Trinity Health

September 17, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies proposed in CMS-1753-P. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns $1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models.

Trinity Health participates in 11 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes five markets partnering as an MSSP Track 3 ACO. We also have three markets partnering as a Next Generation ACO and 2 participating in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Outpatient Prospective Payment System Comments

Use of CY 2019 claims data for CY 2022 OPPS and ASC rate setting

Due to the COVID-19 impact on most recent claims data that significantly affected outpatient service utilization, CMS proposed to use CY2019 data for rate setting for CY2022 rather than use CY2020 data.

Trinity Health agrees COVID-19 has skewed CY2020 data and supports using CY2019 data for rates setting.

Changes to the inpatient only (IPO) list

CMS proposes to halt the three-year phased elimination of the IPO list that was finalized in CY 2021 and conducted a clinical review of the services removed from the IPO list last year. As a result, CMS proposes to add back the 298 services removed in the CY2021 final rule.

Trinity Health was concerned when CMS finalized removal of the 298 procedures in last year's rule without evaluating clinical effectiveness and supports adding these procedures back. The IPO list is a guardrail that was put in place to protect beneficiaries; many of its services are surgical and high risk. They are complicated and invasive procedures with the potential for multiple days in the hospital, an arduous rehabilitation and recovery period, and which require the care and coordinated services provided in the inpatient setting of a hospital**. Overall, we urge CMS to more fully consider stakeholder concerns related to the burden and implementation challenges of future policies and to take it slow rather than moving forward with a regulatory requirement and then needing to re-adjust when the process does not work. In several of these cases, concerns raised by hospital stakeholders could be adapted and requirements adjusted on the front end of the implementation process, rather than adjusting a process that was extremely burdensome to put into place.**

In addition, once a procedure is removed from the IPO, it usually ends up on the ambulatory surgical center (ASC) covered procedures list (CPL). **For future years, after evaluating clinical effectives and determining an item will be removed from the IPO list, CMS should provide more clarity around appropriate settings.** For example, for non-inpatient services, when is a hospital outpatient department more appropriate compared to an ASC? **In addition, we recommend CMS create ASC exclusion criteria for services removed from the IPO list and national guidelines for screening patients to determine appropriate setting.**

Further, CMS must acknowledge the administrative burden providers face from Medicare Advantage (MA) plans and commercial payers. As evidenced by services removed from the IPO list in recent years, health plans use less expensive settings as the default that require lengthy appeal and prior authorization processes to override these defaults—making it harder to ensure patients receive care in the safest, most appropriate setting. If a physician determines a patient would be best served in a specific setting, MA plans (and commercial payers) should not create barriers to receiving care. **To mitigate these practices, we urge CMS to develop national guidelines outlining patients who are appropriate candidates for inpatient vs outpatient authorization, as well as for patients who are reasonable candidates for same day discharge. We believe this would create standardization and help mitigate denials from payers.**

Medical review of certain inpatient hospital admissions under Medicare Part A (2-Midnight Rule)
For CY2022, CMS proposes to revert back to the CY2020 policy of exempting procedures removed from the IPO List from site-of-service review and claims denial for noncompliance with 2-midnight rules for two years following removal from IPO List

Trinity Health recommends CMS maintain the existing policy finalized in CY2021 that would exempt these procedures from site-of-service review and claims denial until a certain percent can be performed on an outpatient basis.

340B Drug payment policy
CMS proposes to continue to pay 340B drugs at Average Sales Price (ASP) minus 22.5%.

Trinity Health is deeply disappointed CMS proposes to continue these deep payment cuts to 340B hospitals and urges CMS to reverse this policy. These cuts are inconsistent with Congressional intent of the 340B Program, represent a further assault on safety-net institutions, and continue to strain our ability to better serve our patients and communities. CMS should immediately restore payments to the appropriate statutory levels and refrain from implementing any future reduction.

Trinity Health is Committed to those who are poor and underserved, we return $1.2 billion to our communities annually in the form of charity care and other community benefit programs. We care for a significant number of vulnerable populations, including low-income patients and those on Medicaid or who are uninsured. The 340B Program provides essential savings critical to helping our eligible hospitals comprehensively serve the most vulnerable and improve the health of communities across the country. Further, the program enables these statutorily eligible Medicaid participating facilities to purchase certain outpatient drugs at discounted prices from manufacturers. Congress created the 340B Program to enable participating entities to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services" and we believe this intent remains relevant today.

In addition to supporting important un-reimbursed and under-reimbursed services for the community, including mental health, cancer and obstetric care, our hospitals use discounts available on certain 340B-priced drugs to provide access to medications that would otherwise be financially infeasible to provide. The cuts to Medicare Part B payments for 340B drugs challenge our ability to continue to offer these and many other services and programs.

Equitable adjustment for devices, drugs, and biologicals with expiring pass-through status
As a result of its proposal to use CY 2019 claims data for CY 2022 rate setting, CMS proposes to use its "equitable adjustment authority" to continue to provide separate payment for up to four additional quarters for 27 drugs and biologicals and one device category whose pass-through payment status will expire between Dec. 31, 2021 and Sept. 30, 2022.

Trinity Health supports this policy.

Allergy testing - recalibration of codes
While not addressed in the regulation, Trinity Health has noted over time our reimbursement for certain codes, including for skin allergy testing, has increased significantly. This procedure is often performed in sequences ranging from 4 – 20 tests during a single visit. The code is reported in units, one for each allergen tested.

The procedure is relatively routine and the most complex sequence consumes approximately one hour of staff time in office followed by patient instruction for home monitoring for 48 hours (95044). However, most tests are concluded in office after administration and relatively short (20 – 30 minute) observation (95004). As demonstrated below, a single unit of 95004 has increased in reimbursement 2,125% since 2014, currently at $919.82 for 2021 and proposed $943.46. This could potentially result in $20,000 reimbursement for a relatively routine and frequently performed in office procedure.

We have noted with the elimination of status indicator X (Ancillary procedure) procedures in 2014, that reimbursement rates have increased exponentially as demonstrated in the tables below. Our primary concern however is with the rates for the allergen testing codes 95004 and 95044.

We aim to be good partners and fiscal stewards with CMS and recommend CMS review the significant reimbursement for these codes to ensure they are being reimbursed appropriately.

Addendum B.-Final OPPS Payment by HCPCS Code for CY 2014 *CPT codes and descriptions only are copyright 2012 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2012 American Dental Association. All Rights Reserved.*									Payment Rate						
HCPCS Cod	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayme	Minimum Unadjusted Copayme	2015	2016	2017	2018	2019	2020	2021
0058T	Cryopreservation ovary tiss	CH	X	0344	2.4724	$179.67		$35.94	$183.62	$102.20	$103.83	$129.17	$144.73	$143.48	$0.00
0059T	Cryopreservation oocyte	CH	X	0344	2.4724	$179.67		$35.94	$0.00	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
0106T	Touch quant sensory test	CH	X	0341	0.1720	$12.50		$2.50	$52.35	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
0107T	Vibrate quant sensory test	CH	X	0341	0.1720	$12.50		$2.50	$52.35	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
0108T	Cool quant sensory test	CH	X	0341	0.1720	$12.50		$2.50	$131.69	$55.94	$54.53	$55.96	$55.90	$55.01	$55.66
0109T	Heat quant sensory test	CH	X	0341	0.1720	$12.50		$2.50	$52.35	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
0110T	Nos quant sensory test	CH	X	0341	0.1720	$12.50		$2.50	$52.35	$91.18	$99.98	$105.03	$106.48	$109.02	$111.95
0179T	64 lead ecg w/tracing	CH	X	0100	3.3604	$244.21		$48.85	$237.95	$30.51	$28.37	$0.00	#N/A	#N/A	#N/A
0208T	Audiometry air only	CH	X	0035	0.3042	$22.11		$4.43	$43.31	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
0209T	Audiometry air & bone	CH	X	0035	0.3042	$22.11		$4.43	$43.31	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
0210T	Speech audiometry threshold	CH	X	0035	0.3042	$22.11		$4.43	$43.31	$30.51	$28.37	$31.80	$32.12	$33.43	$33.84
95004	cut allergy skin tests	CH	X	0370	0.5687	$41.33		$8.27	$131.69	$91.18	$263.49	$444.36	$912.79	$908.84	$919.82

Addendum B.-Final OPPS Payment by HCPCS Code for CY 2014 *CPT codes and descriptions only are copyright 2012 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2012 American Dental Association. All Rights Reserved.*									Payment Rate	Percent Change
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	2021	2021
36425	Vein access cutdown > 1 yr	CH	X	0035	0.3042	$22.11	.	$4.43	$270.22	1122.2%
85097	Bone marrow interpretation	CH	X	0433	0.5027	$36.53	.	$7.31	$656.15	1696.2%
86885	Coombs test indirect qual	CH	X	0345	0.1668	$12.12	.	$2.43	$149.16	1130.7%

86905	Blood typing rbc antigens	C H	X	0345	0.1668	$12.12	.	$2.43	$291.26	2303.1%
86921	Compatibility test incubate		X	0345	0.1668	$12.12	.	$2.43	$149.16	1130.7%
86950	Leukacyte transfusion	C H	X	0345	0.1668	$12.12	.	$2.43	$149.16	1130.7%
88333	Intraop cyto path consult 1		X	0433	0.5027	$36.53	.	$7.31	$656.15	1696.2%
95004	Percut allergy skin tests	C H	X	0370	0.5687	$41.33	.	$8.27	$919.82	2125.6%
95044	Allergy patch tests	C H	X	0370	0.5687	$41.33	.	$8.27	$919.82	2125.6%
G0455	Fecal microbiota prep instil	C H	X	0340	0.7353	$53.44	.	$10.69	$809.60	1415.0%

Request for emergency department (ED) level national standard

Trinity Health urges CMS to develop a national standard for ED visit guidelines for all ED levels. Hospitals are required to treat patients who present at the ED and Commercial payers have developed their own standards that are inconsistent and lead to payment denials.

Outpatient Quality Reporting Program (OQR)

For OQR, CMS proposes to adopt three new measures, remove two measures, and resume the implementation of 2 additional measures.

Trinity Health supports the addition of the COVID-19 Vaccination among Health Care Personnel measure, Breast screening recall rates measure, and the ST-Segment Elevation Myocardial Infarction (STEMI) eCQM. In addition, we agree with removing the measures Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (OP-2) and Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3) as the proposed eCQM for ST-Segment Elevation Myocardial Infarction appropriately replaces these manually abstracted measures and also supports the CMS long-term goal of utilizing electronic measures and eliminating manual abstractions. **However, we do not support the proposed new measure Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31) measure and urge CMS not to finalize.** Cataract surgery is very successful; data from a study of 368,256 cataract surgeries show that corrected visual acuity CDVA of 0.5 (20/40) or better was achieved in 94.3% and CDVA of 1.0 (20/20) or better was achieved in 61.3% of cases (Lundstrom, Barry, Henry, Rosen & Stenevi, 2013); data from a UK multi-center Cataract National Dataset found a postoperative visual acuity of 6/12 (20/40) or better was achieved for 94.7% of eyes with no co-pathologies and in 79.9% of eyes with one or more co-pathologies (Jaycock et al., 2009). **Given these studies, we question the value of implementing this measure at this**

time. **However, if the CMS data collected through voluntary submission of OP-31 indicate that there is still sufficient opportunity for improvement, we would support a measure that aligned with the CMS plan to reduce data collection burden and utilize electronic clinical quality reporting.** While this manual measure has historically been a voluntary measure to date, it is a labor intensive measure. Visual function testing is completed at physician offices, not at the hospital. This measure requires the hospital to establish a process to collect data from physician offices in order to report the data to CMS. This is the only CMS quality measure that would require hospitals to report data collected outside of the hospital where quality reporting is dependent upon physician office practices and responsiveness to the hospital's requests. **The manual collection of data outside of the hospital is not in alignment with the CMS long-term strategy of reducing quality reporting burden or utilizing electronic reporting and eliminating manual processes for data collection.**

In addition, Trinity Health supports the proposed changes to the OQR data validation process beginning in the 2022 reporting period. **However, we urge CMS to coordinate the OQR and Inpatient Quality Reporting (IQR) to ensure that hospitals that are selected for validation are only required to do validation for either the OQR or IQR program---not both simultaneously.**

Validation is a labor-intense year-long process for the quality and health information management departments, where resources are limited. The same staff are supporting improvement initiatives for abstracted measures, eCQMs, and clinical processes. When resources are repeatedly required for administrative processes involved in validation, their availability for important quality improvement initiatives is reduced. **Trinity Health urges CMS to consider this process recommendation.**

ASC Payment

Proposed changes to the list of ASC-covered surgical procedures

CMS proposes to re-adopt the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020 and remove 258 of the 267 procedures that were added to the ASC CPL in CY 2021.

A procedure that can be furnished in a hospital outpatient setting is not necessarily safe and appropriate to perform in an ASC setting. **Trinity Health applauds CMS for reverting back to these policies and doing its due diligence to give careful consideration to safety risks and concerns to beneficiaries prior to determining whether procedures are appropriate in an ASC setting.**

ASC quality reporting (ASQR)

CMS proposed a new measure, Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures (ASC 15a-e).

Trinity Health is supportive of ASC-15a-e as it will provide more real time quality data; however, we urge CMS to delay implementation until 2024. Hospitals are facing staffing shortages and administrative burdens due to the ongoing COVID-19 pandemic and other federally regulated requirements.

Comment solicitation on temporary policies for the COVID-19 public health emergency (PHE)

CMS seeks comment on what flexibilities provided under OPPS during the PHE should be made permanent.

Trinity Health appreciates all of the flexibilities provided by CMS during the ongoing COVID-19 pandemic that have allowed us to be responsive to the crisis. **We urge CMS to maintain provider authority to**:

- Provide care and monitoring through telehealth,
- Furnish services in which the direct supervision was met by the supervising practitioners being available through audio and visual technology, and
- Maintain payment under OPPS for specimen collection for COVID-19. After the PHE ends, there will still be a need for COVID-19 specimen collection including additional PPE. We urge CMS to retain the current code and payment allowance.
- Reimburse the facility component of telehealth provided in a provider-based clinic. If physician office (clinic) visits will be allowed as telehealth after the PHE ends, the technical component of telehealth provided in a provider-based clinic needs to be reimbursable as CMS has recognized during the PHE that the hospital incurs costs even when the visit is provided via telehealth.

Price transparency

CMS proposes a number of modifications to hospital price transparency requirements, including significant increases to the civil monetary penalty (CMP) for noncompliance and clarifications around machine readable files and price estimator tools.

Civil monetary penalty

CMS proposes to scale up the CMP based on bed count, with a minimum of $300/day for small hospitals and an additional $10/bed/day for larger hospital with a daily cap of $5,500.

The hospital price transparency regulations are incredibly complex, and unlike the insurer requirements, hospitals are not getting additional time to implement. For example:

- Hospitals don't contract at the CDM detail level. This requires all hospitals to develop unique allocation formulae from rate to CDM – potentially for each payer rate schedule.
- It is very difficult to predict all the services a patient will receive prior to admission or procedure. It's more likely for simpler procedure but as complexity and patient comorbidity factors increase, so does the ability to project services.
- Hospitals do not have real time access to patient benefits and deductibles. We can query insurers for the information but that impedes the ability to provide real time price transparency tools.

In addition to the insurer price requirements, there are also additional price transparency requirements for hospitals in the surprise billing regulation. **Prior to increasing the CMP, Trinity Health urges HHS to align all price transparency requirements in a way that is useable and helpful for consumers. In addition, this would reduce administrative burden, duplication, and patient confusion.**

Price estimator tools

CMS seeks comment on best practices for price estimator tools, common data elements that should be included, and technical barriers that exist to providing patients with accurate, real-time out-of-pocket estimates.

Trinity Health appreciates how helpful the price estimator tool can be for patients as they plan financially for their care. We provide as up to date insurance information as we can; however, deductibles remain a problem. At any point, an insurer could pay another claim that would change the estimate. In addition, insurers can make changes to a patient's benefit level or site of service that would impact hospital estimates.

In addition, price transparency without a quality component does not provide patients with a clear picture of the type of care they would be receiving at a given facility.

Radiation Oncology (RO) Model

Trinity Health supports including radiation oncologists in quality payment programs; however, we are disappointed Centers for Medicare and Medicaid Innovation has not modified or improved the RO model after engaging stakeholders over the last few years. As currently structured, the RO model focuses on significant payment cuts to radiation oncology—on top of additional payment cuts from elsewhere in the rule---and not health care transformation.

We urge CMMI to make the following changes prior to implementing the RO Model to make it fair, equitable, and truly value-based:

- Grant temporary exemptions from CEHRT in certain unique circumstances. Trinity Health is in the middle of a system-wide phased implementation of Epic across our 22-sttate footprint with the express intent of attaining the Triple Aim. The RO Model CEHRT requirement imposes an undue financial and administrative burden.
- Establish rate stability through the application of a discount factor set at 3% or less and address the impact of continued MPFS payment cuts on RO Model participants.
- Recognize the significant impact that COVID-19 has had on participating practices through the establishment of a COVID-19 adjustment.
- Eliminate barriers to Advanced APM status, including the waiver on the application of the 5% bonus on freestanding technical payments.
- Address the impact of the RO Model on rural practices and those serving disadvantaged practices through the establishment of a Health Equity Achievement in Radiation Therapy payment to cover wraparound services.

In addition, we support recommendations submitted by the American Society for Radiation Oncology (ASTRO).

Equity request for information

Trinity Health supports the Administration's efforts to advance health equity through the work of the Health Equity Task Force, recent requests for information (RFI), and proposed changes in Medicare quality measurement and payment systems. As a system, we acknowledge that racism exists in both health care delivery and financing and that it is a root cause of health inequities. This lack of equity is reflected in limited access to care, restricted affordability, and exacerbated biases that impact health care decision-making and health outcomes.

The Trinity Health Mission and Core Values compel us to advocate for change to the systemic policies that limit and shape opportunities for minority and underserved populations. We have undertaken systemwide efforts led by our senior leadership to examine our role as a health system in advancing equity in every community we serve. As part of this effort, we have developed a set of principles to guide our journey to health equity, which can be found here. The Core Values of reverence, commitment to those who are poor, safety, justice, stewardship and integrity guide this work to improve the health of all communities and dismantle barriers to inequities in health care.

Our comments are aligned with and in support of these principles and goals. We welcome the opportunity to partner with and be a resource to HHS by sharing our experiences and lessons learned as Trinity Health continues on the path to health equity.

Below, we offer comments in support of these shared goals on the three areas included in the RFI: 1) stratifying quality measures by race and ethnicity, 2) improving demographic data collection, and 3) creating a Hospital Equity Score (HES).

Stratification of Quality Measures by Race and Ethnicity
Trinity Health supports efforts to expand stratification of quality measures beyond dual eligible status to race/ethnicity and to include those social factors that impact beneficiary health outcomes, such as housing. We believe it is critical to have accurate and complete information on race/ethnicity, and eventually other social factors that contribute to health, to identify areas where interventions are needed to reduce health disparities and close the health equity gap. However, interventions that are designed using incomplete or inaccurate data will not achieve our shared goals to advance health equity.

In regard to CMS' request for feedback on the benefits and challenges of using indirect estimation for race/ethnicity data, we understand CMS intends to use this method to improve missing race/ethnicity data for reporting purposes at this time and we fully support CMS' focus on minimizing provider burden. However, indirect estimation may not yield accurate data on race/ethnicity, which would seriously limit its utility and could inadvertently lead to the creation of interventions or efforts that do not achieve the intended goals of identifying where disparities exist and advancing equity in the longer term. For instance, race/ethnicity information provided through Medicare claims data are often inaccurate. At a minimum, CMS should provide additional information on the methods that would be used for indirect estimation of race/ethnicity so stakeholders can help assess if the approach would be a helpful stopgap until complete and accurate information are available for all beneficiaries. **Trinity Health urges CMS to focus on developing a plan with providers and other stakeholders to collect race/ethnicity data in a centralized and standardized manner and would discourage using indirectly estimated data for any reporting or payment purposes in the meantime.**

CMS also requested stakeholder feedback on ways to address challenges in defining and collecting demographic information. Again, we believe collecting standardized and accurate information on identified demographic variables, including race/ethnicity, disability, language preference, and housing status, among other variables is foundational to advancing health equity. However, collecting these data at point of admission will require significant training of staff to ensure standardization and accuracy. Our ministry in New York is participating in a CMS pilot, which includes screening for social determinants of health (SDoH). They have used and integrated an abbreviated 8-question tool, but have found that it has been difficult to integrate even a short questionnaire into staff workflow at point of care. From our experience, we have found there is a hesitancy among the workforce to ask about these social and demographic aspects of public health data.

We recommend that CMS explore ways to collect certain demographic variables at point of enrollment in Medicare that would be shared with providers (e.g., race/ethnicity, language preference) so that they are actionable. We also urge CMS to work towards collecting key demographic data using interoperable health information exchange at point of care to ensure communication of both fixed and changing demographic and social factors to providers. **In addition, specific training and educational**

supports are necessary to support staff in addressing the social aspects of how these questions are asked and incorporated into different workflows – and at multiple points in the health care continuum.

Demographic Data Collection to Synthesize Results Across Social Risk Factors
Trinity Health supports efforts to expand and standardize collection of demographic factors such as disability and language preference. **We ask CMS to consider adding housing status, written and spoken primary language, and veteran status as additional factors to be included as part of a minimum set of demographic data elements.** Our system is working with Epic and other health system partners to standardize collection of housing status, among other variables, given the well-documented relationship between housing and health outcomes. Trinity Health would welcome the opportunity to share additional information on these efforts with CMS. In addition, we recommend that CMS examine how Medicaid managed care organizations (MCOs) collect demographic data through comprehensive assessments and the applicability of or lessons learned from this approach that could be applied to the Medicare program.

We believe that standardized, accurate and robust data collection should include race/ethnicity, gender identity and sexual orientation, and that these data should be reported and shared between health systems, other clinical providers, public health departments and government for disease prevention, detection and mitigation. Further, health care and public health professionals should use a mandated standardized data set that includes data elements such as race/ethnicity, gender identity, and sexual orientation.

CMS requested stakeholder feedback on the collection of a defined set of demographic data at the time of admission. We agree with CMS that demographic data collection efforts should be based on standardized electronic data definitions and should be available to providers via interoperable health information exchange. **As CMS develops potential approaches for collecting demographic data at point of admission, the Agency should consider challenges unique to sub-populations of beneficiaries.** For instance, we have found it is very challenging to collect demographic information for homeless patients – and that successful collection requires one-on-one discussion, which is time and resource intensive. **We also recommend that all demographic information be self-reported to ensure accuracy and to eliminate the potential for any bias on the part of those collecting data.**

Creation of a Hospital Health Equity Score (HES)
In the summer of 2020 as the impacts of COVID-19 on minority and unreserved communities became clearer, Trinity Health initiated a systemwide effort led by our senior leadership, including our system CEO, to examine our role as a health system in advancing equity across all of our communities. As part of this effort, we have developed a set of principles to guide our journey to health equity, which can be found here. We have engaged representatives from all of our regional health ministries to both develop our guiding principles and to implement these principles locally to reflect each community's unique strengths, challenges, and needs. We believe our experience can provide an example of how health systems can commit to health equity from the very top to all parts of the organization – and work with the communities we serve to shape these efforts.

As CMS considers creating a hospital Health Equity Score (HES), we would like to share that in our experience this work is local and should reflect the uniqueness of each community. We urge that the Agency allow for local customization and not create a prescriptive HES that may not accurately reflect a hospital's commitment to and work within its community. We also recommend that CMS develop a hospital-specific methodology and approach and not simply apply the Medicare Advantage (MA) HES to the hospital setting

given the differences between the roles of payers and providers – especially health systems – that are trusted members of communities.

Last, Trinity Health is also a safety net provider in many of the communities we serve. We are concerned that hospitals that are working to advance health equity are also often reimbursed at lower rates by commercial payers and are more reliant on Medicaid payments given the patients they serve. For example, a report released by the Massachusetts' Attorney General noted that studies have shown that safety net providers serving more vulnerable populations have been paid less than those who serve populations with fewer health and social challenges.[1] The report recommends that policymakers take steps to ensure payment rates adequately support care for patients in high-need communities. CMS should ensure that any HES would not have the unintended effect of holding reimbursements for these providers at lower levels or further exacerbating gaps between hospitals.

Hospital-Wide All-Cause Unplanned Readmission (HWR) Measure Within Hospital IQR Program
Trinity Health supports efforts to expand stratification, such as for the HWR measure, beyond dual eligible status to include race/ethnicity. However, it is critical to have accurate and complete information on race/ethnicity to identify where and with which populations interventions are needed to reduce disparities in readmissions. The use of data derived from indirect estimation or data that are incomplete or inaccurate will not achieve our shared goals to advance health equity. **We urge CMS to ensure that any stratification of the HWR or other measures uses accurate and complete data and are not publicly reported or used for payment purposes until that point.** Additional comments are provided below in response to proposals to create a hospital leadership engagement in health equity measure and changes to the Hospital Readmissions Reductions Program (HRRP).

Hospital Leadership Engagement in Health Equity Performance Data Measure Hospital IQR Program
Trinity Health has learned important lessons as we have undertaken our national and local effort to advance health equity. We fully agree with CMS that leadership plays an important role in establishing an organizational culture of quality and safety, but stress that this work is very local and CMS should not be too prescriptive.

We recommend CMS partner with health systems and incentivize more community collaboration that is done in line with community needs assessments. Trinity Health is committed to advancing health equity and social determinants of health in our communities. Examples of our commitments include:

- Investing more than $1.3 billion in community benefit in FY20.
- Committing $75 million to the Community Investing Program for initiatives to support low interest loans to community developers and community development finance institutions. Initiatives include housing, community facilities, education, and economic development.
- Committing $2 million annually to internal projects that directly address the needs of those who are poor and vulnerable.

[1] Office of Attorney General Maura Healey, Building Toward Racial Justice and Equity in Health: A Call to Action. Accessed June 15, 2021.

- Established the Community Health Institute for grants to community-based organizations to support innovation in community health improvement. Institute funding has accelerated strategies around tobacco cessation, school wellness, early care and education, breastfeeding, and community food access. In addition, funding from the Institute was also used to provide COVID-19 funding grants to local community-based organizations, focusing on communities of color and vulnerable communities.

- Working with local public health and community-based organizations to vaccinate vulnerable populations including a $1.6 million COVID-19 vaccine education and awareness campaign, It Starts Here. Our partnership in Philadelphia was profiled in the New England Journal of Medicine.

- Using embedded social needs screenings in the EPIC platform and are the first customers to embed the Aunt Bertha social care application into EPIC to integrate social and clinical care.

- Founding members of the Healthcare Anchor Network, a growing national collaboration of 60 health systems from across the country working to improve health and wellness by leveraging their assets, including hiring, purchasing, and investment for equitable, local economic impact.

Last, we also recommend that CMS consider the role of hospitals in conducting needs assessments that would support health equity interventions and initiatives and their implementation in the development of a health equity performance measure.

Hospital Readmissions Reduction Program (HRRP) Changes
As CMS considers stratifying results by race/ethnicity, as well as other factors for measures included in the HRRP, we urge the Agency to again ensure that any data used for stratification are complete and accurate. We are also concerned that CMS' timeline for stratifying measures and providing them to hospitals in confidential HSRs in the spring of 2022 is too short given that race/ethnicity data are likely to be indirectly estimated. **Conceptually, we agree these data could be very helpful to hospitals in identifying gaps and advancing equity, but the stratification, confidential reporting, and then eventual public reporting must be done with consideration.** We also recommend that CMS consider housing status as a factor for collection and stratification given its impact on readmissions.

Conclusion
We appreciate CMS' ongoing efforts to improve delivery and payment systems. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org or 202-909-0390

Sincerely,

/s/

Jennifer Nading
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Trinity Health