



June 28, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1752-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

SUBMITTED VIA REGULATIONS.GOV

RE: Comments to Notice of Proposed Rulemaking entitled “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 Medicare Shared Savings Program.” (86 FR 25070) (CMS-1752-P)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide input on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rulemaking entitled “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 Medicare Shared Savings Program.” (86 FR 25070) (CMS-1752-P) (Proposed Rule).

The Arizona Hospital and Healthcare Association (AzHHA) is Arizona’s largest statewide trade association for hospitals, health systems, and affiliated healthcare organizations. We represent short-term acute care, behavioral health, post-acute care, and critical access hospitals, as well as their affiliated clinics and staff. AzHHA is also contracted with the state of Arizona, the federal government, and private foundations to administer programs to improve quality of care, patient safety, and emergency preparedness. AzHHA and its over 80 members are united with the common goal of improving healthcare delivery in Arizona. Our comments to the Proposed Rule are made in light of this goal.

### **Medicare Advantage Price Transparency Requirements**

In the [Hospital Inpatient Prospective Payment Systems Final Rule for Fiscal Year 2021](#), CMS finalized a proposal that each hospital must report on its Medicare cost reports the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organization payers by MS-DRG. The charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the [Hospital Price Transparency Final Rule](#).

In this Proposed Rule, CMS proposes to repeal the requirement that hospitals report their median payer-specific charges for MA organizations and likewise repeal utilizing the median payer-specific rates in calculating new market-based MS-DRG relative weights.

AzHHA has consistently expressed strong support for price transparency. We believe in driving value by empowering patients to be active consumers. In our view, however, the price transparency requirements finalized by CMS in the 2021 rule were both unlawful and entailed a large administrative burden that would not further CMS's goal of paying market rates that reflect the cost of delivering care. Our largest concern centered on the requirement that hospitals make public privately negotiated rates, which are driven by a number of factors and do not provide the most meaningful, actionable information for consumers. Consequently, we support CMS's current proposal to repeal the transparency requirements for MA plans. Additionally, we urge CMS to repeal other price transparency requirements that are unduly burdensome and do not further the goal of yielding meaningful price transparency information for consumers.

### **Covid-19 Add-On Payment**

In November 2020, CMS issued an [Interim Final Rule](#) that established the New COVID-19 Treatments Add-on Payment (NCTAP), which provides an enhanced payment when hospitals use certain new products with current FDA approval or emergency use authorization to treat COVID-19. The NCTAP was originally effective from November 2, 2020, until the end of the COVID-19 public health emergency (PHE).

In this Proposed Rule, CMS would extend the NCTAP for cases involving eligible treatments for the remainder of the fiscal year in which the PHE ends. AzHHA strongly supports this extension of the NCTAP as the COVID-19 emergency is far from over, especially due to emerging variants, which could lead to new hospitalization waves in areas of the country with larger unvaccinated populations.

## **Graduate Medical Education**

### **Distributing 1,000 New FTE Residency Positions**

Under the Proposed Rule, CMS is implementing provisions of the Consolidated Appropriations Act (CCA) of 2021 that would add an additional 1,000 Medicare Graduate Medical Education (GME) positions over the next five years. Beginning in FY 2023, CMS proposes no more than 200 new full-time equivalent (FTE) positions would be phased in each year until the 1,000 positions have been distributed. CMS proposes to limit the increase in the number of residency positions to individual hospitals to no more than one FTE per year.

While we understand CMS's rationale for limiting hospitals to no more than one FTE per hospital per year, this could impact the ability of hospitals to establish new programs in underserved areas. Moreover, it would likely result in a burdensome and unpredictable reapplication process, which will weigh heavily on smaller facilities. Because there is no assurance that a hospital will receive funding in each of the three years needed to support a resident, the hospital risks being left to fully fund the resident or relocate the resident. As such, we urge CMS to provide at least one FTE slot times the length of the relevant residency program. For example, if a hospital were to apply for slots for a three-year residency, it should be able to obtain at least three FTE positions at once in order to sustain training in the program over time.

Pursuant the CCA, CMS must distribute at least 10 percent of the aggregate number of total available residency positions to each of four categories of hospitals: rural hospitals, hospitals above their current residency cap, hospitals located in states with new medical schools or branch campuses, and hospitals that serve Health Professional Shortage Areas (HPSAs). Accordingly, CMS will give priority for allocation of the 200 additional residency slots to hospitals that fall into at least one of the four categories, with a higher priority given to hospitals that qualify under more categories.

CMS points out that it may receive more applications than the number of available residency positions. In that case, CMS proposes to prioritize applications from hospitals serving Health Professional Shortage Areas (HPSAs) with the highest scores. CMS notes this approach will also help advance health equity by targeting additional residency positions to programs serving underserved populations. AzHHA shares CMS's goal of addressing health inequities and improving access to care for underserved populations. However, we also want to ensure that this approach does not exacerbate the existing maldistribution of residency positions between states and the maldistribution of physicians practicing in rural verses urban areas, as addressing these inequities were two of the driving factors behind the enabling legislation. Consequently, we urge CMS to adopt the approach of working with stakeholders in a deliberative process to identify a prioritization framework that will provide the most optimal outcomes going forward.

### Promoting Rural Hospital GME Funding Opportunity

CMS proposes to implement the Promoting Rural Hospital GME Funding Opportunity to allow certain rural training hospitals to receive a GME cap increase. Specifically, CMS proposes to provide an adjustment to Directed Graduate Medical Education (DGME) and Indirect Medical Education (IME) FTE resident caps each time an urban hospital and a rural hospital establish a Rural Training Track (RTT), even if the RTT is not “new” as defined by Medicare. This change is meant to remedy the current situation in which only urban hospitals establishing a rural track from an existing residence program would see an increase in their FTE resident cap.

CMS also proposes that an urban hospital that adds an additional RTT may receive adjustments to their rural track FTE resident caps, in addition to the corresponding participant rural hospital. The stated purpose of this change is to allow experienced and successful urban hospitals to partner with additional rural communities rather than relying on starting RTTs from scratch as part of a strategy to address rural healthcare workforce shortages.

Under the Proposed Rule, hospitals could seek additional funding opportunities for rural tracks developed in specialties other than family medicine. In order to receive rural track FTE adjustment, a hospital’s program, regardless of specialty, must be entirely accredited by the Accreditation Council for Graduate Medical Education, and the residents must spend more than 50% of the entire program in a rural area, except for family medicine. Beginning Oct. 1, 2022, hospitals that train residents in newly created RTTs will have a five-year cap building window.

AzHHA is a longstanding supporter of the RTT program and believes that these proposed changes would support the program by increasing the pool of rural hospital participants, encouraging more urban RTTs to partner with rural communities, and providing the opportunity for residents to receive extensive training in rural areas.

### Adjustment of Low Per Resident Amounts and Low FTE Resident Caps

Consistent with the Consolidated Appropriations Act of 2021 (CAA), CMS proposes to allow certain hospitals with low resident caps to reset their per resident amounts (PRA). Specifically, if a hospital had a PRA of less than one FTE before October 1, 1997, or if a hospital had a PRA that was no more than 3 FTEs on their cost report from October 1, 1997, to December 27, 2020 (the date of enactment of the CAA), the hospital may reset its PRA for DGME payments and establish a new cap for DGME and IME payments. CMS would not set a cap for any hospital that has trained fewer than one FTE resident on or after December 27, 2020.

The recalculation period would last five years beginning on December 27, 2020. The cap would be determined in the fifth year based on the number of residents in training at that time. CMS will consider resetting each during a five-year window starting at enactment, Dec. 27, 2020, and ending Dec. 26, 2025.

AzHHA supports CMS's proposal in line with the CAA to reset the PRAs for hospitals with low resident caps as well as to establish the base period as the first five-year period after enactment of the CAA. We would highly recommend that CMS determine and communicate as soon as possible the hospitals that would fit the criteria for a PRA reset.

### **Hospital Inpatient Quality Reporting Program**

CMS is proposing a number of significant policy changes to the Hospital Inpatient Quality Reporting (IQR) Program to account for the impact of COVID-19 and to add several quality measures and remove others.

In one proposal, CMS would create a new quality measure for COVID-19 vaccination among health care personnel (HCP). Hospitals would be required to submit data beginning on October 1, 2021, that would reflect the cumulative number of HCP eligible to work in the hospital for at least one day during the reporting period who received a complete vaccination course, excluding those with contraindications to the vaccine. Each hospital's quarterly rate of vaccination among HCP would be publicly reported on the *Care Compare* website.

AzHHA appreciates that this proposal is intended to address an urgently important topic; however, due to the unique nature of the COVID-19 pandemic and the limited experience the nation has with the vaccine products currently available, we do not recommend implementing this measure this year. We believe its use could have negative unintended consequences and might not be the most useful tool to promote vaccination. Instead, we recommend that CMS either delay adoption and mandatory reporting of the measure for at least one year (i.e., until Oct. 1, 2022), or adopt the measure for voluntary reporting for at least the first year, which should not be publicly reported.

CMS also proposes that, beginning with the FY 2023 IQR program, hospitals must report a measure reflecting whether they participate in collaborative efforts related to reducing maternal morbidity. As maternal morbidity and mortality have been increasing, AzHHA strongly agrees that reducing maternal harms is a national priority. In fact, AzHHA's commitment may be demonstrated by our current implementation of a maternal health initiative through a contract with the Arizona Department of Health Services. The initiative is grant-funded by the CDC and HRSA with the aim of improving maternal health outcomes. In this program, AzHHA is partnering with hospitals throughout the state to implement evidence-based care improvement measures. Because social determinants of health clearly play a role in maternal health outcomes, this initiative has a particular focus on health disparities.

However, we are concerned that the proposed maternal morbidity measure will not yield the highest long-term value. The proposal reflects participation in maternal health initiatives but does not provide actual performance data on maternal morbidity to patients and families trying to make a better-informed decision about where to receive their maternal care. We believe

that hospitals could make more progress, and that CMS and the public would be better informed of this progress, if CMS were to pursue measures that more directly assess the quality of maternal care. Accordingly, while we do not object to implementation of this proposal, we urge CMS to adopt it temporarily while it develops more robust maternal morbidity measures.

### **Request for Information on Health Equity**

In furtherance of the Administration's efforts to address health equity, CMS has requested stakeholder comments on creating a hospital equity score and on revising several programs to bolster reporting requirements of health disparities based on social risk factors and race and ethnicity.

The proposed hospital equity score would be modeled on the equity scores in the MA program. The equity score would reflect an aggregation of several hospital quality measures and would supplement the measure data already reported on the *Care Compare* website. The summary score would provide information on the extent to which disparities exist within individual facilities and across facilities nationally. Initially, the score would be confidential for each facility's internal use, but CMS mentions the possibility that the score could become publicly available on the *Care Compare* website at a later time.

CMS is requesting feedback on additional methods by which it could expand data collection considering the significant gaps in the availability of demographic and social risk data. The Proposed Rule contemplates a policy that would require hospitals to collect a minimum set of demographic, social, psychological and behavioral data elements at the time of admission using structured, interoperable data standards. The agency also mentions the possible use of electronic health records as a data collection mechanism and contemplates that the data could be used for a variety of tracking and quality measurement purposes.

CMS also proposes stratifying individual quality measure results by dual-eligibility status. In other words, CMS would calculate performance on quality measures, such as hospital readmissions, for individuals who are eligible for both Medicare and Medicaid and for those who are not dually eligible and compare the results to determine whether eligibility status affected outcomes. CMS is also considering stratifying individual quality measure results by race/ethnicity.

AzHHA applauds CMS's focus on addressing disparities in health outcomes by thoughtfully considering how to best collect and leverage data. We agree that providing equitable care begins with understanding the unique needs of patients. Data and analytics allow hospitals, health systems, and post-acute care providers to see the challenges and barriers some patients may face when accessing care. This information can help pinpoint where resources may be deployed to address gaps in access or quality of care as well as provide deeper insights to instruct and inform intentional actions by leadership and clinical teams.

As in the rest of its quality measurement enterprise, we would suggest that CMS strive for a streamlined and parsimonious set of data elements to increase the likelihood of collecting precise information in the most efficient way possible. AzHHA encourages the agency to strive for consistency and alignment across all of its provider measurement programs and with other entities within the federal government. We would also suggest that CMS expand its health disparities proposals to explore other demographic and social risk factors in addition to dual eligibility and race/ethnicity.

Additionally, we would urge CMS to be judicious in requests for new data to ensure that efforts to collect health equity data achieve an appropriate balance of value and administrative burden. As CMS notes in the proposed rule, “the development of consistent and sustainable programs to collect data on social determinants of health can be considerable undertakings.” Indeed, data reporting often involves investments in systems and personnel, and redesigns of workflows to ensure data can be captured. We encourage CMS to engage patients and providers extensively as it explores additional data collection.

Last, AzHHA encourages CMS to ensure that its regulatory framework for health disparities data collection aligns with the quality improvement work under the new CDC health equity grant program. AzHHA has recently received approval under the grant program to work with rural communities across Arizona in conducting Health Equity Organizational Assessments (HEOAs) using the survey developed by CMS. HEOAs are designed to gather information to determine a facility’s (1) preparedness to address health disparities through the consistent collection of accurate demographic data; (2) use of demographic data to identify and resolve disparities; and (3) implementation of organizational and cultural structures needed to sustain the delivery of equitable care. Once the data is collected and analyzed, AzHHA will assist these rural communities with closing health equity gaps. We believe that aligning the regulatory requirements for health disparities data collection with the CDC grant program will optimize and streamline the collection of this valuable health disparities data.

Thank you for the opportunity to comment on the Proposed Rule. The health and well-being of our state and our nation is our top priority, and we look forward to continuing to work with you to serve that goal.

Sincerely,



Ann-Marie Alameddin  
President and Chief Executive Officer  
Arizona Hospital and Healthcare Association