CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 7, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

***SUBJECT: CMS–1750–P, Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021 (FY 2022) Proposed Rule, Federal Register (Vol. 86, No. 69), April 13, 2021***

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems — including 84 hospitals subject to the inpatient psychiatric facility (IPF) prospective payment system (PPS) — the California Hospital Association (CHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed payment and quality provisions for federal fiscal year (FFY) 2022. California hospitals providing acute psychiatric inpatient care are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, and adults with mental health and substance use disorders.

Like all hospitals, California's IPFs have been significantly impact by the COVID-19 public health emergency (PHE). We appreciate CMS' efforts to address the impact of COVID-19 in its payment and quality programs, as well as its strong commitment to improving health equity. CHA offers the following comments on specific proposals.

## PROPOSED COVID-19 VACCINATION COVERAGE AMONG HEALTH CARE PERSONNEL MEASURE

CMS proposes to add a new process measure to the IPF Quality Reporting (IPFQR) Program beginning with FFY 2023 to track the percentage of health care personnel who receive a complete COVID-19 vaccination course. CMS proposes an initial data submission period of October 1 through December 31, 2021, for use in the FFY 2023 IPFQR Program, with data reported for at least one week of every month in the reporting period using the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) web-based surveillance system. For FFY 2024 and subsequent years, CMS proposes a full calendar year reporting period. CMS proposes to publicly report the CDC's quarterly summary of the COVID-19 health care personnel vaccination measure.

California's hospitals strongly support the nation's COVID-19 vaccination efforts and have been leaders in vaccinating their communities. **Hospitals remain committed to achieving high levels of vaccination among their employees; however, we are concerned that the adoption of a measure to assess COVID-19 vaccination rates among IPF staff is premature for FFY 2023 with reporting beginning October 1.**

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The first COVID-19 vaccine was approved by the Food and Drug Administration (FDA) under emergency use authorization (EUA) on December 11, 2020. EUAs have subsequently been issued for two additional COVID-19 vaccines, and the early evidence has been promising both in terms of vaccine safety and efficacy. Despite increasing levels of COVID-19 vaccination, a degree of vaccine hesitancy remains among the general population as well as hospital staff. Given the recent availability of vaccines (barely six months), misinformation, and because the vaccines are currently authorized for emergency use — rather than FDA approved — many facilities have encouraged vaccination among their staff but have not established vaccination as a condition of employment and do not control the vaccination status of their employees. As accurate information about the vaccines dispels myths and the vaccines receive full FDA approval (as opposed to emergency use authorization), we are hopeful more health care personnel will become vaccinated.

The measure will also increase data collection and reporting burdens on IPFs that do not provide COVID-19 vaccinations directly to their employees and staff. While CMS says that it has modeled this measure after previously required measures to assess influenza vaccination rates among health care personnel, there are key differences between COVID-19 and flu vaccination administration and data collection among staff. Whereas it is common, and in fact state laws like in California require, that health care facilities provide influenza vaccination for their employees on an annual basis, COVID-19 vaccination administration has been much more fragmented.

All Californians receive their COVID-19 vaccinations through providers that have been selected by the state's third-party administrator as part of the state's vaccination network, or through pharmacies participating in the Federal Pharmacy Partnership. Although some general acute care hospitals have participated, IPFs have not been part of the state's network in California.

Though early COVID-19 vaccination efforts prioritized certain health care personnel — some of whom were vaccinated within their facilities or health systems — the measure includes a very broad definition of health care personnel, which would include many employees, independent contractors, and volunteers who would have been vaccinated in the community. **This measure will place additional burden on IPFs to seek and verify complete vaccination status from their employees whose vaccine may have been provided in settings outside of the facility, such as a local pharmacy or county mass vaccination clinic. IPFs will need to devote significant resources to developing systems to track employee vaccination, including which vaccines and how many doses are required for complete vaccination.**

CHA is also concerned that the definition of the measure numerator could be significantly impacted by the potential need for booster shots. Currently, the numerator would assess the cumulative number of health care personnel eligible to work in the hospital or facility for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. Unlike the influenza vaccination — which requires an annual course of vaccination — much remains unknown about the long-term efficacy of the existing COVID-19 vaccines, and a requirement for a booster shot could modify the definition of a "complete vaccination course." **CHA urges CMS to consider delaying adoption of such a measure until more is known about the long-term efficacy, final FDA approval, and vaccination schedule for COVID-19 vaccines.**

IPFs will be further burdened by developing processes to submit data to the CDC NHSN web-based surveillance system, as CMS notes that IPFs no longer report any current measures to the portal. Currently, psychiatric hospitals can voluntarily report COVID-19 vaccination rates for health care personnel to the Department of Health and Human Services (HHS) through weekly COVID-19 Hospital Data Reporting via the TeleTracking portal. The proposed NHSN fields to capture health care personnel

vaccination data will require additional information that is more detailed than what is submitted via the TeleTracking portal and will require more time and effort to collect. We urge CMS to consider the significant burden imposed on hospitals in reporting increasingly detailed health care personnel vaccination data, in addition to reporting duplicate data to different portals for various purposes. We believe a voluntary approach is more appropriate given these challenges.

**CHA is also concerned that the vaccination rates for this measure could vary significantly from the time of data submission to public reporting.** In the proposed rule, CMS does not specify a timeline for publicly reporting IPF data. However, for other settings, CMS proposes public reporting on Care Compare in September or October 2022 for the data submitted during the fourth quarter of 2021. We are concerned that the significant lag time between data submission and reporting will not provide patients with accurate data on the vaccination status of health care personnel in a specific facility. In addition, should a booster shot be required for any of the currently available vaccines, the definition of a fully vaccinated individual could change between the data submission and public reporting of the data, providing an even more incomplete window into health care personnel vaccination rates.

Finally, the measure proposed by CMS has not been fully specified, tested, or endorsed by the National Quality Forum (NQF). While CHA understands the immediate challenges posed by the COVID-19 pandemic and the benefits of understanding health care personnel vaccination rates, we do not support the inclusion of measures that have not been thoroughly tested and are not endorsed by the NQF in the Medicare quality reporting programs. **CHA urges CMS not to adopt a COVID-19 health care personnel vaccination measure beginning with FFY 2023, and to fully develop and test the measure for reliability and validity — and seek NQF endorsement — prior to adopting it as a required measure in the IPFQR Program.**

### Proposed Follow-Up After Psychiatric Hospitalization Measure

CMS proposes to adopt a new measure that would expand on and replace the IPFQR Program's existing Follow-up after Hospitalization (FUH) for Mental Illness measure beginning in FFY 2024. The new measure — Follow-up After Psychiatric Hospitalization (FAPH) — would assess the follow-up rates for hospitalized patients in a population that is expanded to include both those with a mental illness diagnosis and substance use disorder (SUD). The measure would also expand the types of providers that can provide the outpatient follow-up visit.

**CHA agrees with CMS that appropriate follow-up is essential to improving patient outcomes for those hospitalized for mental illness and SUD.** We also appreciate that CMS continues its work to improve the IPFQR Program by developing measures that move beyond those specific to mental illness to include patients with SUD diagnosis and recognize the role of primary care providers in providing follow-up care for behavioral health services. However, we are concerned that the outcomes assessed by the proposed measure rely heavily on factors outside the control of an IPF, and as a result may not reflect the quality of care provided in the IPF or have a significant impact on quality improvement.

CHA agrees that IPFs can support patients in receiving follow-up care with appropriate discharge planning and case management. However, despite the best efforts of the inpatient facility, many patients in California are challenged by a lack of access to outpatient behavioral health care in their communities. In addition, the measure fails to account for the many real-life logistical and patient-level factors that significantly impact the likelihood that a patient will complete an outpatient follow-up visit, including sociodemographic factors such as lack of transportation or homelessness.

Finally, CHA does not support measures that have not been endorsed by the NQF. We note that the Measures Application Partnership raised concerns in its conditional support of the measure, and we urge the agency to achieve NQF endorsement before inclusion of a measure in any quality reporting program. In addition, while CHA is generally supportive of claims-based outcomes measures in quality reporting programs, a process measure that assesses whether the IPF has made all reasonable efforts to connect a patient with outpatient care following discharge may be more appropriate than the proposed — and existing FUH — measures.

**CHA opposes the addition of the FAPH measure and urges the agency to consider developing a measure that better assesses the IPF's role in providing follow-up care.**

### Proposed Removal of Measures from the IPFQR Program

CMS proposes to remove several measures, including the previously mentioned FUH measure and three additional measures beginning with FFY 2024. CMS notes that for two measures — Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a), and Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a) — data show significant quality improvement with little room to improve. CMS also proposes to remove the Timely Transmission of Transition Record measure due to its overlap with a new Medicare Condition of Participation that requires IPFs to generate electronic patient event notifications in the event of a patient's admission, discharge, or transfer. **CHA agrees that the removal of these measures will reduce burden on IPFs and strongly supports the proposal.**

### Proposal to Adopt Patient-Level Reporting for Chart-Abstracted Measures

Currently, IPFs report aggregated information on the chart-abstracted measures under the IPFQR Program. CMS proposes to incrementally begin requiring IPFs to report patient-level information for numerators and denominators for the chart-abstracted IPFQR Program measures, with voluntary reporting beginning for FFY 2023 and required reporting by FFY 2024. **CHA urges CMS to provide IPFs with additional guidance and education prior to the voluntary reporting period, and to ensure IPFs have gained sufficient experience prior to required reporting of patient-level data.**

### Request for Information on Closing the Health Equity Gap in CMS Quality Programs

California hospitals are committed to improving health equity and eliminating disparities in health care outcomes. Unequal access to health care and health resources due to race, socioeconomic status, and other social determinants of health has long been of concern to our members. However, the COVID-19 pandemic has further demonstrated racial and ethnic health disparities that can no longer be ignored. The reasons for health equity disparity are multi-faceted, and answers to the problem are just as complex. Overcoming these obstacles will require a long-term, systemic approach with collaboration across all levels of government and institutions.

**CHA applauds the administration for its strong commitment to addressing health equity, as evidenced by several of President Biden's executive orders.** We appreciate that as an early step, CMS is seeking comments on how it can leverage Medicare quality reporting programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for facilities, providers, and patients. Hospitals are uniquely positioned to help advance health equity and reduce disparities, and many of our members have already invested in efforts to improve data collection on race, ethnicity, language preference, and other sociodemographic data. As the agency considers its

future steps, we offer the following high-level principles on improving demographic data collection, stratification of quality measure results, and future measures to assess health equity.

*Improving Demographic Data Collection*
The collection of standardized, comprehensive, and accurate data is essential to assessing disparities that exist in our health care system. Hospitals have invested significant resources in collecting these data from their patients; however, the data are not always captured in a consistent manner and format. For example, it is common for race and ethnicity information to be collected at registration, but other social demographic factors, such as access to transportation or food insecurity, may be captured as part of discharge planning or case management services. The data may also be maintained across separate systems and departments. **CMS should engage stakeholders to understand the current practices for demographic data collection and provide education to promote best practices that ensure consistency in these efforts.**

CHA also urges CMS to assess current efforts to collect demographic data beyond race and ethnicity, such as the standardized patient assessment data elements (SPADEs) required for post-acute care (PAC) settings and International Classification of Diseases, Tenth Revision (ICD-10) z-codes. CHA notes that while CMS expanded the SPADEs to include a new category for social determinants of health, data collection has been delayed due to the COVID-19 PHE. **CMS should implement and learn from the experience of PAC providers collecting the existing SPADEs before expanding to other settings or adding additional data elements. We also urge CMS to engage stakeholders in understanding how z-codes are currently used and consider how to better standardize and incentivize this coding.**

*Stratification of Quality Measure Results*
CMS says that it is considering providing facilities with reports that would stratify quality measure results by race and ethnicity, similar to its current approach to provide hospitals with confidential hospital-specific reports (HSRs) for several condition- and procedure-specific readmissions measure strategies for dual-eligibility status in the Hospital Readmissions Reduction Program. **CHA supports providing hospitals with confidential HSRs stratified by race and ethnicity in order to expose significant disparities. We also believe that understanding the additional causes of disparities— such as housing instability, access to healthy foods, and community violence — is key to addressing health inequity and requires an even more granular level of data collection.** While dual eligibility status and race or ethnicity have been shown to be accurate proxies for social risk, those characteristics intersect with other systemic factors that result in inequities in our health care system. We encourage CMS to continue to explore how it could provide hospitals with actionable data that allow them to work with community partners in advancing health equity in their communities.

*Future Measures to Assess Health Equity*
In the IPF proposed rule RFI, CMS discusses the possible creation of a Facility Equity Score that would synthesize results across multiple social risk factors and disparity measures. **CHA is concerned that a measure requiring a complex aggregation methodology is unlikely to produce results that are actionable to the facility for quality improvement purposes.** We urge CMS to rethink the development of an aggregate Facility Equity Score and instead focus its resources on improving and standardizing data collection and reporting of social demographic data in such a way that provides facilities with accurate and specific data on disparities within and across their facilities.

CHA appreciates the opportunity to share our comments on these important issues. If you have any questions, please do not hesitate to contact me at (202) 488-3742 or mhoward@calhospital.org, or Sheree Lowe, vice president, behavioral health at (916) 552-7576 or slowe@calhospital.org.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy