. Therefore, **Premier now supports the refined measure as proposed for adoption into the Hospital IQR Program starting with CY 2024 reporting**. We do note that the overall number of inpatient naloxone rescue events is small and we recommend that CMS collect and analyze several years of measure results before considering the addition of this measure into any of the IPPS pay-for-performance programs or into other clinical settings.

7. ***Global Malnutrition Composite Score eCQM***

CMS proposes adding a nutrition measure -- Global Malnutrition Composite Score electronic clinical quality measure (NQF #3592e) -- to the Hospital IQR Program measure set beginning with the CY 2024 EHR reporting period. There are four measure components, one for each element of recommended, optimal, nutritional care: screening, complete assessment of patients screening positive, documentation of degree of malnutrition, and nutritional care plan development. The measure score would be an unweighted average of the four individual component scores.

Premier recognizes the substantial adverse effects on patient health that can results from nutritional disorders and their consequences in the inpatient setting. We support this measure conceptually but are concerned that it may be difficult for vendors to roll out and hospitals to operationalize given its interlocking component structure and separate component scores.

8. ***Adopting Hospital-Level Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) PRO-PM***

CMS proposes to adopt the Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #3559) into the Hospital IQR Program. This is a patient-reported outcome measure that includes standardized functional status data that is collected preoperatively and for one year postoperatively. Two sets of voluntary collection and submission periods would run from October 2022 through September 2024 and from April 2023 through September 2025, respectively. The first mandatory data collection and submission cycle would begin in April 2024 and run through September 2026, and measure results would be used for the FY 2028 payment determination year.

Premier generally supports the addition of patient-reported outcome measures to CMS quality programs related to clinical scenarios for which reliable outcome tools are available for patient completion. Hospitals participating in the Comprehensive Care for Joint Replacement (CJR) payment model have had the option of reporting this measure since the model began in 2016 in exchange for bonus points under the model's quality reporting program. However, CMS has not yet publicly released any results related to this measure. Many model participants have found that the burden of data collection for this measure outweighed any potential for bonus points for successful measure reporting. The completion rates for the measure have also been low despite the incentive for bonus points.

Premier does not support adoption of the THA/TKA PRO-PM measure to the Hospital IQR Program at this time. We strongly recommend that CMS not adopt this measure until it shares lessons learned from the CJR Program, including how it plans to address operational challenges identified by CJR participants.

9. ***Adopting Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA Measure***

CMS proposes to return the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA measure to the Hospital IQR Program beginning with the FY 2024 payment determination. The original measure version was removed from the Hospital IQR Program as part of burden reduction efforts during FY 2018 IPPS rulemaking. The measure is currently still in the HVBP Program. Since its removal from the Hospital IQR Program, the measure has undergone comprehensive review. The proposed measure differs from the original

measure by the addition of 26 ICD-10 diagnostic codes for mechanical complications to the numerator specifications. Statute requires CMS to adopt a measure and publicly display its results for at least one year prior to adopting it into the HVBP Program. As a result, if finalized, CMS plans to propose to adopt the revised measure into the HVBP Program at a future date.

Premier conceptually supports the adoption of the proposed revised version of the THA/TKA Complications measure into the Hospital IQR Program. However, we are concerned that this proposal will result in two slightly different measure specifications, which could yield differing results, one set for the Hospital IQR Program measure (revised measure) and a second set for the HVBP Program measure (original measure). This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to monitor and validate two different performance rates.

Premier recommends that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. Specifically, CMS should only publicly report the existing measure; allowing at least one year of reporting for the new measure before it is publicly reported. This will help improve the usability of data by consumers and reduce the potential for any confusion caused by two different publicly reported rates. CMS should also closely monitor the measure results for both programs and versions for unintended consequences, particularly during any period in which the measure specifications are not aligned. Finally, even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospital will still face when it comes to monitoring and validating performance using different measure specifications.

10. ***Adopting Medicare Spending Per Beneficiary—Hospital Measure***

CMS proposes to return the Medicare Spending Per Beneficiary—Hospital measure to the Hospital IQR Program beginning with the FY 2024 payment determination. The original measure version was removed from the Program beginning with the FY 2020 payment determination, because the administrative costs of the measure were judged to outweigh its benefits. However, the measure remains in the HVBP. Since that time, the measure has undergone comprehensive review. The proposed revised measure differs from the original measure by (1) adding new service inclusion and exclusion rules that reduce the capture of services outside of the control of providers, (2) allowing readmissions to trigger new episodes, and (3) modifying the measure calculation from sum of observed costs divided by sum of expected costs to mean of observed costs divided by expected costs. CMS plans to replace the predecessor measure that currently remains in the HVBP Program with the revised measure if finalized and once the statutory requirement for public display under the Hospital IQR Program have been met.

Premier conceptually supports the adoption of the proposed revised version of the MSPB-Hospital measure into the Hospital IQR Program. We ask that CMS provide example calculations under the revised and original measure versions to illustrate the potential effects of the proposed measure calculation changes. Further, we are concerned that for a period of one to two years, two slightly different versions of this claims-based measure will be applied to hospital performances, which could yield differing results between the Hospital IQR and HVBP programs. This could make it difficult for hospitals and consumers to accurately interpret performance results. Additionally, the policy will increase burden on hospitals as they will now be required to validate two different performance rates.

Premier recommends that CMS suppress one set of measure results from public reporting but maintain both results in the downloadable files. Specifically, CMS should only publicly report the existing measure; allowing at least one year of reporting for the new measure before it is publicly reported. This will help improve the usability of data by consumers and reduce the potential for any confusion caused by two different publicly reported rates. CMS should also closely monitor the measure results for both programs and versions for unintended consequences, particularly during any period in which the measure specifications are not aligned. Finally, even though the measures are calculated by CMS based on claims, CMS should remain cognizant of the increased burden that hospital will still face when it comes to monitoring and validating performance using different measure specifications.

Measures proposed for refinement

CMS proposes to refine two Hospital IQR Measures

1. ***Refining Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA and/or TKA***

   CMS proposes to adopt a refined version of the current Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA and/or TKA measure beginning with the FY 2024 payment determination. The measure numerator would be revised to include 26 additional ICD-10 diagnostic codes for complications of THA or TKA. The proposed update was developed as a result of routine measure maintenance review. The added diagnoses are the same as those proposed for addition to the THA/TKA Complication Measure, which is discussed above. **Premier supports adoption of the refined measure as proposed.**

2. ***Refining Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)***

   CMS proposes to refine the current Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) measure by increasing the minimum case count from 25 to 50 cases to address reliability concerns identified during routine measure maintenance review.

   As we have stated previously, **Premier continues to believe that the AMI EDAC measure should be removed from the Hospital IQR Program**. The proposed revision does not address concerns we have raised previously. Specifically, the measure lumps readmissions, observation stays and ED visits into a single category. However, each of these settings reflect widely different approaches to patient-centered care and cannot be meaningfully interpreted from a single number of days. Additionally, this measure was added on the assumption that then-new readmission measures would increase use of observation stays and ED visits, but evidence to support that assumption has not emerged.

eCQM Reporting Requirements

Increasing Total Number of eCQMs for Required Reporting

CMS proposes to modify the current eCQM reporting requirements by increasing the number of required eCQMs a total of four eCQMs (one mandatory and three self-selected) to six eCQMs (three mandatory and three self-selected), beginning with the CY 2024 reporting period/FY 2026 payment determination. The proposed increase would maintain alignment between the Hospital IQR and PIP programs.

Premier does not support increasing the number of eCQMs at this time. As we have noted previously, feedback to hospitals about their performances on eCQMs is infrequent and seldom helpful as a basis for performance improvement. Until regular, more frequent, and actionable eCQM performance feedback is provided, CMS should not increase the number of required eCQMs. We also strongly recommend that CMS address the eCQM reporting challenges before requiring additional eCQMs to be reported. Challenges include difficulties extracting data from "production-ready" eCQM products delivered by developers and insufficient time to complete testing, validation, staff education, and rollout of eCQMs before their reporting is required . Costs to hospitals also remain a substantial obstacle to eCQM adoption.

Addition of New Measures: Cesarean Birth and Severe Obstetric Complications eCQMs

CMS proposes to add the proposed Cesarean Birth and Severe Obstetric Complications eCQMs to the Hospital IQR Program measure set for a one-year period of optional, self-selected reporting in CY 2023, followed by mandatory reporting beginning with the CY 2024 reporting period. **Premier does not support the addition of these two measures to the eCQM list until CMS addresses concerns regarding feasibility and reliability, as well as NQF endorsement, which we detailed above.** Additionally, if adopted, CMS should maintain the two eCQMs as optional until which time hospitals have time to test, validate, and educate staff on these measures.

Maintaining CMS Program Alignment

Premier is appreciative of ongoing efforts by CMS to maintain alignment between the eCQM reporting requirements of the Hospital IQR and Promoting Interoperability programs. However, we do not regard maintaining alignment as a sole and sufficient justification for adopting flawed measures into either program.

PROMOTING INTEROPERABILITY PROGRAM

e-Prescribing Objective: Mandatory Reporting Query of Prescription Drug Monitoring Program

After several years of optional reporting under the e-Prescribing Objective, CMS proposes to require reporting of the Query of Prescription Drug Monitoring Program (PDMP) measure beginning with the CY 2023 EHR reporting period. CMS believes that PDMPs are now sufficiently accessible and integrated into health IT systems to allow reporting by hospitals without undue efforts. The mandatory measure would be expanded to include Schedules III and IV controlled substances (in addition to Schedule II), and satisfactory measure reporting would be valued at 10 points. Exclusions would be available for hospitals lacking access to a pharmacy that can accept electronic prescriptions for controlled substances and those who cannot report on this measure in accordance with applicable law. The PDMP query must occur before electronic transmission of the associated controlled substance prescription. CMS hopes to transition the measure from its current Yes/No response to a scored numerator/denominator-based configuration in the future.

Premier is generally supportive of measures addressing opioid use in inpatient and ambulatory settings. We support measure expansion to include Schedule III and IV controlled substances. However, **we strongly recommend that Query of PDMP measure reporting remain optional until ongoing challenges are addressed.** CMS needs to address residual inconsistencies across state PDMPs and to

work with states to resolve the barriers to data access by clinicians that are presented by heterogeneous state licensing requirements. For example, the state of Missouri PDMP remains untested and RxCheck remains in the prototype testing stage. If CMS wants to promote routine electronic queries of PDMPs, it should work with ONC to support development of data and interoperability standards that would enable this type of electronic exchange. CMS should work with ONC to include data elements within the USCDI and functionality within CEHRT to enable better monitoring and reporting of opioid-related care, treatment, and outcomes. Additionally, given the ongoing criticality of addressing issues regarding opioid use, we once again urge CMS and ONC to identify and prioritize the need for revised or new CEHRT criteria as well as the potential need for development, adoption and support for additional data, interoperability, and transmission standards.

Health Information Exchange (HIE) Objective: Measure Addition and Scoring Modification

CMS proposes to add a new measure – Enabling Exchange under TEFCA (Trusted Exchange Framework and Common Agreement) – to the HIE Objective beginning with the CY 2023 EHR reporting period. The new measure would serve as a third alternative by which hospitals could satisfy the HIE Objective requirements (i.e., in addition to either reporting the HIE Bi-Directional Exchange measure or the pair of referral loop support measures – sending and receiving/reconciling). Credit for the proposed measure would be awarded when a hospital attests to 1) participating as a TEFCA Framework Agreement signatory, and 2) under the Framework Agreement is using the functions of CEHRT, in production, to support bidirectional exchange of patient information. Concomitantly, CMS proposes to change the total points available under this objective from the current 40 points to 30 points. The deleted 10 points would be transferred to the e-Prescribing Objective's Query PDMP measure, as that measure is proposed to change from optional, bonus-point reporting to required beginning with CY 2023 reporting.

Premier appreciates the efforts by CMS to encourage the use of interoperable health IT and to increase Promoting Interoperability Program reporting flexibility for hospitals.

Premier remains cautiously optimistic that TEFCA, once fully implemented, will help achieve nationwide interoperability as envisioned by the ONC Interoperability Roadmap and the 21st Century Cures Act. However, progress towards TEFCA implementation is slow and incremental and much remains to be accomplished to operationalize TEFCA. We caution CMS about offering new measures such as Enabling Exchange under TEFCA before additional TEFCA milestones are confirmed and achieved.

Public Health and Clinical Data Exchange Objective: Mandatory Measure Addition, Active Engagement Revisions, and Scoring Modifications

CMS first proposes a new measure -- Antimicrobial Use and Resistance (AUR) Surveillance – be added for mandatory reporting beginning with the CY 2023 EHR reporting period, resulting in a total of five mandatory measures and two optional measures under this objective.8 Hospitals reporting a "Yes" response or meeting an exclusion criterion would receive credit for the measure. **Premier supports the addition of this measure.** We do remain concerned about holding hospitals responsible for any mandatory measures prior to such functionality or capabilities being incorporated into ONC's certification criteria and the conditions and maintenance of certification requirements.

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[8] The four currently mandatory measures are Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Reportable Laboratory Results Reporting, Electronic Case Reporting; the two optional measures are Public Health Data Registry Reporting and Clinical Data Registry Reporting.

For this objective, CMS also proposes to incent hospitals to more quickly reach a higher level of active engagement in reporting measures under this objective by revising the current level options beginning with the CY 2023 EHR reporting period. Hospitals would only be allowed to remain at the revised Option 1 Level – Pre-production and Validation – for a single EHR reporting period before moving to the Option 2 Level – Validated Data Production. CMS further proposes that a hospital would be required to submit its engagement option level for each of the measures it reports, whether mandatory or optional. A hospital would be permitted to remain at revised Option Level 1 for one additional year if the hospital switches between one or more clinical data registries or public health agencies. **Premier supports the proposed changes to the active engagement level requirements as part of a renewed commitment to public health reporting throughout the healthcare delivery system triggered by the COVID-19 PHE.**

Finally, CMS proposes to adjust scoring of the Public Health and Clinical Data Exchange Objective beginning with the CY 2023 EHR reporting period to further emphasize the significance of public health data exchange by hospitals with clinical registries and public health agencies. The points available for reporting mandatory measures under this objective would increase from 10 points currently to 25 points; awarding of points requires reporting for all of the mandatory measures. The added 15 points would come from reducing the points associated with the Provide Patients Electronic Access to Their Healthcare Information measure under the Provider to Patient Exchange Objective from the current 40 points to 25 points. This scoring change combined with that proposed under the HIE Objective would result in the following PIP point distribution: 20 points for the e-Prescribing Objective, 30 points for the HIE Objective, 25 points for the Provider to Patient Exchange Objective, and 25 points for the Public Health and Clinical Data Exchange Objective. The COVID-19 PHE has clearly demonstrated the importance of smooth flow of information between hospitals and public health agencies, and Premier supports the proposed higher value for the Public Health and Clinical Data Exchange Objective.

Public Reporting of Medicare Promoting Interoperability Data

CMS proposes to begin reporting of individual hospital overall Promoting Interoperability Program scores accompanied by their CMS EHR certification IDs, beginning with the CY 2023 EHR reporting period. Hospitals would have a 30-day preview period before data would be publicly posted to the Care Compare website.

Premier generally supports providing Medicare beneficiaries and the public with hospital performance data. However, we are somewhat skeptical that hospital overall Promoting Interoperability Program scores and the identity of hospitals' EHR products will be of interest to or understandable by beneficiaries. We also doubt their usefulness to beneficiaries during their healthcare decision making. CMS may wish to consider instead adding the hospital Promoting Interoperability Program scores information to the downloadable database (Provider Data Catalog). If and when CMS considers expanding the publicly reported Promoting Interoperability Program scores data, we strongly recommend that 1) measures for public reporting should demonstrate stable performance profiles; 2) performance results should represent meaningful differences; 3) measures have been confidentially reported to hospitals for at least two years; and 4) measures have results that are easily understood by patients as determined in consultation with patients and other stakeholders.

Promoting Interoperability Program eCQM Requirement Changes

CMS proposes modifications to continue the alignment between eCQMs in the Promoting Interoperability Program scores and the Hospital IQR Program: adding two eCQMs for required reporting (Cesarean Birth and Severe Obstetric Complications) and thereby increasing the total number of required eCQMs to six

beginning with the CY 2024 EHR reporting period. Voluntary, self-selected reporting of the two new measures would be an available option for CY 2023.

Premier remains appreciative of the continued efforts made by CMS to maintain alignment between the eCQM requirements of the Promoting Interoperability Program scores and the Hospital IQR Program. While Premier is not opposed to gradually increasing the number of required eCQMs over time, we continue to have concerns that eCQM adoption by providers remains a costly and prolonged process and we recommended a phased, incremental timeline. Regarding the two proposed new measures, we have already described several methodological concerns about them in our Hospital IQR Program comments above. Should these two measures be finalized, we do not support their proposed mandatory reporting in either the Promoting Interoperability Program scores or the Hospital IQR Program. We strongly recommend that CMS instead make the two measures eligible for self-selection by hospitals beginning with the CY 2024 EHR reporting period and subsequent years.

CONCLUSION

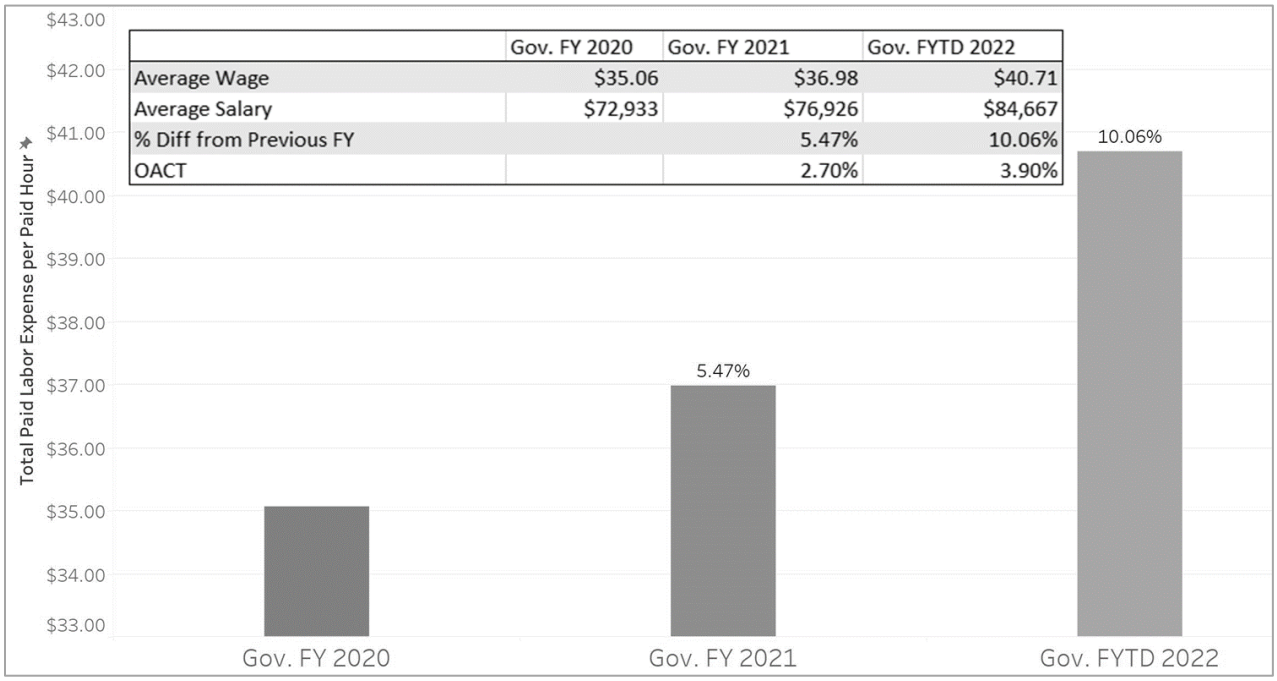
In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the IPPS proposed rule. If you have any questions regarding our comments or need more information, please contact Soumi Saha vice president, advocacy, at soumi_saha@premierinc.com or 202.879.8005.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance

APPENDIX

Figure 1: Percent Change Year over Year Total Paid Labor Expense (Excl. Bonuses) Per Paid Hour (All Staff + All Hour Types)



	Gov. FY 2020	Gov. FY 2021	Gov. FYTD 2022
Average Wage	$35.06	$36.98	$40.71
Average Salary	$72,933	$76,926	$84,667
% Diff from Previous FY		5.47%	10.06%
OACT		2.70%	3.90%