CHRISTUS Health

June 28, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

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

Re: 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
Re: CMS-1752-P

Dear Ms. Brooks-LaSure:

CHRISTUS Health appreciates the opportunity to provide comments on the proposed Hospital Inpatient Prospective Payment System rule as published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register May 10, 2021. CHRISTUS Health is an international, faith-based, not-for-profit health system comprised of nearly 350 services and facilities, including more than 50 hospitals, primarily located in Texas, Louisiana, and New Mexico. CHRISTUS Health offers the following comments on the proposed rule.

I. Disproportionate Share Hospitals (DSH)

A. Determining the Aggregate Pool of Uncompensated Care Payments

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The amount received by a given hospital from this aggregate pool of uncompensated dollars is based upon that hospital's share of national uncompensated care costs using Worksheet S-10 of the Medicare cost report.

CMS estimates that the amount available to distribute as uncompensated care will decrease from $8.3 billion in FY 2021 to $7.6 billion in FY 2022, a decrease of 8 percent or $662 million. The calculation of aggregate uncompensated care, once determined, is not changed to reflect subsequent updates to the data sources. For this reason, it is critical that CMS' estimates accurately reflect the latest information available.

Factor 1 is determined by taking CMS' estimate of Medicare DSH payments from FY 2018 (if Medicare were to have paid 100 percent of the formula) and applying increase factors to estimate FY 2021 DSH payments and multiplying the result by 0.75. The increase factors account for the IPPS update, changes in fee-for-service discharges, case mix and an "other" or residual of all other factors affecting Medicare DSH payments including changes in Medicaid enrollment.

Of these factors, the reduction in Medicare discharges for FY 2020 (-14.7 percent) and FY 2021 (-3.2 percent) explains in large part why Factor 1 is showing a decrease from FY 2021 to FY 2022. The proposed rule indicates that these figures are based on the Office of the Actuary's (OACT) January 2021 Medicare DSH estimates, which were based on data from the September 2020 update of the Medicare costs reports and the FY 2021 IPPS final rule impact file. CMS states these figures will updated using "more recent data that may become available for purposes of projecting the final Factor 1 estimates for the FY 2022." (88 FR 25445). Since CMS is using data for the Factor 1 estimate for FY 2022 from September of 2020 and March of 2020 (as that is the data source for the FY 2021 IPPS impact file), it is critically important that these data be updated to reflect the latest discharge information for FY 2022 to ensure that hospitals are accurately paid for their uncompensated care costs. **CHRISTUS Health urges CMS to update the data used to forecast Factor 1 for FY 2022 in the IPPS final rule.**

The "other" factor is +0.23 percent for FY 2020 and -2.46 percent for FY 2021—the latter which further contributes to the Factor 1 reductions between FY 2021 and FY 2022. The rule indicates that primary factors that influence this factor are: the difference between the total inpatient hospital discharges and the IPPS discharges, the change in rates for the 2-midnight stay policy and the 20 percent add-on for COVID–19 discharges and changes in Medicaid enrollment. The rule indicates that OACT estimates Medicaid enrollment increasing 2.9 percent in FY 2020 and 1.2 percent in FY 2021 yet the "other" factor is +0.23 percent and -2.46 percent respectively.

It is not clear from the proposed rule what factors accounts for the difference between the increase in Medicaid enrollment and the "other" factor. Of those mentioned, the 2-midnight rule is not likely to explain the difference as that policy has been in effect for many years. The 20 percent add-on for COVID-19 discharges would contribute to an increase, not a decrease in the "other" factor. The only other factor mentioned that could account for this difference is the adjustment for the difference between total inpatient hospital discharges and IPPS hospital discharges. **CHRISTUS Health requests that CMS clarify how the difference between total inpatient discharges and IPPS hospital discharges affects the determination of the "other" factor.**

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2021 to the number of uninsured in calendar year 2013, before the Affordable Care Act went into effect. OACT uses estimates of the uninsured from the National Health Expenditure Accounts (NHEA) based on the latest historical data through 2018 (85 FR 32751).

In selecting use of the NHEA to determine Factor 2, OACT states:

> Timeliness and continuity are important considerations because of our need to be able to update this estimate annually. Accuracy is also a very important consideration and, all things being equal, we would choose the most accurate data source that sufficiently meets our other criteria." (86 FR 25448)

Further, OACT states "we may also consider the use of more recent data that may become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2022." (86 FR 25449) **CHRISTUS Health urges OACT to update Factor 2 with more timely and accurate data to reflect the increase in FY 2021 and FY 2022 in uninsured patients.**

B. Distributing Uncompensated Care Payments

For FY 2022, CMS proposes to use one year of audited Worksheet S-10 data from FY 2018 for distributing uncompensated care payments. **CHRISTUS Health supports CMS using FY 2018 audited Worksheet S-10 data in the uncompensated care distribution.**

CMS has previously used three years of data to distribute uncompensated care payments. Using three years of data lessens instability and mitigates wide swings in hospital payments from year to year. CMS proposes to use only one year of data, stating that using multiple years of data would potentially dilute the effect of revisions to the cost reporting instructions that were effective on October 1, 2017 (FY 2018 cost reports) while introducing unnecessary variability into the uncompensated care determinations.

CHRISTUS Health disagrees that using multiple years of data will create unnecessary instability in the determination of a hospital's uncompensated care payment. Rather, CHRISTUS believes using multiple years of data will improve stability in the determination of these payments. While CMS is correct that FY 2018 and FY 2017 cost reports were submitted under different Worksheet S-10 instructions, both years of cost reports have been audited. For this reason, **CHRISTUS Health requests that CMS consider basing the uncompensated care distribution on two years of Worksheet S-10 data in FY 2022 (FY 2017 and FY 2018 cost reports) and three years of Worksheet S-10 data in FY 2023 (FY 2017, FY 2018 and FY 2019 cost reports) to mitigate large year-to-year changes in a hospital's uncompensated care payments.**

C. Definition of Uncompensated Care

CMS does not propose any changes to its definition of uncompensated care from prior years. Under this definition, CMS would recognize non-Medicare bad debt and charity care. However, CMS would not recognize payment shortfalls from public health programs like Medicaid, the Children's Health Insurance Program and state and local indigent care programs. **CHRISTUS Health believes that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, the Children's Health Insurance Program and**

state and local indigent care programs. This approach would lead to a more equitable allocation of uncompensated care to hospitals, especially given that analyses we have reviewed suggest that hospitals located in states that opted out of Medicaid expansion do significantly better under the CMS proposed approach than hospitals located in states that have expanded Medicaid. Broadening the definition to include Medicaid shortfalls and other forms of unreimbursed costs of other public health care programs would help make the allocation more equitable.

II. Payments for Indirect and Direct Graduate Medical Education Costs

The Consolidated Appropriations Act, 2021 (CAA), division CC, contained 3 provisions affecting Medicare DGME and IME payments to teaching hospitals.

A. New Residency Positions

Section 126 of the CAA makes available 1,000 new Medicare-funded GME positions (but not more than 200 new positions for a fiscal year) to be distributed beginning in FY 2023, with priority given to hospitals in 4 statutorily-specified categories:

1. Hospitals located in rural areas or treated as rural for IPPS purposes;
2. Hospitals that are training more residents than their FTE cap;
3. Hospitals in states with new medical schools or additional locations and branches of existing medical schools; and
4. Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs).

As CMS is limited by statute in the number of additional resident slots it may award and it expects hospitals will qualify for more residents than the limit, CMS is proposing to limit any qualifying hospital to 1.0 per hospital per year. CMS would further prioritize among hospitals based on residency programs that provide services to medically underserved populations using health professional shortage area scores as a measure of the severity of a primary care or mental health shortage.

Alternatively, CMS considered prioritizing hospitals that qualify in more than one of the four statutory eligibility categories. Hospitals that qualify under all four categories would receive top priority, hospitals that qualify under any three of the four categories would receive the next highest priority, then any two of the four categories, and finally hospitals that qualify under only one category.

CHRISTUS Health supports CMS' proposed policy of prioritizing allocation of new resident slots among those areas that are primary care and mental health shortage areas. We ask, however, that CMS clarify that shortage areas can be rural or urban.

B. Rural Training Tracks (RTT)

Section 127 of the CAA makes statutory changes relating to the determination of both an urban and rural hospital's FTE resident limit for direct graduate medical education (DGME) and indirect medical education (IME) payment purposes. These changes address shortcomings of the prior

statute that generally only provided exemption from FTE caps to urban hospitals participating in RTTs and not the rural hospitals that provided training sites.

CMS is proposing that each time an urban hospital establishes a relationship with a new rural hospital for an RTT, both the urban and rural hospital would receive a 5-year exemption for the new program from the DGME and IME FTE caps to allow the program to grow to full capacity. **CHRISTUS Health supports this proposal.**

CMS further proposes technical changes consistent with the CAA that would allow for RTT programs in any specialty—not just family practice. As long as 50 percent or more of the training occurs in a rural area, CMS would allow the program to qualify as an RTT for the 5-year exemption to the DGME and IME FTE cap. **CHRISTUS Health supports this proposal.**

C. Resident Caps and Per Resident Amount for Hospitals that Hosted a Small Number of Residents for a Short Duration

Section 131 of the CAA makes statutory changes to the determination of DGME per resident amounts (PRA) and DGME and IME FTE resident limits of hospitals that hosted a small number of residents for a short duration. This provision allows particular hospitals that may have inadvertently established a low PRA or an FTE cap based on small number of residents rotating in from another hospital's residency program to have their PRA and FTE caps reset.

The threshold for resetting the PRA and FTE cap differs based on whether the hospital's cap was less than 1.0 FTEs (for cost reporting periods beginning before October 1997) or 3.0 FTEs (for cost reporting periods beginning on or after October 1, 1997 and before December 20, 2020 consistent with the statute. CMS proposes that the cap and PRA can be reset for hospitals that meet the requisite thresholds that are training residents between the December 27, 2020 enactment of the CAA and December 26, 2025 (5 years from enactment). A hospital can qualify for a reset FTE cap or PRA regardless of whether the residency program is new or existing. **CHRISTUS Health supports this proposal.**

III. Medicare Bad Debt Policy

Medicare bad debt is uncollectible deductible and coinsurance amounts owed but not paid by Medicare beneficiaries. Under specific circumstances, Medicare bad debt can be partially reimbursed to hospitals. In the case of dual eligible Medicare/Medicaid beneficiaries, hospitals are obligated to bill the beneficiary's state Medicaid plan to determine whether the state is responsible for paying Medicare deductibles and coinsurance. The state Medicaid plan would then be obligated to provide remittance advice indicating whether it is responsible for beneficiary cost-sharing.

In the FY 2021 IPPS rule, CMS reported that state plans do not always fulfill their obligation to provide remittance advice (85 FR 59001). The lack of remittance advice from the relevant state agency means the hospital cannot claim the unreimbursed amounts as bad debt. In the FY 2022 IPPS proposed rule, CMS proposes a state Medicaid agency would be required to allow enrollment of all Medicare-enrolled providers and suppliers for purposes of processing claims to determine Medicare cost-sharing if the providers or suppliers meet all Medicaid enrollment requirements,

even if the Medicare-enrolled provider or supplier is of a type not recognized by the state Medicaid agency. **CHRISTUS Health supports this proposal.**

IV. Cross-Program Measure Suppression Policy: Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing Program (HVBP), and Hospital-Acquired Condition Reduction Program (HAC RP)

CHRISTUS Health appreciates that CMS recognizes the many and significant ways, largely outside the control of hospitals, that the COVID-19 public health emergency (PHE) has impacted the Medicare program's quality data collection, reporting, and results for hospitals. We further appreciate that CMS has broadly applied its discretionary authority during the PHE to support continuous delivery of patient-centered care by hospitals and their personnel through granting policy waivers and adopting regulatory flexibilities. We also share the particular concern expressed by CMS that, absent policy interventions, the payments and penalties of its pay-for-performance (P4P) programs could be inequitable, especially for hospitals treating large numbers of COVID-19 patients. We are grateful to CMS for their proposals regarding cross-program and individual program measure suppression as the net outcomes generally help support CHRISTUS in continuing our mission to extend the healing ministry of Jesus Christ.

CHRISTUS Health supports the purpose of the cross-program measure suppression policy proposed by CMS for application to the inpatient hospital pay-for-performance (P4P) programs, namely, preservation of equitable payments across hospitals under these three programs. Our understanding is that the policy would permit CMS to suppress the use of data from one or more measures in a P4P program when the agency judges that PHE-related circumstances have significantly compromised measure data and resulting performance scores. Coincident with data suppression, CMS would design performance scoring and payment calculation modifications for each program to preserve payment equity across hospitals required to participate.

CMS proposes a set of Measure Suppression Factors to guide its determination of when to apply the cross-program measure suppression policy. We support the proposed set of factors to be comprehensive and rational decision-making guides. CMS further proposes that the policy would begin in FY 2022 and apply for the duration of the PHE. CMS also proposes to report performance results to hospitals calculated using available data and to continue public results reporting as provided for in previously established P4P individual program policies. The agency states that publicly reported information would be accompanied by an explanation of the source data limitations due to the COVID-19 PHE.

V. Hospital Readmissions Reduction Program (HRRP)

CHRISTUS Health supports the agency's proposal to suppress the pneumonia readmission measure for FY 2023,[1] and not to use an excess readmission ratio based on this measure for calculating payment reductions for hospitals. We also agree with the exclusion of cases with COVID-19 diagnoses from calculations for payment reductions to hospitals under the HRRP.

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[1] Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506)

VI. Hospital Value-Based Purchasing Program (HVBP)

CHRISTUS Health supports measure suppression and the special scoring policy as proposed for the HVBP for FY 2022. We greatly appreciate the stability provided by what is essentially a budget-neutral solution for hospitals. We also support continued suppression of the pneumonia mortality measure for FY 2023 along with technical updates of the other HVBP Clinical Outcomes domain measures to exclude cases with COVID-19 diagnoses from calculations. **We support the proposed removal of the persistently controversial CMS PSI 90 measure from the HVBP measure set beginning with the FY 2023 payment year.**

VII. Hospital-Acquired Condition Reduction Program (HAC RP)

CHRISTUS Health has ongoing concerns about a program that imposes a substantial penalty on a fixed number of hospitals each year, regardless of whether quality improvement has occurred. That said, we fully support the proposed suppression of Q3 and Q4 CY 2020 data and scoring for multiple HAC RP measures, including all of the National Health Safety Network (NHSN) Hospital Associated Infection (HAI) measures that are reported to the Centers for Disease Control and Prevention (CDC). Some hospitals would still be required by their states to report the NHSN measures to CDC for other purposes. CMS advises these hospitals to apply for individual extraordinary circumstance exceptions (ECEs) so that such reported data would be excluded from all total HAC score calculations. We urge CMS to create a streamlined sub-regulatory process for such hospitals to self-identify to CMS and thereby be automatically granted the necessary ECEs.

VIII. Market-Based Medicare-Severity Diagnosis-Related Group (MS-DRG) Relative Weights

In the fiscal year FY 2021 IPPS rule, CMS adopted a policy requiring hospitals to report the median payer-specific negotiated charge negotiated by a hospital with all of its Medicare Advantage (MA) plans, by MS-DRG and the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG. Hospitals are currently required to report this information on their Medicare cost reports for cost reporting periods ending on or after January 1, 2021, for potential use in setting the IPPS MS-DRG relative weights beginning in FY 2024.

Public commenters on the change to the Medicare cost report made as part of the Paperwork Reduction Act process raised questions about the usefulness of this data. CMS also further considered the many contract arrangements hospitals use to negotiate rates with MA plans. For these reasons, **CMS proposes to repeal the reporting requirement and its plan to use payer-specific MA negotiated rates in the MS-DRG relative weight methodology for FY 2024 and subsequent fiscal years. CHRISTUS Health supports CMS' proposal.**

IX. FY 2022 Outlier Threshold

CMS proposes an FY 2022 outlier threshold of $30,967, a 6.5 percent increase over the FY 2021 outlier threshold of $29,064. Normally, CMS would calculate the outlier threshold based on the latest claims and cost report data. For FY 2022, the latest year of claims data would be from FY

2020 and the latest cost report data would be from 2019 and 2020. However, CMS provides an analysis showing that the latest available data is from the 2020 period of the COVID-19 public health emergency (PHE) and is atypical and will impact the outlier threshold.

These data are atypical because of the suspension of elective admissions and the high number of COVID-19 respiratory cases during the early months of the pandemic. If CMS continued to use the latest available data, its analysis shows that the FY 2022 threshold would be $36,483 or $5,516 higher than threshold proposed. **CHRISTUS Health supports CMS' proposal to continue using claims data and cost report data from prior to the pandemic to set the FY 2022 outlier threshold.**

X. Request for Information: Closing the Health Equity Gap in CMS Hospital Quality Programs (Equity RFI)

A. General Considerations

CHRISTUS Health is committed to ensuring health care is equitable for all and applauds CMS' commitment to achieving equity in the provision and quality of health services. CHRISTUS has considerable experience with the delivery of culturally competent care and meeting the special needs of patients whose social risk factors complicate their care, such as physical and sensory disabilities, housing and food insecurity, and limited English proficiency. Further, recognizing that racism is an affront to the core values of Catholic social teaching, CHRISTUS is committed to promoting the common good and seeking justice by being actively anti-racist and accountable in effecting positive change in the communities we serve. To that end, we have committed:

- To act for COVID-19 equity by ensuring that testing for COVID-19 is available and accessible in minority communities and that new treatments are distributed and used equitably as they become available;
- Enacting change across our own health system by examining how we recruit, hire, promote and retain employees; how we conduct business operations, including visible diversity and inclusivity at the decision, leadership and governance levels; and how we incentivize and hold our leaders accountable;
- Advocating for improved health outcomes for minority communities and populations; and
- Strengthening trust with minority communities.

We agree with CMS that more could be done to use performance measurement systems to identify, understand, and eliminate health disparities. While the Equity RFI poses numerous questions, it focuses on three areas for potential future actions by the agency: 1) stratifying quality measures by social risk factors, 2) improving demographic data collection, and 3) creating a Hospital Equity Score that incorporates multiple social risk factors.

As a foundation for our comments, we suggest the following as essential characteristics of measures focused on issues of health:

- Data-driven – be developed based upon well-documented outcome disparities with clear associations to well-defined social risk factors;
- Actionable – be designed to yield performance results for which change is possible;

- Have utility – in the near-term, process measures may be more feasible and could point the way to meaningful outcome measures
- Give feedback – be constructed for timely performance scoring and prompt provider feedback; and
- Feasible – based on considerations of provider burden and CMS operational capabilities.

B. Stratified Results Reporting by Race and Ethnicity

CHRISTUS supports the use of performance measure stratification as a valuable tool to identify and reduce health disparities in tandem with risk adjustment for social risk factors as appropriate. While differences in performance measure outcomes due to actual variation in the quality of care provided to subgroups of patients should not be tolerated, outcome variation independent of quality of care must be explored. The choice of social risk factors for stratification should reflect their distribution within a given quality program's patient population. CHRISTUS agrees that race and ethnicity are reasonable choices for stratification for several CMS quality programs using the CMS Disparity Methods, including the Hospital Readmissions Reduction Program (HRRP), in which reporting stratified by dual eligibility status is already underway.

CHRISTUS notes that results stratification for race and ethnicity would depend upon having standardized definitions of race and ethnicity and accurate and reproducible race and ethnicity information for all beneficiaries. **To that end, we favor the practicality of the Office of Management and Budget's standard minimum set of five racial and one ethnicity categories over the added precision of the 900 race and ethnicity concepts of the CDC's code system.**

We agree that measure results stratified by race and ethnicity must first be reported confidentially to hospitals. Public reporting should not be pursued until sufficient time has elapsed for establishing processes for review and correction and for data validation, demonstrating that the imputed data and results based upon them are highly reliable and reproducible, allowing for emergence and identification of unintended consequences. Prior to public reporting, we strongly recommend that CMS undertake focus groups to test messaging and understanding of the data, so that the results reported are clear and actionable for patients, families, and caregivers. CMS should also consider a broad outreach program to educate beneficiaries about stratified results.

CHRISTUS emphasizes the unassailable importance of privacy safeguards for all uses of sensitive personal information such as race, ethnicity, and other social risk factors. A starting point would be to treat these variables as protected health information along with using industry best practices for data protection from cyberattack.

C. Improving Data Collection

CHRISTUS currently uses EHR capabilities for collection and we routinely collect race, ethnicity, and language preference data, and have efforts underway to link data to quality measurement. We have also implemented effective programs to train our staff to interact with patients and families in culturally competent and respectful ways when collecting sensitive information. We appreciate the value from a quality measurement standpoint of collecting a standardized set of social,

psychological, and behavioral data along with race and ethnicity for each patient to be shared with multiple users for a variety of purposes. However, we have concerns about the privacy, burden, and cost implications of doing associated with these efforts as most of these burdens would fall on hospitals. **CHRISTUS Health does not support additional reporting requirements as we are already collecting this data and additional obligations will exacerbate the strain on our health care system as we continue to deal with the COVID-19 pandemic.**

D. Hospital Equity Score

CMS seeks input about a summary score aggregating hospital performance data across multiple quality measures and social risk factors as a means of enhance the utility of stratified data reporting publicly providing easy to interpret information. The Hospital Equity Score (HES) would be modeled on the Health Equity Summary Score (HESS) recently developed and implemented by CMS and its contractors for stratified reporting to MA plans about their performances on certain quality and patient experience measures by race, ethnicity, and dual eligibility. A period of undefined duration during which confidential results would be shared with hospitals would precede any public reporting.

CHRISTUS commends CMS for forward thinking about a key end-user of hospital quality performance results – the beneficiary – and agrees generally that a HES-type score could resonate well with patients and their families. More detailed comments about the HES, however, we view as quite premature. The HESS, model for the HES, has only been described publicly to date in proof-of-concept terms; no actual implementation experience appears to be available. We do note that in the proof-of-concept HESS simulation study, HESS scores for both CAHPS and HEDIS measures were calculable for only 44 percent of 398 MA plans analyzed using a combination of self-reported and indirectly estimated race and ethnicity data for stratification.

XI. Medicare and Medicaid Promoting Interoperability Program (PIP) and Hospital Inpatient Quality Reporting (IQR) Program

CHRISTUS Health appreciates that CMS is working to reduce burden in the Promoting Interoperability Program and Hospital IQR Program as organizations implement and adapt to new technology and adjust to ramping back up after the impacts of the COVID-19 pandemic.
However, there are a few areas of concern, and CHRISTUS Health recommends that CMS consider the following.

We recommend the removal of the retroactive requirement for data availability for the Provide Patient's Electronic Access to their information going back to January 1, 2016. If not completely removed, we recommend starting the expectation for persistent access via application programming interfaces (APIs) for encounters on or after January 1, 2023. It is impractical to expect organizations to migrate all USCDI data when implementing new systems or to retain and maintain decommissioned systems indefinitely to comply with such a requirement. It is also not feasible to retroactively bring previously decommissioned systems (from previous EMR conversions and acquisitions) to USCDI standards that were not applicable at that time.

Further, we recommend aligning with the 21st Century Cures Act exclusions: preventing harm, privacy, security, infeasibility, and Health IT performance. Tremendous resources would be required to assess exclusions to all USCDI elements (such as clinical notes) that existed prior to implementation of the Cures Act provisions. We recommend offering bonus points in the PI program for reporting on additional public health measures for the 2022, 2023, and 2024 reporting years. We recommend making them required in 2025 to provide more time for readiness of states, EMR vendors, and organizations.

We recommend that CMS consider allowing sites to select one of the available SAFER guides to complete in 2022. For each subsequent year, a new guide would need to be selected and completed.

Further comments on specific aspects of the proposed rule relating to Medicare and Medicaid Promoting Interoperability Program (PIP) and Hospital Inpatient Quality Reporting (IQR) Program are attached.

XII. Conclusion

CHRISTUS Health appreciates the opportunity to provide feedback on the proposed rule, and in particular, we applaud CMS' goal of closing the health equity gap. Please do not hesitate to contact us or our staff if CHRISTUS Health can be a resource. Thank you for your consideration.

Sincerely,

Randy Sefadi
EVP & Chief Financial Officer
CHRISTUS Health

Sam Bagchi, MD
EVP & Chief Clinical Officer
CHRISTUS Health

Proposal	Comments
Maintain minimum 90-day PI Performance period	We support continuing the continuous 90-day reporting period for EH's and CAH. We recommend that CMS consider continuing the 90-day EHR reporting period in 2024 to allow more flexibility and time to optimize CEHRT updates.
2015 CEHRT and/or Cures Update in 2022	We support the transition to the Cures Updates, however we recommend that CMS allow more time to implement 2015 Edition Cures Update, such as continued flexibility to use 2015 Edition CEHRT in 2023.
Increase PI score requirement to 60 points	We do not support increasing the minimum score for the objectives and measures from 50 point to 60 points while simultaneously making changes to the individual measures that make them more difficult to achieve at a time when hospitals and healthcare systems face continuing uncertainty with staffing and patient volume during the national pandemic emergency. If retaining the changes to the individual measures, we recommend that the current score requirement remain at 50 points.
Electronic Prescribing 10 Points Query of PDMP *Bonus* 10 points	We support the Electronic Prescribing measure and the Query of the PDMP for an additional 10 bonus points but we ask for your consideration for providing an exclusion for our rural hospitals who may have less than 50 opioid prescriptions during a 90-day reporting period. Some of our rural facilities are unable to take advantage of the 10 bonus points due to the lack of narcotic prescribing even though PDMP functionality is available. This puts them at a disadvantage for their overall score. We recommend that PDMP functionality be documented by attestation. <u>Request for Information</u> CMS solicits feedback on prerequisites that would need to be addressed before required reporting on the Query of PDMP measure. CMS would need to establish standards for PDMP integration as organizations currently have a variety of methods that can be utilized to access or query PDMP data from the state. States also have varying policies for how information from the PDMP can be viewed or integrated into the EMR. Once standards are established, organizations need to be given sufficient time to implement the new standards before required reporting goes into effect.
Health Information Exchange Bi-Directional Exchange 40 Points	We support the new, optional HIE bi-directional exchange measure that can be reported in place of the two existing HIE measures.
Provider to Patient Exchange 40 Points	We recommend the removal of the retroactive requirement for data availability for the ***Provide Patient's Electronic Access to***

Proposal	Comments
	their information going back to January 1, 2016. If not completely removed, we recommend starting the expectation for persistent access via APIs for encounters on or after 1/1/2023. This will give organizations the ability to plan for additional hardware and storage needs to support persistent access. Exclusions that address situations where organizations transition to new EMR software (upgrades, complete conversions, or system acquisitions) should also be considered as creating custom conversions to migrate all data in the old or decommissioned systems can be time consuming, costly, or otherwise infeasible. It is equally infeasible to require organizations to retain and maintain decommissioned systems indefinitely to comply with such a requirement. We recommend that CMS consider a reasonable timeframe for retention and API access to historical patient data (i.e., 5 years). We also recommend aligning with the 21st Cures Act exclusions: preventing harm, privacy, security, infeasibility, and Health IT performance.
Public Health and Clinical Exchange 10 Points Bonus 5 points	CMS proposes to require attestation to all four public health measures including Electronic Case Reporting, Syndromic Surveillance, Immunization Registry Reporting, and Electronic Lab Reporting, unless exclusions apply. We support CMS' efforts to incentivize increased data exchange with public health agencies, however there is a sufficient lack of readiness that our organization will need time to overcome: 1) Most of our hospitals are in Louisiana, Texas and New Mexico which do not currently support all public health registries., 2) Our MEDITECH 5.67 EMR does not currently support eCR. An upgrade or new code will likely be required to implement eCR which will take time, resources, and funding. 3) Within our EPIC facilities, we utilize a Cerner LIS for which we have not licensed or implemented ELR. As we are in the beginning stages of an enterprise-wide EMR project to update or replace the EMR in all our acute care facilities, this requirement would force our organization to expend significant time, resources, and funding to implement new public health interfaces in our EMRs that will be decommissioned in 2 to 3 years while simultaneously working to implement our new EMR. Implementing a new public health registry is highly dependent upon the availability of limited state resources. We feel that the number of other hospitals trying to get in the queue would impede or prevent many hospitals from meeting the 2022 proposed time frame.

Proposal	Comments
	We recommend offering bonus points in the PI program for reporting on additional public health measures for the 2022, 2023, and 2024 reporting years. We recommend making them required in 2025 to provide more time for readiness of states, EMR vendors, and organizations.
SAFER Guides	CMS proposes to require hospitals to complete an annual self-assessment using ONC's SAFER Guide worksheets. We support the promotion of best practices for the safe use and maintenance of health IT by hospitals. In addition to the annual SRA (security risk analysis) requirement the proposal to complete all 9 safer guides would be time and resource intensive. We fully anticipate that not all of our 3rd party contracted SRA vendors will be able to add the SAFER Guides to their existing scope for the 2022 timeline. Also, many of the Safer Guide elements represent one-time configuration or verification steps that would be unchanged from year to year for many organizations which reduce the positive benefit to completing the guides while adding a significant annual administrative burden. We recommend that CMS consider allowing sites to select one of the available guides to complete in 2022. For each subsequent year, a new guide would need to be selected and completed. **Request for Clarification** We request that CMS explain the impact of attesting "no" to the SAFER Guides measure on PI program compliance.
eCQM alignment with IQR Program	CMS proposed to add two new measures in 2023 and removing four existing measures in 2024. We recommend that CMS consider additional eCQM options in anticipation of having fewer available measures in 2024 if four are removed. If new eCQMs are introduced, vendors and organizations will need additional time to implement.
Additional Requests for Information	**FHIR and the Health Information Exchange** CMS solicits input on the degree to which stakeholders are currently using or interested in using FHIR APIs to exchange information in support of the measures under the HIE objective in Promoting Interoperability. Within our organization, the direct messaging standard and/or vendor-neutral networks using the IHE XCPD and XCA Integration profiles are predominantly utilized for the exchange of patient records for treatment. We recommend that CMS monitor the transition to the use of FHIR and RESTful APIs to

Proposal	Comments
	conduct exchange over the coming years to inform its approach for incorporating API usage into the measures for the HIE objective. As nationwide networks and exchanges are still determining how to incorporate the use of FHIR, CMS should refrain from including FHIR in a performance-based metric for health information exchange. If CMS does incorporate the use of FHIR APS into its existing HIE measures, we recommend that CMS consider whether or how to rewrite the denominator of the volume-based measure for Receiving and Reconciling Health Information. **FHIR and Public Health Agencies** We recommend that CMS continue to provide options within new or proposed measures that allow public health agencies to utilize either existing standards-based interfaces (e.g., HL7 v2 interfaces) or FHIR for reporting.