June 28, 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-1752-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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program

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

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on the proposed policy and payment changes set forth in CMS-1752-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.

Rate Setting

Due to the COVID-19 impact to the most recent claims and cost report data, CMS proposed to use FY19 claims and FY18 cost reporting data for rate setting in the FY2022 regulation.

Trinity Health supports this policy.

Market-Based MS-DRG Data Collection Weight Calculation

CMS proposes to repeal a requirement finalized in the FY2021 IPPS rule that would have required hospitals to report median payer specific charges for Medicare Advantage organizations for future calculation of a new market-based MS-DRG relative weight.

Trinity Health applauds CMS on reversing this requirement, as this policy may have led to a distortion of the rate-setting process that could have led to a less informed and less precise cost setting methodology**.** As reiterated in our comments on prior IPPS regulations, Trinity Health supports price transparency efforts that help patients access their specific financial information based on their coverage and care.

Medicare DSH

Distributing Payments

CMS proposes to continue to use a single year of uncompensated care data from Worksheet S-10 to determine the distribution of DSH uncompensated care payments for FY 2022 and notes averaging multiple years of data could "dilute" the effect of auditing and potentially lead to a less smooth result.

Trinity Health disagrees with this assessment and recommends CMS continue to use a three-year average as this would mitigate the impact of significant swings from year to year and help ensure predictability for CMS rate setting and provider budget planning by providing more predictability and less variance.

New COVID Treatment Add on Payments (NCTAPS)

CMS established the NCTAPs for COVID-19 cases and pays paid hospitals the lesser of 65% of the operating outlier threshold for the claim or 65% of the amount by which the costs of the case exceeded the standard DRG payment. CMS proposes to extend NCTAP for the remainder of the fiscal year in which the public health emergency ends (PHE).

Trinity Health supports the extension of these payments through the end of the fiscal year in which the PHE ends and urges CMS to maintain flexibility to be able to continue these payments beyond the proposed timeframe in the event hospitals continue to treat patients with COVID-19.

Wage Index

Transition Hold Harmless

Due to COVID-19, CMS seeks comments on the appropriateness of applying a transition to the FY 2022 wage index for hospitals that would be negatively impacted by the adoption of OMB Bulletin 18-04 and proposes to hold harmless any hospital who would receive a reduction in their FY2022 wage index compared to FY2021 in a budget neutral manner.

Trinity Health applauds CMS for addressing the ongoing COVID-19 pandemic and considering relief in the form of a hold harmless transition to reduce volatility. However, we are concerned that while CMS is acknowledging the unprecedented nature of the ongoing COVID-19 PHE, CMS is only offering a hold harmless transition to those providers negatively impacted by OMB Bulletin 18-04. **We recommend CMS apply a hold harmless transition to all hospitals for the FY 2022 wage index as the OMB 18-04 impact is just one example of hardship providers have faced during the ongoing COVID-19 pandemic (the occupational mix adjustment is another example).** To only propose relief for a small subset of these providers is not equitable in this extraordinary environment. **Further, we recommend that the hold harmless transition not be budget neutral, relief should not come at the expense of the providers themselves. We also urge CMS to consider establishing a permanent 5% floor on wage index decreases to reduce volatility in the wage index.**

Low-Wage Index Hospital Policy
CMS proposes to continue its policy to increase wage index values for low-wage index hospitals that was finalized for FY 2020 to be effective for four years. Specifically, for hospitals with a wage index value below the 25th percentile, the agency would increase the hospital's wage index in a budget neutral manner by adjusting the national standardized amount for all hospitals.

Trinity Health recognizes the need for policies to help support rural hospitals and the communities they serve. **We continue to urge HHS and Congress to develop a comprehensive, long-term approach to help these facilities.** As disparities among geographic regions and challenges faced by rural hospitals continue to grow, HHS should work with Congress to create a new designated pool of funding for low-wage hospitals that is not subject to budget neutrality.

Rural Floor Calculation
As finalized in FY 2020, CMS would continue to exclude the wage data of urban hospitals that reclassify to rural areas when calculating the wage index for the rural floor.

Trinity Health supports this and also urges CMS to treat hospitals that classify as rural, per the Medicare Geographic Classification Review Board, as rural for all instances including the rural floor calculation.

Graduate Medical Education
CMS proposes to distribute 1,000 new Medicare-funded medical residency positions. Beginning in FY 2023, it would phase in no more than 200 positions each year until 1,000 have been distributed.

Trinity Health applauds CMS for this increase, as Health systems face workforce challenges that have been exacerbated by COVID-19 including colleague burnout. **We also urge HHS to incentivize efforts to allow providers including psychiatrists, psychologists, social workers, nurses, care coordinators, CHWs and peer-to-peer support specialists to practice in collaborative, team-based environments according to their highest level of education, training and licensure and support efforts to facilitate care delivery across states, such as through Licensure Compacts for providers**.

Organ Acquisition Payment
CMS proposes to codify into Medicare regulations some longstanding Medicare organ acquisition payment policies, as well as and some new policies, including clarifying definitions for "transplant hospital," "transplant program" and "organs." In addition, CMS proposes that transplant hospitals and organ procurement

organizations count and report Medicare usable organs to ensure such organs are accurately allocated to Medicare.

Trinity Health is concerned about the proposed policy that would require a transplant center that procures an organ that is subsequently transplanted elsewhere to determine the insurance status of the recipient and we urge CMS not to finalize with provision. This would significantly increase burden on hospitals and may impact beneficiary access. In addition, we recommend CMS conduct a comprehensive study of the potential impact of the transplant-related provisions in the proposed rule on patient access to transplantation.

Currently, the Medicare program reimburses hospitals for the cost of organ acquisition for those kidneys that are excised at our hospital but are sent to the OPO for transplantation at another site as these are counted as Medicare organs. However, under the proposed policy, in order to include these excised organs as Medicare organs, our hospital would need to be able to track and confirm who received the organ excised to confirm that the recipient is a Medicare recipient. It would require additional administrative work and coordination with multiple individuals and organizations and would also require specific guidance on what information is deemed admissible to include these organs as Medicare organs.

<u>Hospital Quality Reporting and Value Programs</u>
Cross Program Measure Suppression Policy
CMS proposes to suppress the use of quality measures in certain programs if determined COVID-19 has had a significant impact on measures and calculations.

Trinity Health applauds CMS for recognizing the impact COVID-19 has had on these programs and supports this policy, including the outlined suppression factors. In addition, we agree CMS should have the flexibility to activate a similar suppression process in future public health emergencies without needing to go through the formal rulemaking process. However, CMS should obtain feedback and input from stakeholders prior to rolling out any changes should they be outside of the regulatory process to ensure appropriateness for the programs.

Hospital Value Based Purchasing Program
In addition to measures CMS proposed to suppress, **CMS should also suppress the Patient Safety and Adverse Events Composite measure (CMS PSI 90) for CY2021 because at least one of the patient safety indicators incorporated in PSI-90 (pressure ulcers) was significantly impacted by COVID-19 patients and the COVID-19 PHE impact extended into CY2021**. Increased pressure ulcer prevalence was not necessarily due to pressure ulcers, but documentation associated with skin breakdown caused from the COVID-19 virus and as such, this measure should be suppressed.

Hospital Acquired Condition Reduction Program (HAC)
CMS proposes to apply the measure suppression policy to each of the six HAC Program measures for the FY 2022 and FY 2023 payment years.

Trinity Health Supports this proposal. There is emerging peer reviewed evidence – including a recent analysis by CDC's NHSN team, that HACs involving healthcare associated infections (HAIs) have also been

significantly impacted by the pandemic of COVID-19.[1234] We have also observed this elevated risk among patients we've cared for with COVID-19. Notably patients with COVID-19 are disproportionately dependent on devices like central lines, urinary catheters, and mechanical ventilators. Even when healthcare personnel apply bundles to prevent infections associated with these devices with 100 % perfection, those with COVID-19 remain and extraordinarily high risk of these HACs. This skews HAI surveillance findings and because of the unprecedented global impact of the pandemic we advocate for suspending use of HAI data for performance measure and incentive throughout the quarters in which this fell, i.e. Q1 CY2020 – Q1 2021.

Inpatient Quality Reporting (IQR)

CMS proposes a series of changes for the IQR program including:

- Adding five new quality measures;
- Removing five existing quality measures; and
- Revising current electronic health record certification requirements.

New IQR Measures

Trinity Health supports the proposed Maternal Morbidity Structural Measure and recommends CMS broaden its definition of a structured state or national perinatal QI collaborative to also include quality initiatives with patient safety organizing or insurers. **In addition, we recommend delaying the proposed Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure by one full federal fiscal year after the end of the public health emergency.** Our vendors do not yet have a way to run the files necessary for this measure and are still trying to operationalize the existing readmission measure. We do appreciate this is being proposed as a mid-year submission that would not occur during eCQM submission.

CMS proposes a new measure, COVID Vaccination Coverage Among Health Care Personnel (HCP), beginning with a shortened reporting period of October 1, 2021- December 1, 2021. **Prior to requiring reporting on this measure, CMS should better define who is considered a HCP.** For example, does this include anyone who works in a health care facility, such as maintenance and administrative staff, or would the measure be applicable just to people with certain licensure such as clinicians. **We recommend using CDC's definition of healthcare personnel that is inclusive and has been incorporated into CMS's prior influenza vaccination among HCP reporting requirement.**

In addition, there would need to be sufficient lead time for CDC's NHSN team to develop a vaccine reporting module and the logistics of transfer to CMS to fulfill this should CMS finalize this measure.

---

[1] McMullen KM, et al. Impact of SARS-CoV-2 on hospital acquired infection rates in the United States: Predictions and early results. Am J Infect Control 2020;48(11):1409-1411.

[2] Fakih M, et al. Coronavirus disease 2019 (COVID-19) pandemic, central-line–associated bloodstream infection (CLABSI), and catheter-associated urinary tract infection (CAUTI): The urgent need to refocus on hardwiring prevention efforts. Infect Control Hosp Epidemiol 2021; Feb 19;1-6. doi: 10.1017/ice.2021.70. Online ahead of print.

[3] Patel PR, et al. Impact of COVID-19 Pandemic on Central Line-Associated Bloodstream Infections During the Early Months of 2020, National Healthcare Safety Network. Infect Control Hosp Epidemiol 2021 Mar 15;1-4. doi: 10.1017/ice.2021.108. Online ahead of print.

[4] 4. Marcus JE, et al. Elevated secondary infection rates in patients with coronavirus disease 2019 (COVID-19) requiring extracorporeal membrane oxygenation. Infect Control Hosp Epidemiol 2021; 42(6):770-772.extracorporeal membrane oxygenation. Infect Control Hosp Epidemiol 2021; 42(6):770-772.

Removal of Existing IQR Measures
We appreciate CMS seeking to streamline and remove measures. However, **we recommend CMS maintain the Admit Decision Time to ED Departure (ED-2) eCQM measure.** Rural and critical access hospitals do not have a lot of options for measures and the ED-2 measure is one these facilities use. If eliminated, it will present challenges for these facilities and may negatively impact the ability of these hospitals to reports on a measure set.

Promoting Interoperability Program (PIP)

- CMS proposes a number of changes in the FY2022 proposed, including:
- Changing the reporting period;
- Increasing the minimum threshold score;
- Modifying attestation requirements; and
- Changing objectives and measures.

EHR Reporting Period
For CY2024, CMS proposes an EHR reporting period of a minimum of any continuous 180-day period for new and returning participants. **Trinity Health recommends CMS gradually ramp up to the continuous 180-day period as sites transition to EHRs during the calendar year.** For example, CMS could require for CY2024 reporting a 120-day period and phase up to a 180-day period for CY2025. For CMS awareness, some vendors do not provide PI reports until a time period after the close of the previous year's attestation submission period. It could be an additional challenge in selecting a reporting period.

Objective and Measure Changes
Scoring Methodology Changes
Trinity Health supports raising the minimum threshold score from 50 to 60 points; however, we recommend CMS consider including a minimum threshold denominator to take into account rural and critical access hospitals that have smaller volumes. For these hospitals, scores fluctuate significantly based on volume. If there's a minimum denominator for all measures, rural and critical access hospitals could take an exclusion for a specific measure if they come under the minimum threshold denominator.

Electronic Prescribing Objective
CMS acknowledges continued stakeholder concerns that PDMPs are not yet consistently integrated into EHR workflows and proposes to maintain this measure as optional for FY2022.

Trinity Health supports keeping it an optional measure for FY2022, as there are some states which do not yet have a PDMP and some vendors are not ready to allow reporting on the measure.

Health Information Exchange (HIE) Objective
CMS proposes to add a new, optional HIE Bi-Directional Exchange objective for the 2022 reporting period as a yes/no attestation. **Prior to finalizing this measure, CMS should clarify what needs to be exchanged with the HIE.** For example, does this measure include the data contained via the summary of care record like the other HIE measures, or something different such as admit, discharge, and transfer (ADT) notifications, lab results, etc.? This HIE measure should prioritize the same set of data as the other HIE measures and CMS should consider aligning the data exchanged across all HIE measures.

Provider Patient Exchange Objective
Beginning in 2022, CMS proposes to modify the provider to patient exchange objective to require eligible hospitals and CAHs to ensure that patient health information remains available indefinitely. This would include all patient health information from encounters on or after Jan. 1, 2016.

Trinity Health agrees this a good measure; however, we recommend the time period this measure covers be revised to instead be the effective date of the final FY22 IPPS regulation forward rather than retroactive back to 2016. A retroactive compliance requirement would be challenging for a number of reasons. For example, some hospitals have changed EHRs, vendors may not be able to back load this data in, and there has been a change in data standards from CCD to USCDI. In addition to modifying the timeframe for which providers would be required to comply, CMS should clarify how they are defining "indefinitely" and how they will measure compliance.

Public Health and Clinical Data Exchange Objective
Beginning with the EHR reporting period in 2022, CMS proposes to require reporting “yes” or requesting exclusions on four measures: Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting and Electronic Reportable Laboratory Result Reporting. The remaining two measures (Public Health Registry Reporting and Clinical Data Registry Reporting) would be optional.

Trinity Health recommends CMS begin with three registries rather than four for reporting period 2022, as hospitals face competing priorities with the public health emergency, other proposals in the IPPS rule, and the implementation of changes from the information blocking regulation. These competing priorities require the same resources we will use to implement an additional registry reporting. **Trinity Health also recommends keeping the public health registry requirement as an alternative to one of the four proposed registries. Trinity Health also recommends keeping the public health registry requirement or allow this registry to be an option in the same category as the four proposed registries.** This will help rural and critical access hospitals meet requirements under the public health and clinical data exchange objective.

Protect Patient Health Information Objective
ONC originally developed and released the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) in 2014 which provide recommended safety practices during planned or unplanned EHR unavailability, due to events like system disruptions, systems failures or natural disasters. CMS proposes to require hospitals and CAHs to attest to having completed an annual assessment of all nine guides in a newly proposed SAFER Guides measure.

Trinity Health is concerned this objective will not provide much value as guides have not been updated since 2016 and EHR criteria has changed since 2016. CMS should first update guides and provide additional guidance on operationalizing compliance to the measure prior to finalizing this objective.

Prevention of Information Blocking Attestation Requirement
CMS proposes to remove statements 2 and 3 of the information blocking attestation, due to the confusion that could be created as a result of similarities between practices described in statements 2 and 3, and the practices that could constitute information blocking under ONC’s information blocking regulations.

Trinity Health supports this change.

PIP Requests for Information

Patient access outcomes measures

CMS seeks comments on ways to better target patient access outcomes related to use of patient portals or third-party applications. We note it is challenging to be able to share health information through a portal to minors while ensuring their privacy is protected from others (i.e. caregivers). There are state law protections for privacy of minors and **we recommend CMS encourage the ability to keep this information private for these patients through certain CEHRT criteria for EHR records to ensure vendors have a way to identify, label and code certain information for minors only to ensure privacy.**

CMS asks whether they should consider requiring providers to maintain a record of third-party applications which patients have used to access their patient health information. Trinity Health already does this tracking and would support continuing to do so.

CMS also seeks whether stakeholders would support designating high-performance hospitals in context of EHR excellence. **Trinity Health supports the idea of incentivizing providers to go above and beyond minimum threshold requirements, but we encourage CMS not to make the process laborious.**

Digital Quality Measures Request for Information

CMS is planning to move fully to digital quality measures in CMS quality reporting and value- based purchasing programs by 2025 and asks a series of questions in a request for information to inform this transition.

Trinity Health supports simplifying and standardizing quality measure reporting. Today when we submit measures, we have to create thousands of QRDA files and current mapping to platforms is cumbersome to vendors. Using FHIR as the platform will create a consistent standard and help streamline reporting, especially considering FHIR is already being implemented across CMS and ONC interoperability initiatives.

Data Aggregation

CMS is considering expanding and establishing policies and processes for data aggregation and measure calculation by third-party aggregators that include, but are not limited to, HIEs and clinical registries.

A core challenge with data aggregation is patient data matching—we need to ensure data being submitted from multiple third-party sources is being submitted for the same patients. Consistency in patient data matching is foundational to interoperability and is essential to patient safety and ensuring the information in a patient's electronic medical records actually belongs to that patient and includes all available information. Further, the lack of consistent patient matching strategy is one of the primary challenges impeding the safe secure electronic exchange of health information. **Trinity Health is supportive of CMS examining this issue; however, expenses associated with improving data matching should not be borne by providers. For additional recommendations on patient matching, please see our comment letter on the CMS interoperability proposed rule CMS-9115-P.**

Alignment of Measure Reporting Requirements

CMS seeks feedback opportunities to collaborate with other Federal agencies, states, and private sector to adopt standards and tech driven solutions to addressing quality measurement priorities across sectors.

Trinity Health applauds CMS for beginning to think through collaboration across federal agencies, states, and the private sector. **Trinity Health recommends CMS take lessons learned from COVID as policies are**

discussed, including developing a federal immunization registry and reviewing professional organizations that have launched outcome registries for best practices.

Equity RFI

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.[5] 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).

---

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

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.

- 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's ongoing efforts to improve payment systems across the delivery system and the many extraordinary efforts made to provide relief to providers during the COVID-19 pandemic. 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
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health