



September 13, 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-1751-P; Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

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

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies proposed in CMS-1751-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.

### Payment Updates

The proposed conversion factor for 2022 is \$33.5848, which reflects the expiration of the 3.75 percent increase for services furnished by Congress in the Consolidated Appropriations Act.

Trinity Health recognizes clinical labor pricing needs to be updated; however, cuts of this magnitude--- including the expiration of the 3.75 percent payment increase, are extremely challenging at a time when hospitals and health systems continue to experience high costs and lost revenue as a result of the ongoing COVID-19 pandemic. **We urge CMS to take this into account and work with Congress to find a permanent solution to these payment cuts.**

### Payment for Evaluation and Management (E/M)

CMS proposes various policies to the E/M visit code set, including adopting the CPT prefatory language for critical care in the CPT Codebook except in certain circumstances. **Trinity Health recommends CMS more fully align with the AMA's prefatory language for critical care for services the AMA has determined appropriate, including allowing for more than one E/M code to be billed for the same patient on the same day as a critical care services when performed by the same practitioner or by practitioners in the same specialty and same group.**

### Telehealth Services

The proposed rule includes several proposals to extend temporary coverage of some telehealth services and make permanent coverage and payment for other services, including retaining all services added to the Medicare telehealth services list on a New Category 3 finalized in the CY2021 regulation until the end of CY 2023. CMS also proposes to codify certain telehealth-related provisions authorized by the Consolidated Appropriations Act that addressed the provision of mental health telehealth services. For treatment of mental health disorders, CMS proposes to allow audio-only telehealth if the beneficiary is unable to use or does not wish to use two-way audio/visual technology.

Trinity Health applauds the extension of Category 3 services through CY2023, as this would allow the provision of telehealth services while CMS collects data to determine what authority provided during the COVID-19 pandemic should be made permanent. In addition, we support continuing to allow for flexibility for direct supervision following the end of the public health emergency and permanently adopt payment for extended virtual check ins. **We urge CMS to work with Congress to provide a similar bridge for those authorities that require Congressional action, including the removal of originating and geographic site restrictions. To ensure CMS obtains necessary information on telehealth, we also recommend CMS release what specific data points they are aiming to collect as soon as possible so that providers can begin pull together that information.**

For mental health services, the rule outlines a requirement that people must have an in-person visit within six months of the first telehealth service and at least once within six months of subsequent service. **These requirements may ultimately create a barrier to needed mental health services, we recommend CMS remove these criteria.**

### **Trinity Health urges CMS and Congress work together to permanently achieve the following:**

- Trinity Health supports permanently removing the geographic and originating site restrictions, expanding types of providers who can offer health services and types of services that can be reimbursed via telehealth, as outlined in the Cures 2.0 discussion draft. In addition, Trinity Health recommends Congress:
- Allow clinicians to furnish and bill with parity of payment for in-office visits across all payers and settings
- Remove limitation on frequency of service
- Clarify the facility component of telehealth provided in a provider-based clinic is eligible for reimbursement after the public health emergency ends. 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.

- Maintain flexibility afforded for remote patient monitoring
- Reimburse providers for telehealth services in home health benefits during public health emergencies
- Include attribution to an Accountable Care Organization (ACO) as evidence of an existing provider-patient relationship
- Ensure audio-only remains a reimbursable option for physicians to care for patients who do not have audio and visual technology or capability
- Ensure expanded covered services include prescribing and behavioral health
- Incentivize states to adopt laws that allow providers to practice across state lines and at the top of their license

#### Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) flexibility

If finalized as drafted, the rule would allow RHCs and FQHCs to receive payment for hospice attending physician services, allow them to concurrently bill for chronic care management and transitional care management services, and be paid in full for mental health services furnished through telehealth. **Trinity Health supports these changes; however, we reiterate our concern that requiring in person visits for mental health services within 6 months of first telehealth services and at least once within six months of subsequent service would create a barrier to needed mental health services. We recommend CMS remove this criteria for RHCs and FQHCs.**

#### Appropriate Use Criteria (AUC)

CMS provides clarifications and proposals related to the scope of the AUC program and in response to claims processing issues that have arisen, among other proposals. In addition, in light of the complexities of these changes and the AUC program itself, as well as the ongoing COVID-19 public health emergency (PHE), CMS proposes to delay the payment penalty phase of the program to the later of Jan. 1, 2023, or the Jan. 1 that follows the end of the PHE.

Trinity Health supports delaying the penalty until 2023. **However, we have concerns with redefining the modifier MH (which indicates the AUC consultation information was not provided to the furnishing professional/facility).** When the penalty phase begins, hospitals and furnishing providers will still need this modifier to identify when the ordering professional does not consult AUC or does not provide that consultation information on the order. **We cannot impose additional operational burden for hospitals and furnishing providers to track down AUC information from the ordering professional. We urge CMS to maintain this modifier as it is currently defined as it allows us to indicate a physician did not provide AUC information—this modifier remains necessary.** Further, we already have our hospital and physician systems programmed to accommodate the MH modifier as currently defined. It will take a significant amount of resources to reprogram a change and provide/complete training—we have spent more than \$3 million to date implementing the AUC and will have additional costs if CMS makes more changes.

**In addition, we ask CMS to exclude all ED visits from the AUC.** Hospitals approach every patient as if they have an emergency medical condition. The requirement that AUC must be consulted for emergency room patients without an emergency medical condition results in confusion and inconsistent practices within the emergency department. This may result in burden of consulting the AUC for patients where it is not needed or the potential to miss AUC consultation for those cases an auditing body decides were not emergency medical conditions.

#### Provider enrollment

CMS proposes to expand 424.530(a)(2) categories of parties within the purview of denial and revocation provisions to include excluded administrative or management services personnel who furnish services payable by a federal health care program, such as a billing specialist, accountant or human resources specialist.

**Trinity Health doesn't have any objection to the expansion, though it would pose an unreasonable burden for organizations to provide a full listing of these administrative or management services personnel and would result in a constant need to update enrollments due to the high turn-over in these areas. We urge CMS to clarify that this would be implemented through an attestation either in the "Individuals with Organizational Ownership and Control" Section or the "Adverse Legal History" Section versus through a requirement for individual listings.**

In addition, CMS proposes to remove the requirement in 424.535(a)(8) that percentage of denials be considered in light of the entire history of the provider or supplier's claims submissions.

**Due to the complex nature of claims billings which can cause it to take a period of time for a provider or supplier to both recognize an issue with claims being submitted and implement corrections to future claims, not requiring a minimum time frame be considered when looking at claims denials is not reasonable.** We do not object to changing paragraph 424.535(a)(8)(ii)(A) to remove the requirement that the entire claims history be weighed against claims denials, but we submit that there should still be a minimum period that percentage of claims denials must be considered against total claims submitted.

**We propose that a minimum 180 day subset would be a reasonable time period to use as this would provide a window that more accurately reflects claims within a specified period (rather than the full claims history) while considering the complicated nature of supplier and provider claims systems.** This would allow a reasonable window for the correction of short periods where unintentional, non-nefarious errors are able to be corrected without revocation of a provider or supplier's enrollment a way consistent with the intent of the section as a whole.

While we do not object to the intent of the revisions proposed, we disagree with the underlying premise that length of time that a pattern persists is not relevant and should not be considered and we would object to removal of 424.535(a)(8)(ii)D.

Due to the ability to offset against future claims payments and to take-back payments, we believe that CMS has adequate protection and that the stated purpose of the proposed revisions would still be met by including a 180 day minimum lookback period for claims and to leave in place the current provision that looks at the length of time over which a pattern has continued.

#### Medicare Diabetes Prevention Program (MDPP)

To increase beneficiary participation and access these services, CMS proposes changes to the MDPP to facilitate provider enrollment.

**Trinity Health supports the removal of both the MDPP application fee and the second year of maintenance requirements. In addition, Trinity Health supports the reallocation of the reimbursement dollars as a result of the removal of the second year.**

In order to align with the current Diabetes Prevention Recognition Program (DPRP) Standards (March 2021), **Trinity Health recommends the following changes:**

- The addition of a quality measure for A1C as reflected in the DPRP Standards. Failure to add this as a measure produces a clinical barrier for health systems.
  - If this measure is added, the cost to deliver the lab test should be added as well (this is a health equity issue).
- Align the glucose range for eligibility to 100.
- Eliminate the one-time MDPP benefit.
- Re-evaluate the supplier status category for MDPP (high risk) for health systems. The MDPP fee schedule was designed to support Community based organizations and should consider evaluating health systems differently.

If aligning the metrics with the DPRP Standards is not the goal, we recommend CMS completely remove the weight related performance metrics from the fee schedule completely. MDPP is the only program that bases reimbursement amounts on weight loss outcomes. Trinity Health suggests replacing these with attendance measures as there is a suggested relationship between weight loss and attendance.

#### Medicare Shared Savings Program (MSSP)

##### *Quality reporting*

In the CY21 PFS rule, CMS made significant changes to MSSP quality reporting. In response to concerns about the proposal, CMS is proposing a longer phase in requirement to report the APP performance measure set.

**Trinity Health supports the two-year implementation extension in the proposed rule; however, we continue to have significant concerns moving away from the web interface.** For organizations with large footprints and multiple electronic health records (EHRs), such as Trinity Health, the administrative burden and costs to set up full eCQM reporting will be significant. Trinity Health has more than 300 EHRs and it would occupy resources we would otherwise put toward care coordination in order to implement eCQM reporting, thereby significantly reducing resources for advancing clinical transformation. Given the scope of work involved in transitioning to eCQM, we estimate it will cost our health system at minimum \$1 million to come into compliance. **We are fully supportive of interoperability and understand the web interface is expensive for CMS to maintain; however, we urge CMS and Congress to provide much-needed infrastructure funding to transform reporting and not put the onus on providers without providing financial support for the build.**

**Further, CMS should work with ACOs and the electronic health record (EHR) vendor community to find solutions to data aggregation problems. Until these resources and solutions are widely available, eCQMs should not be mandated for ACOs. We urge for continued delay of eCQM or allow ACOs to continue to choose to report through either the eCQM or the web interface.**

In addition, we are greatly concerned with CMS requiring ACOs participating in Medicare to be required to report data on patients that are not in the Medicare ACO to meet the all-payer completeness standard. CMS is proposing to require Medicare ACOs to provide PHI for patients are not in Medicare and do not know their data will be transmitted to CMS—this does not seem to be in the spirit of HIPAA and is out of scope for CMS to require. **We strongly urge CMS to remove the all-payor requirement for ACOs reporting eCQMs and instead require reporting on a sample of ACO assigned patients meeting the denominator criteria.**

##### *Minimum quality standard*

The rule would freeze minimum quality standard at 30th percentile of the MIPS quality performance category score and increase to the 40th percentile in PY 2024.

**Trinity Health strongly recommends CMS continue to freeze the quality standard at the 30<sup>th</sup> percentile for PY2024.** Moving up to a 40<sup>th</sup> percentile is significant, and CMS has not been transparent in how they are calculating the threshold. Without transparency into this methodology, ACOs aren't able to do their own analysis on programmatic impact and the stakes are high for ACOs who could lose all the savings they generate by missing this by one percentile. **Further, it is inappropriate to compare ACO quality performance to MIPS final quality scores. In the traditional MIPS quality category, providers pick and choose measures they know they will perform well on while ACOs are required to report on set measures and still must perform well on all.**

**In addition, CMS needs to provide clarity around measure requirements.** For example, in PY2022 CMS proposes that if an ACO reports on the three eCQM measures you only have to meet the 30th percentile on one measure to meet the attainment threshold. Does this mean the measure vs its benchmark to 30th percent? Or is it the measure's rate vs the 30th percentile of the overall MIPS quality score? We urge CMS to provide additional information.

#### *TIN Level Reporting*

CMS seeks comment on the feasibility of allowing ACOs to submit eCQM measures at the ACO participant TIN level rather than having to aggregate data.

While reporting TIN level data would save ACOs resources on the front end and make it easier to report, ACOs would still need to aggregate the data internally in order to know how our ACOs are performing.

**Trinity Health would be supportive of this change if CMS could commit to providing ACOs their aggregated data in a timely way.**

#### *Reporting options for specialist providers within in ACO*

CMS seeks comments on reporting options for specialist providers within an ACO.

Engaging specialists and all clinicians in an ACO is critical to achieving the population health goals of the MSSP Trinity Health agrees specialists should be included on patient experience metrics around access, use of generics, and coordination on care and have them select quality metrics specific to conditions they primarily manage (such as surgeries, imaging, antibiotic use, infection rates, etc.). **We recommend only making visits with a specific type of provider eligible to be in the denominator for specific measures.** For example, if a patient sees an orthopedic surgeon and a diabetes diagnosis is captured in the clinical record, the measure itself will be attributed to this provider visit and our ACO should report the visit as denominator eligible (even though this type of provider does not manage or clinically intervene because its outside their specialty). **In addition, we recommend allowing specialists to select measures that are appropriate for their specialty.**

#### *Additional services and telehealth*

Trinity Health fully supports expanding access and appreciates the codes that are being added and extended for telehealth. **We request CMS closely monitor the impact telehealth has on populations attributed to ACOs and, if there is a challenge with losing attribution as a result of telehealth visits with telehealth vendors that are not ACO participants, establish a requirement that the telehealth vendor be an ACO participant or preferred provider.**

#### *Changes to beneficiary notification*

ACOs that elected prospective assignment must provide notify each assigned beneficiary prior to or at first primary care visit of the performance year.

**Trinity Health fully supports keeping beneficiaries informed and engaged; however, we recommend CMS does not finalize this policy. Further, we recommend the beneficiary notice policy remain as it is now, whereby beneficiaries are alerted to changes by a notice in their provider's office. This method allows beneficiaries to have a face-to-face conversation with staff if there are any questions or confusion.**

A significant number of the notices we mail out are returned because the addresses CMS provides are incorrect. **If a mail notification is required, CMS should build out and update the infrastructure used to keep track of beneficiary information to ensure it is as accurate as possible.**

#### *Risk adjustment*

CMS seeks input on ACO benchmarking and risk adjustment methodology.

Trinity Health is increasingly concerned risk adjustment increase is capped for ACOs but not for Medicare Advantage nor for the population used for risk score normalization. In addition, only increases are capped and not decreases. This has a significant impact when taking into account the dramatic changes to individual risk scores we are seeing and expect to see from COVID-19. **We recommend CMS implement a floor on the risk score and to adjust for COVID, and apply a cap to the increase, if any, that is the same for all Medicare populations.**

## Quality Payment Program (QPP)

### *APM incentive payment*

Under the current statute, the Advanced APM incentive payment expires in 2024. More time and incentives are needed to achieve the original goal of substantially shifting Medicare payments to value—**we urge CMS to work with Congress to extend the incentive payment, freeze the incentive payment at the current level, and ensure thresholds are set at an attainable level.** Absent these changes, it will be increasingly challenging to get providers to participate in advanced, risk-bearing models. In addition, we recommend CMS signal this is a position they support and are working toward to encourage additional and continued provider participation.

## 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.<sup>1</sup> 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.

---

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

- 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' ongoing efforts to improve delivery and payment systems and to implement policies that further support delivery of value-based care. If you have any questions on our comments, please feel free to contact me at [jennifer.nading@trinity-health.org](mailto:jennifer.nading@trinity-health.org) or 202-909-0390

Sincerely,

/s/

Jennifer Nading  
 Director, Medicare and Medicaid Policy and Regulatory Affairs  
 Trinity Health



Michael A. Slubowski, FACHE, FACMPE  
 President and Chief Executive Officer  
 Trinity Health