799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

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

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation (CMS-1771-P)

Dear Administrator Brooks-LaSure,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding the fiscal year (FY) 2023 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals (CMS-1771-P) (hereinafter, "Proposed Rule"). Many of the topics in the Proposed Rule have a significant impact on our members and the patients they serve. Given the financial uncertainty and increased costs that stems from the disruptions caused by the pandemic and other external factors, Vizient is concerned that several of the Proposed Rule's policies do not capture hospitals' increased costs. Vizient encourages CMS to advance payment policies that provides both stability and adequate reimbursement.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality and market performance for more than 50% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics and advisory services, as well as a contract portfolio that represents more than $100 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

In our comments, we respond to various issues and proposals provided in the Proposed Rule and offer our responses to the agency's various requests for information. We thank CMS for the opportunity to share recommendations related to IPPS, quality programs, the Medicare Promoting Interoperability Program and health equity, among other topics. In addition, we

offer future recommendations for the agency's consideration as the Proposed Rule is finalized and to inform future rulemaking.

Proposed IPPS Payment Rate Updates for FY 2023 and the Market Basket

CMS indicates that after accounting for inflation and other adjustments required by law, the Proposed Rule would increase IPPS operating payment rates by 3.2% in FY 2023 for hospitals that successfully participate in the Hospital IQR Program and are meaningful electronic health record (EHR) users. In determining this increase, CMS estimated that the market-basket update will be 3.1%. In the FY 2022 IPPS Final Rule, CMS rebased and reviewed the hospital market basket using the 2018-based IPPS hospital market basket to replace the 2014-based IPPS market basket, effective October 1, 2021. In Vizient's comments regarding the FY 2022 IPPS proposed rule, we expressed concern regarding this process as the impact of COVID-19 would not be accounted for in the updated market basket.

Vizient appreciates that CMS uses recent data to estimate the market basket but encourages CMS to consider whether additional changes are needed regarding the rebasing and revising of the market basket, given data from 2018 was relied upon in the FY 2022 IPPS final rule to determine the appropriate mix of goods and services, which may have been impacted be COVID-19. For example, as CMS is aware, during the pandemic there has been increased use of personal protective equipment (PPE), yet this utilization would not be captured in the market basket which was rebased and revised in the FY 2022 IPPS final rule. Vizient recognizes the difficulty in developing an accurate prospective payment system, particularly during a pandemic which has impacted how care is provided currently, and likely will shape care in the future. As a result, Vizient encourages CMS to review payment factors, such as the market basket, and the long-standing policy it uses to derive such factors, especially in the context of the COVID-19 pandemic.

Vizient notes that the market basket update of 3.1% as provided in the Proposed Rule does not reflect the ongoing and significant cost increases hospitals have faced, specifically as a result of inflation and labor. In the FY 2020 – FY 2022 IPPS Final Rules the market basket update ranged from 2.4% to 3.0%.[1,2,3] Vizient encourages CMS to consider more nuanced differences from the proposed and prior market basket updates to better determine whether current factors (e.g., inflation and labor costs) are appropriately considered in the FY 2023 proposed market basket. Vizient reiterates our concern that the proposed update is inadequate.

For example, regarding medical equipment and supply manufacturing costs, Vizient analyzed the U.S. Bureau of Labor Statistics (BLS) Producer Price Index (PPI) data[4] to better understand these cost increases. According to BLS, "The Producer Price Index (PPI) program measures the average change over time in the selling prices received by domestic producers for their output.

[1] CMS, FY 2022 IPPS Final Rule, available at: https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf, estimating the IPPS operating market basket to be 2.7 percent.
[2] CMS, FY 2021 IPPS Final Rule, available at: https://www.govinfo.gov/content/pkg/FR-2020-09-18/pdf/2020-19637.pdf, estimating the IPPS operating market basket to be 2.4 percent.
[3] CMS, FY 2020 IPPS Final Rule, available at: https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf, estimating the IPPS operating market basket to be 3.0 percent.
[4] U.S. Bureau of Labor Statistics, Producer Price Indexes, last updated June 14, 2022, available at: https://www.bls.gov/ppi/.

The prices included in the PPI are from the first commercial transaction for many products and some services." Vizient notes that the PPI can be used an indicator of future costs that hospitals will incur when purchasing medical equipment and supplies.

Table 1 includes the rate of cost increases to produce medical equipment and supplies (and, as such, does not include hospital labor costs) in 2021, May 2021 – May 2022 and January 2022 – May 2022. The 2021 percent change was 0.9%. In contrast, over the 12-month period of May 2021 to May 2022, the rate increased substantially to 3.2%, with a short-term trend (January 2022 – May 2022) showing continuous increases with an increase of 3.4%. In other words, since 2021, the PPI for medical equipment and supplies manufacturing has increased 2.5%, yet the market basket, as proposed, will have only had a modest increase of 0.4% from FY 2022. Thus, Vizient is concerned the current proposed market basket increase of 3.1% does not adequately capture these price increases. Additionally, the extreme inflation that all sectors are experiencing is largely reflected on the input costs of making products, which medical suppliers have just begun to pass along to the end users – which, in this case, are health care providers.

Time	Percent change medical equipment and supplies manufacturing (PPI Industry PCU 3391)
2021	0.9%
May 2021 – May 2022	3.2%
January 2022 – May 2022	3.4%

Table 1 Vizient analysis of BLS PPI data, including May 2022 data.

In addition, labor costs have drastically increased as well. The Vizient Operational Data Base (ODB), which provides hospitals with insights in support of performance improvement and includes data that is submitted by 75% of academic medical centers and represents more than $370 billion in operating expenses, showed an increase of 66% in licensed nursing staffing turnover in the 4th Quarter of 2021. That turnover and other staffing shortages have also led to a dramatic increase in hours paid for contract nursing (+250%) and an increase in overtime as a percent of worked hours (+33.5%), compared with the 4th Quarter of 2020. Higher use of contract nursing and greater utilization of overtime has resulted in the average hourly wage range (area wage index adjusted) increasing by 19.7%. Despite these pressures, nurses have also been spending less time at the bedside, with a reduction of 5.4% in registered nurse working hours per patient day. Combined, these issues have led to median labor cost increases of $114, or 16.4% per patient day. As such, Vizient emphasizes to CMS that the market basket, and ultimately the proposed payment rate increase, has not captured the increased costs that hospitals are enduring. We urge the agency to reconsider the proposed approach. Vizient also notes our willingness to leverage our data sources to help the agency in making this determination, however, CMS's data needs are unclear.

As an alternative, Vizient also encourages CMS to rely on more recent forecasts that the agency has published for FY 2023.[5] For example, in CMS's own forecasts for Q1 2022, the agency anticipates the market basket to be 4.1%, which is greater than the percentage provided

[5] Centers for Medicare and Medicaid Services. Market Basket Data, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData, last accessed: June 7, 2022.

in the FY 2022 IPPS final rule. Given that the market basket estimates which CMS previously relied upon appear to be inaccurate, we believe CMS should work to correct this issue proactively and reconsider the current, proposed market-basket, including underlying assumptions or data sources that may be causing greater-than-normal variation.

Proposed Payment Adjustment for Disproportionate Share Hospitals

Payment Reductions

In the Proposed Rule, CMS anticipates that disproportionate share hospital (DSH) payments would be reduced by more than $800 million in FY 2023, driven, in part, by an anticipated reduction in uninsured individuals. Vizient notes our concerns with the uninsured rate that the agency is relying on given the ongoing uncertainty related to COVID-19 flexibilities, particularly for Medicaid enrollment and uninsured rates. Vizient members rely on DSH payments, and we encourage CMS to provide more transparency and information regarding sources, including those used by the Office of Actuary, so that other stakeholders may similarly evaluate and compute DSH payments

Factor 3 Recommendations

To determine the uncompensated care payment, CMS considers three factors.[6] Of these three factors, "Factor 3" is a hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals, which known as Factor 3. For Factor 3, for FY 2023, CMS proposes to use two years of Worksheet S–10 audited data. Specifically, for FY 2023, CMS proposes to use data from FY 2018 and FY 2019 cost reports. For FY 2024, CMS indicates it plans to use three years of audited cost report data, which Vizient believes is a positive change. Vizient is supportive of using audited cost report data, and recommends CMS regularly assess and identify unusual or irregular trends in the data. In addition, we continue to encourage the agency to work with auditors to streamline the audit process and enhance consistency.

Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

States interested in designing their own Medicaid program may seek approval for a demonstration project under Section 1115 of the Social Security Act. In seeking approval, states can also ask that certain Medicaid requirements are waived, in accordance with the law. CMS proposes to revise regulations regarding its interpretation of "regarded as eligible for Medicaid assistance", which impacts the calculation of the Medicaid DSH fraction. Among other changes, CMS would only count individuals as being Medicaid eligible in the Medicaid fraction if those patients obtain health insurance directly or with premium assistance that provides essential health benefits (EHB) or patients for whom the premium assistance is equal to or greater than 90 percent of the cost of the health insurance, provided the patient is not also entitled to Medicare Part A. Consistent with Vizient's FY 2022 IPPS comments, Vizient is concerned that such a policy shift, if finalized, unnecessarily disrupts the DSH calculation for many hospitals and health systems in a manner that was not clarified as these waivers were advancing within the state and up to CMS for approval.

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[6] *See* Center for Medicare and Medicaid Services, (March 2021). MLN Connects Medicare Disproportionate Share Hospital (DSH), available at: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf, last accessed June 10, 2022.

More broadly, CMS acknowledges financial uncertainty regarding this proposed policy. CMS notes that the impact of this proposal on expenditures could not be estimated because it "does not have information on the number of section 1115 days by hospital which could be included in the Medicaid fractions absent the proposed revision to the regulation, which would be required to make an estimate."[7] Further, the policy could have far reaching consequences on hospitals' overall stability, as it could significantly impact their Medicaid DSH payments, threaten their participation in the 340B Program and would disproportionately harm hospitals in non-expansion states. As hospitals look to emerge from the COVID-19 Public Health Emergency (PHE), Vizient recommends CMS refrain from its proposed revision to the Medicaid fraction of the DSH calculation and instead continue to implement policies, such as those adopted in the American Rescue Plan Act, that encourage state expansion of Medicaid.

Proposed Changes Related to Medicare Severity Diagnosis-Related Group (MS-DRG) and Relative Weights

10-percent Cap on the MS-DRG Relative Weight

In the Proposed Rule, to avoid relative weight fluctuations, CMS proposes a permanent 10-percent cap on the reduction to an MS-DRG's relative weight in a given fiscal year, beginning FY 2023. CMS proposes to apply a budget neutrality adjustment to the standardized amount for all hospitals to ensure that the application of the proposed 10-percent cap does not result in an increase or decrease of estimated aggregate payments. CMS notes that this proposed policy would limit declines in the relative weight for 27 MS-DRGs. Vizient appreciates CMS's efforts to provide greater stability to the Medicare program, including through use of the proposed 10-percent cap. Given that CMS proposes to make this policy permanent, we encourage the agency to monitor for any unintended consequences, particularly since it would be implemented in a budget neutral fashion.

Request for Information: Reporting Social Determinants of Health Diagnosis Codes

In the Proposed Rule, CMS provides a Request for Information (RFI) on how the reporting of diagnosis codes in categories Z55-Z65 may improve the agency's ability to recognize severity of illness, complexity of illness and/or utilization of resources under the MS-DRGs. Vizient agrees that there is a need to improve documentation, including inclusion of Social Determinants of Health (SDOH) Z Codes. However, Vizient encourages CMS to provide incentives to providers, rather than mandates or potential penalties to increase Z code documentation.

In the Proposed Rule, CMS notes, "If SDOH Z codes are not consistently reported in inpatient claims data, our methodology utilized to mathematically measure the impact on resource use, as described previously, may not adequately reflect what additional resources were expended by the hospital to address these SDOH circumstances…"[8]. In response to the need to better understand the degree to which Z Codes are reported, Vizient performed an analysis using Vizient's Clinical Data Base (CDB).[9] Since Vizient accepts 99 diagnosis codes (as opposed to

[7] 87 Fed. Reg. 90 at 28713
[8] 87 Fed. Reg. 90 at 28179
[9] The Vizient® Clinical Data Base (CDB) is the definitive health care analytics platform for performance improvement. CDB provides high-quality, accurate and transparent data on patient outcomes — such as mortality, length of stay, complication and readmission

CMS's 25 diagnosis code limit) our data is unique from other sources, particularly for patients with more than 25 diagnosis codes. Vizient analyzed 6.6 million encounters using 2021 CDB data and found that of encounters with at least one SDOH Z Code, 79% had 25 or fewer diagnosis codes. As a result, SDOH Z codes may be more frequently reported than CMS estimates given only 25 diagnosis codes can be included on CMS claims.

For the remaining 21% of encounters (i.e., encounters with more than 25 diagnosis codes and at least one SDOH Z Code), Vizient found that the Z Code was more frequently (52%) recorded below the 25th position. In other words, had the same encounter data been reported on a Medicare claim, over half of those SDOH Codes would not be captured because only 25 diagnosis codes are included on CMS claims. Therefore, should CMS seek to accurately capture encounters where SDOH Z Codes are included, we urge the agency to permit more than 25 diagnosis codes on Medicare claims and to consider upwards of 99 diagnosis codes.

Vizient also notes that SDOH Z Code documentation has been increasing recently, but that we believe SDOH codes are largely underreported. As shown in Figure 1, which compares encounters from 2019-2021 with at least one SDOH Z Code, 2.9% of inpatient encounters included at least one SDOH Z Code and this number grew to 4.1% in 2021. Considering emergency department and observation encounters in 2021, only 1.4% of encounters included use of SDOH Z Codes and that only 0.2% of outpatient encounters have any SDOH Z Codes. Also, as shown in Figure 2, Vizient believes this information is important for CMS's consideration as it demonstrates that Z Code use is slowly increasing and that there is variability within and between settings.

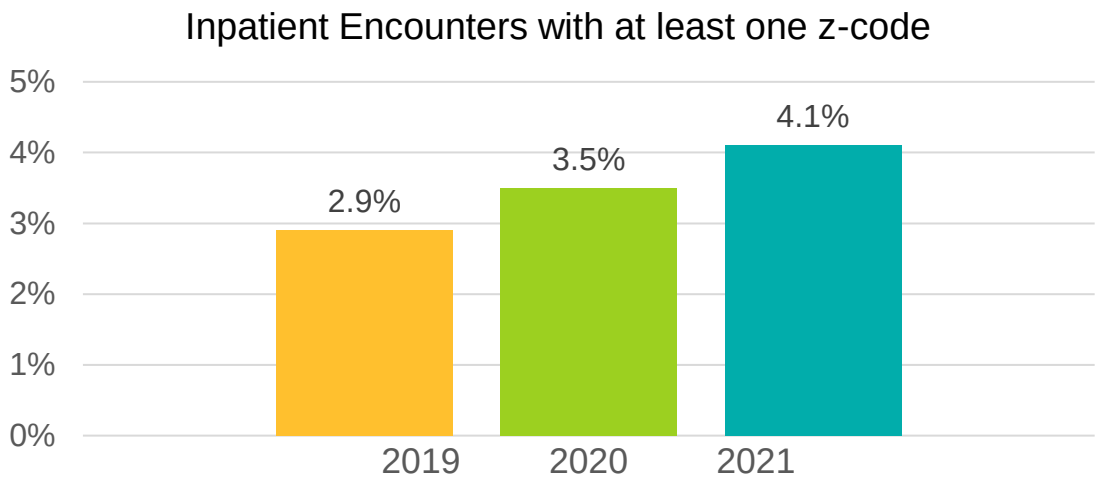

Figure 1 Graph showing the increasing amount of Z Codes included in patient encounter data from 2019 to 2021.

rates, and hospital-acquired conditions — that enable hospitals to benchmark against peers; identify, accelerate and sustain improvements; reduce variation; and expedite data collection to fulfill agency reporting requirements.

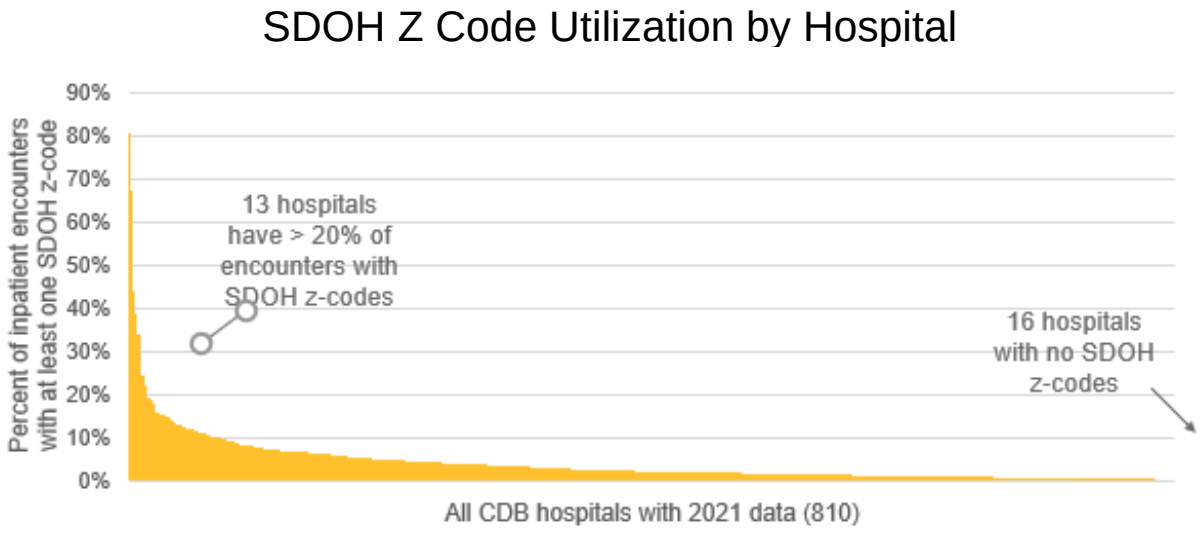

Figure 2 Graph showing that SDOH Z Code utilization is extremely variable by hospital.

In addition, regarding settings, Vizient notes that collection of SDOH information occurs during inpatient visits, but we offer that SDOH data collection may be actually best suited to office visits, where providers may have a greater opportunity to interact with their patients and consider more proactive approaches to help address their social needs. Therefore, as CMS considers approaches under IPPS, we also suggest the agency consider similar approaches in relation to the Outpatient Prospective Payment System and Physician Fee Schedule Rules.

CMS seeks comment on whether the agency should consider requiring more robust documentation and claims data reporting to help inform the agency's decisions regarding the most appropriate complication or comorbidity (CC) subclass (i.e., NonCC, CC or Major CC(MCC)) assignment for each SDOH Z code as a secondary diagnosis. Vizient discourages mandatory reporting requirements in this context as it may excessively increase provider burden and result in redundant questions being asked of patients. As an alternative to a mandate or penalty, Vizient instead suggests CMS provide incentives to support increased documentation of SDOH Z Codes. We note that alternative approaches to incent reporting may be warranted given there is significant variation regarding which Z Codes are reported, the frequency in which they are reported and provider variation. Based on Vizient's CDB analysis, Table 2 shows the top ten reported Z Codes. While CMS seeks feedback regarding which specific SDOH Z codes are most likely to increase hospital resource utilization related to inpatient care, we suggest the agency also consider why certain codes are documented more frequently than others. While Vizient is not suggesting the most frequently reported code are those that are most likely to increase hospital resource utilization, given the agency's broader aim to increase Z Code documentation, it may be important for the agency to consider current drivers of Z Code reporting.

Diagnosis	ICD Set	Cases
z590 - homelessness	10	118,972
z560 - unemployment, unspecified	10	78,771
z602 - problems related to living alone	10	39,718
z62810 - personal history of physical and sexual abuse in childhood	10	37,467
z5900 - homelessness unspecified	10	30,570
z634 - disappearance and death of family member	10	18,425
z597 - insufficient social insurance and welfare support	10	18,018
z638 - other specified problems related to primary support group	10	17,104
z599 - problem related to housing and economic circumstances, unspecified	10	12,131
z609 - problem related to social environment, unspecified	10	10,723

Table 2 Top ten most frequently reported diagnosis codes identified in Vizient analysis of CDB data.

In the Proposed Rule, CMS also requests feedback regarding whether Z59 (Homelessness) has been underreported. Vizient anticipates that homelessness, along with several other Z Codes, are being underreported. Vizient encourages the agency to consider using an index, such as the Vizient Vulnerability Index™ (VVI™),[10] as a resource when making determinations regarding whether certain Z Codes are underreported. Vizient has utilized the VVI to learn that SDOH Z-Code utilization increases with neighborhood vulnerability, as shown in Figure 3. Of the 6.6 million encounters with patients from neighborhoods with a VVI > 1, 450,000 (6.8%) have at least one SDOH Z Code. Of those reported codes, less than 1% of encounters have codes indicating education needs, food insecurity or inadequate drinking water. This information is relevant, as shown in Figure 4, as the VVI could be used to help demonstrate whether there is a significant gap in reported Z Codes and social vulnerability. Further, specific domains within the VVI can also be used independently to better gauge whether certain SDOH Z Codes are underreported based on aggregated data. Vizient welcomes the opportunity to further discuss this approach with the agency.

[10] Vizient developed a unique vulnerability index that serves as a singular clinical data index for SDOH at the neighborhood level. The index integrates publicly available data from various U.S. government agencies including the Census Bureau, Department of Agriculture, Department of Housing and Urban Development and the Environmental Protection Agency to provide deeper insights regarding community needs.

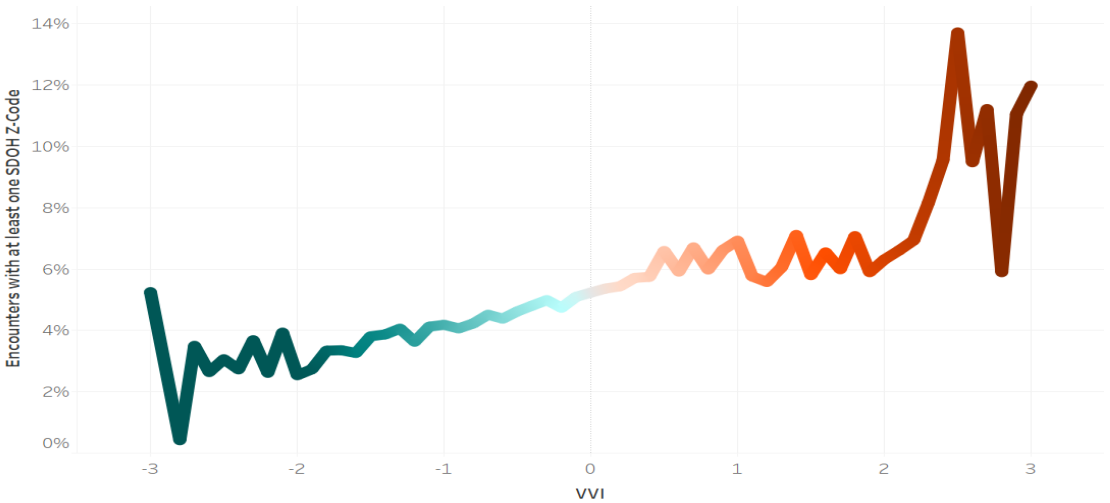

Figure 3 Application of the VVI to determine whether there is a relationship between more vulnerable neighborhoods (those with a VVI index score from 0-3) and whether encounter data includes at least one Z-Code.

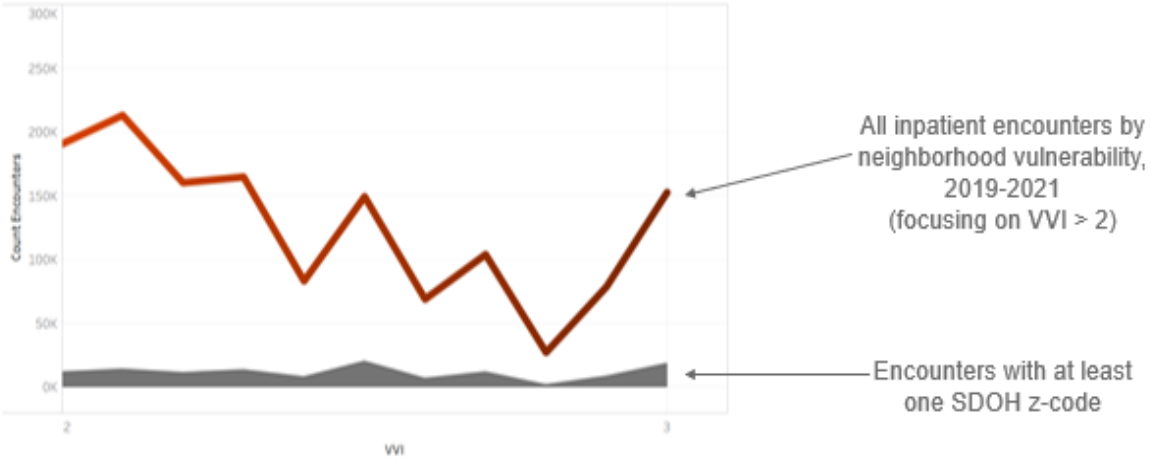

Figure 4 A comparison of the number of high-vulnerability encounters, where vulnerability is based on the VVI, compared to encounters with at least one SDOH Z Code.

Lastly, as CMS considers approaches to improve documentation, we recommend CMS also account for provider burden and potential challenges in obtaining information from patients. For example, patients may question why a provider is asking questions related to SDOH that may not be directly applicable to why they are seeking care, or if they are asked the same questions multiple times. Patients may also question why this information is being tracked and included on claims. Thus, we encourage CMS to identify opportunities to standardize screening efforts so that SDOH information can be more routinely collected, consistently captured, and ideally, appropriate interventions considered. Further, additional resources and training may be helpful to improve communications and support providers seeking to address patients' social needs.

Criteria to Create a New Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC) Subgroup within a Base MS-DRG

In the Proposed Rule, CMS restates its FY 2021 IPPS final rule policy to expand the criteria to create a new CC or MCC subgroup within a base MS-DRG to include the non-CC subgroup for a three-way severity level split. Vizient applauds CMS for again deciding to delay implementation of this policy for FY 2023, as we agree that it would cause significant disruption.

In the Proposed Rule, CMS does not provide information regarding future implementation of this policy. As such, should the agency plan for FY 2024 implementation, we encourage the agency to work closely with stakeholders to develop a phased-in approach to minimize disruption.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires that the Secretary of Health and Human Services adjust the standardized amounts for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. The proposed FY 2023 wage index values are based on Medicare cost report data for cost reporting periods beginning October 1, 2018, and until October 1, 2019. Given the strain of the PHE and significant variation in staffing trends, Vizient is concerned that CMS's data sources do not capture these changes. However, Vizient is supportive of efforts to provide stability, like CMS's proposal to apply a 5 percent cap on wage index decreases to prevent fluctuations. While we believe this approach will help hospitals, we also encourage CMS to consider other opportunities to improve its policies related to the wage index.

In the Proposed Rule, CMS notes its consideration of the best available data for purposes of the wage index. Based on the agency's review and analysis of the FY 2019 wage data, CMS found that the data is not significantly impacted by the COVID-19 PHE. However, based on the agency's description, the specifics of this analysis are unclear, as the agency does not reference specific tables or files for the public to review to confirm the agency's conclusion. Similarly, it is confusing why CMS would state that FY 2019 wage data was not impacted by the PHE given the PHE did not begin until March 2020. Vizient encourages CMS to share their source information so stakeholders can better understand the agency's position, particularly given our review of data, as described above, suggests that the cost of staffing has increased substantially.

Also, given CMS may be anticipating using data in future years that is more clearly affected by the COVID-19 PHE, Vizient suggests CMS clarify its anticipated approach to establishing the wage index and work with stakeholders on further developing or refining such an approach to promote stability and accuracy.

Proposed Use of National Drug Codes (NDCs) to Identify Cases Involving the Use of Agents Approved for New Technology Add-On Payments

For FY 2024, CMS proposes to use National Drug Codes (NDCs) to identify cases involving the use of therapeutic agents approved for new technology add-on payments (NTAPs). CMS notes that adequate time is likely needed for regular use of NDCs with the NTAP for health care providers and hospital professionals. As a result, CMS proposes a transitional period for

FY 2023, where CMS would utilize both NDCs and the ICD-10-PCS Section X codes to identify when an NTAP would apply. Vizient supports the use of NDCs to identify cases involving the use of agents approved for NTAPs and agrees that additional time is needed for this transition.

In addition, CMS indicates that since some therapeutic agents with an NTAP do not have an NDC (e.g., blood, blood products), CMS would identify these based on the assigned ICD-10-PCS procedure code and/or ICD-10-CM diagnosis code. Vizient recommends CMS provide additional education to providers regarding billing for these specific therapeutic agents and more broadly, for other products during FY 2023. We also encourage the agency to gain stakeholder feedback during the transitional year to determine whether additional time, technical changes or other work is needed to support providers.

Outlier Payment Adjustment

For cases with extraordinarily high costs, a hospital may be eligible to receive a payment in addition to the base prospective payment. More specifically, as provided by CMS, to qualify for an outlier payment, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any indirect medical education (IME) and DSH payments, uncompensated care payments, any NTAPs, and the "outlier threshold" or "fixed-loss" amount. Per the Social Security Act, outlier payments for any year should be projected to be between 5 percent and 6 percent of total operating DRG payments (not including IME and DSH payments), plus outlier payments.

In the Proposed Rule, CMS proposes to increase the outlier threshold to $43,214, which is a $12,266 increase from the FY 2022 outlier threshold. Regarding this increase, CMS indicates that the charge inflation factors calculated using the two most recently available years of MedPAR claims data (FY 2020 and FY 2021) are abnormally high as compared to recent historical levels prior to the COVID–19 PHE. CMS notes that it believes this abnormally high charge inflation level was partially due to the high number of COVID-19 cases with higher charges that were treated in IPPS hospitals in FY 2021. Since CMS anticipates fewer COVID-19 cases in FY 2023 than FY 2021, CMS proposes to use the March 2019 MedPAR file of FY 2018 (October 1, 2017, to September 30, 2018) charge data and the March 2020 MedPAR file of FY 2019 (October 1, 2018, to September 30, 2019) charge data to compute the proposed charge inflation factor. Vizient agrees with the need to consider COVID-19 in establishing payment policies under IPPS. However, Vizient is concerned that the increase to the outlier threshold increase would be to the financial detriment of many hospitals, even though CMS's target to have 5.1% of total IPPS payments to be used to pay for outliers has not changed. Given the drastic increase in the proposed outlier threshold for FY 2023 compared to FY 2022, Vizient urges CMS to consider whether any other authorities or policies can be applied to lower the threshold so is it more closely aligns with prior years' amounts and trends. Vizient also suggests CMS consider policies to mitigate future fluctuations in the outlier threshold to help maintain stability for hospitals.

Indirect and Direct Graduate Medical Education

CMS proposes to allow urban and rural hospitals that participate in the same separately accredited 1-2 family medicine rural track program (i.e., 1 year of training in a large, urban residency program followed by 2 years in a rural community) and have rural track FTE limitations to enter into "rural track Medicare GME affiliation agreements". CMS notes that

such affiliation agreements may be appealing because cap slots may be shared, and cross-training of residents can be better facilitated. Also, CMS proposes to only allow urban and rural hospitals to participate in rural track Medicare GME affiliated groups if they have rural track FTE limitations in place prior to October 1, 2022. CMS provides that eligible urban and rural hospitals may enter into rural track Medicare GME affiliation agreements effective with the July 1, 2023 academic year. CMS clarifies that under this proposal, no newly funded cap slots will be created. Vizient appreciates CMS's efforts to allow Medicare GME affiliation agreements and to provide additional clarity regarding this policy. Should implementation issues arise, Vizient encourages the agency to be flexible in its approach and, if needed, to consider future regulatory changes should implementation barriers emerge.

Hospital Readmissions Reduction Program

COVID-19 Related Changes

Due to the impact of COVID-19, in the FY 2022 IPPS final rule, CMS finalized suppression of the CMS 30-Day Pneumonia Readmission Measure for the FY 2023 program year. Beginning with the FY 2024 program year, CMS proposes to resume use of this measure in the Hospital Readmissions Reduction Program (HRRP). However, CMS indicates that patients with principal or secondary COVID-19 diagnosis from both the cohort and the outcome would be excluded. Vizient appreciates CMS's efforts to include the CMS 30-Day Pneumonia Readmission Measure beginning with the FY 2024 program year. However, to help hospitals better prepare for FY 2024 and future years where COVID-19 patients may be included, we suggest the agency share measurement information with hospitals that both includes and excludes patients with principal or secondary COVID-19 diagnosis.

Given the uncertainty regarding future rates of COVID-19 and the unknown effects of long-COVID on readmissions, Vizient also encourages CMS to consider whether any additional changes may be warranted.

Lastly, Vizient also encourages CMS to conduct an impact analysis of including and excluding COVID-19 diagnosis on future reports as alternatives are considered for future rulemaking. Such information will help stakeholders better understand the implications of such policies, especially given the uncertain future of the pandemic.

Request for Public Comment on Possible Future Inclusion of Health Equity Performance in the Hospital Readmissions Reduction Program

Vizient supports CMS's commitment to reducing health inequities by enabling providers to make more informed decisions and promoting accountability across the healthcare system. As a precursor to including health equity performance in the HRRP, Vizient provides various recommendations related to measurement and performance improvement.

As demonstrated in Figure 5, Vizient recommends CMS consider the multiple dimensions that impact health care disparities, including systemic, community, institutional, interpersonal, and intrapersonal, as categorized by the National Academics of Sciences. We also suggest CMS consider how each of these levels contribute to health care disparities. For example, Figure 6 highlights some examples at each level that would impact a patient with heart failure.

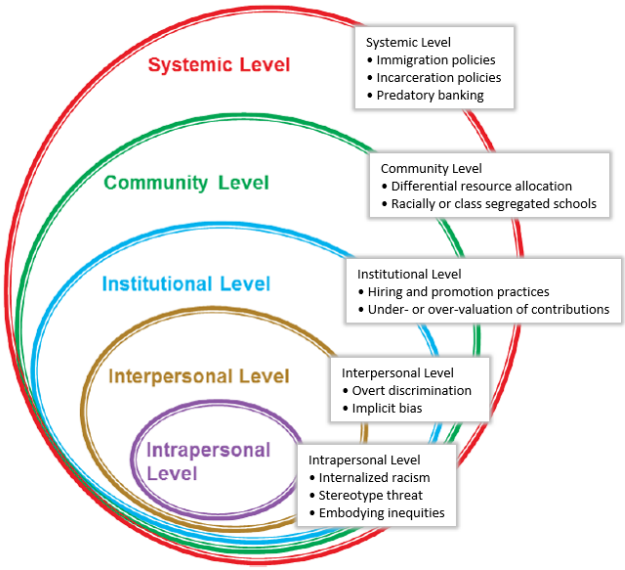

Figure 5. Social ecological model[11] that may be useful to CMS as health equity approaches are considered.

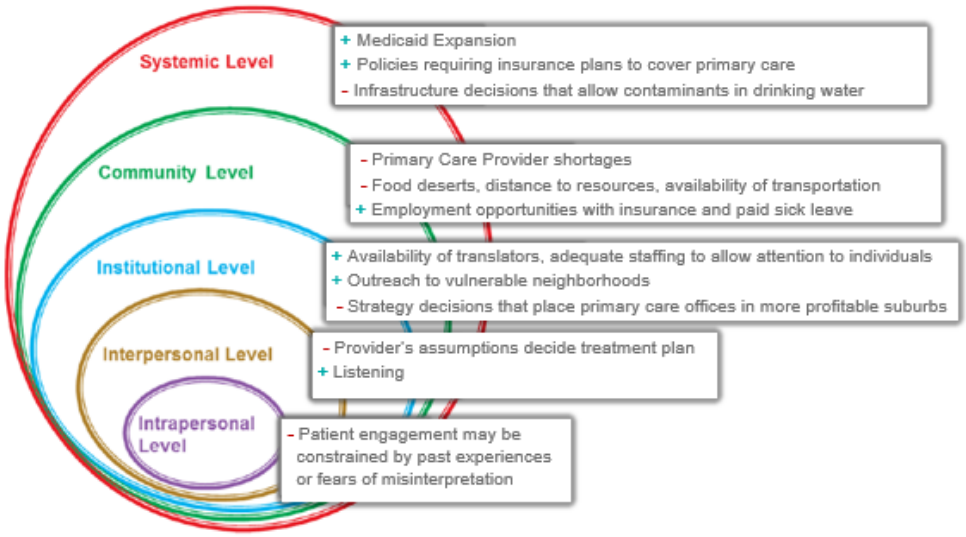

Figure 6. Social ecological model with Vizient-provided examples of constructs impacting a patient's health care journey.[12]

[11] *See* National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/2462, sourcing, a concept from McLeroy, K. R., D. Bibeau, A. Steckler, and K. Glanz. 1988. An ecological perspective on health promotion programs. Health Education Quarterly 15:351–377.

[12] *See* National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/2462, sourcing, a concept from McLeroy, K. R., D. Bibeau, A. Steckler, and K. Glanz. 1988. An ecological perspective on health promotion programs. Health Education Quarterly 15:351–377.

Measurement Considerations and Performance Improvement
To support providers with the information needed to drive quality improvement while ensuring accountability, Vizient recommends CMS adopt the following principles related to measure selection when inclusion of health equity performance is being considered:

- Measures should be within the provider's locus of control (i.e., a combination of outcome process measures that providers have direct influence/control over);
- Measures should be defined and based on clinically meaningful and cohesive patient populations; and
- Identify those measures in which 100% of the patients should receive care or "zero harm" measures for reporting.[13]

Once these measures have been identified and defined, to drive performance improvement, Vizient recommends CMS provide detailed encounter level assessments for providers to review and improve upon. These assessments can include meaningful stratification (e.g., race, ethnicity, gender) and must be thoughtful regarding the appropriateness of social risk factors for risk adjustment.

Vizient has a long history in quality measurement, including providing Ambulatory Care Quality and Accountability Rankings that measure the quality of outpatient care in five domains, one of which is equity. In Vizient's experience in measuring health care disparities, we have focused on a clinically specific condition that evaluates the combination of process and outcome measures that are directly within the provider's locus of control. For example, Vizient has measured both lactate lab draws within 12 hours of a patient arriving to the hospital with severe sepsis present on admission and associated in-hospital, risk adjusted sepsis mortality stratified by race, gender and payer. Vizient then evaluates statistical differences between each stratum and shares with providers encounter-level details for review and performance improvement. Vizient members have found this approach meaningful in identifying clear opportunities for improvement (e.g., a hospital where performance differences are identified can better understand the circumstances of those cases and evaluate the lactate timing differences and improve processes of care). We encourage CMS to take a similar approach, as our members have used this information to help guide various process improvements to enhance performance to the benefit of patient.

Readmission Measures
Vizient cautions CMS that evaluating health care disparities for 30-day readmission rates is highly challenging given the multiple layers that influence the outcome of 30-day readmission measures. Locus of control regarding 30-day readmissions spans the full spectrum of influences from community, provider, payer and patient. Given these multi-locus of control factors, providers will be limited in their ability to influence these factors and thus, unlikely to meaningfully improve performance if performance is measured too broadly. Currently, Vizient does not evaluate health care disparities for 30-day readmission rates for the aforementioned reasons and instead we offer reporting on 7-day and 14-day readmissions within our CDB. In turn, Vizient does not recommend CMS penalize hospitals based on 30-day readmissions at this time. Rather, CMS should consider this only if systemic factors influencing these measures are quantified and appropriate attribution is assigned to all accountable parties.

[13] Zero harm measures for reporting are hospital-acquired condition measures.

As a short-term step, Vizient does support CMS reporting and stratifying HRRP measures by REaL and SOGI and dual eligibility payer status for insight into disparities; however, Vizient emphasizes that we do not support penalizing hospitals for failure to address factors outside their locus of control. In turn and as noted above, Vizient recommends CMS identify measures more within the provider's locus of control, such as adherence to clinical care practices or possibly a shorter readmission assessment period (e.g., 3 to 7-days), given the agency's aim of including SDOH factors into adjustment. Vizient believes these types of measures, when appropriately reported and stratified, enable healthcare providers to make more informed decisions and provide clearer lines of accountability than 30-day readmissions. Additionally, focusing on a more provider-focused set of measures would minimize the need for additional social risk factor adjustments, such as dual-eligibility or place-based social needs indices. Vizient recognizes this would be a significant shift from the current HRRP measurement framework, however, given the aim of eliminating healthcare disparities, having a clear, actionable measurement from which providers can identify and clearly drive change is paramount.

Use of a Social Needs Index in the HRRP

However, Vizient understands that CMS may not adopt our recommendations. Should the agency instead decide to pursue inclusion of health equity performance in the HRRP, we offer additional recommendations. More specifically, as CMS is contemplating using a social needs index, we urge the agency to consider using the VVI, which was designed for health equity purposes. Before developing the VVI, Vizient conducted an extensive analysis of different social needs indices, as outlined in Table 3 and Attachment 1.

	Area Deprivation Index	Distressed Communities Index	Social Vulnerability Index	Intercity Hardship Index	Child Opportunity Index	AHRQ Socioeconomic Status Index	Vizient Vulnerability Index
Data granularity	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code × Census Tract × Block Group	✓ County • Zip Code possible ✓ Census Tract • Block Group possible	• County possible • Zip Code possible • Census Tract possible • Block Group possible	× County ✓ Zip Code ✓ Census Tract × Block Group	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code ✓ Census Tract ✓ Block Group
Timeliness	Updated in 2015 and 2019	Updated annually	Updated every two years	Not provided at the national level; algorithm available	2010 and 2015	Updated in 2015 and 2019	Updated annually
Social Determinants of Health Domains	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation ✓ Social Environment ✓ Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing ✓ Health Systems ✓ Transportation ✓ Social Environment ✓ Physical Environment × Public Safety (in development)
Health Care Focus	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence ✓ Readmissions ✓ ED utilization ✓ Maternal Health
Measurement Focus	17 components 2 components account for almost all of the variation (income and housing) Intended to predict mortality, but a poor fit to life expectancy (r^2 0.25)	7 components 2 components account for almost all of the variation (income and housing) Intended to describe economic differences; poor fit to life expectancy (r^2 0.31)	14 components in 4 domains, 2 components account for almost all of the variation (income and education) Intended for disaster management planning; poor fit to life expectancy (r^2 0.20)	6 components 2 components account for almost all of the variation (income and education) Intended to describe economic differences; poor fit to life expectancy (r^2 0.14)	29 components in 3 domains no serious issues with partial correlations Reports a moderate relationship to life expectancy (r^2 0.43)	7 components no serious issues with partial correlations Intended to describe economic factors related to health care access; poor fit to life expectancy (r^2 = 0.30)	19 components in 8 domains. All are significant in different locations Intended to describe differences in life expectancy (r^2 0.63)
Geospatial Adjustments	Single index algorithm for the whole country	Single index algorithm for the whole country. Small zip codes excluded	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country, but with state or local standardization options	Single index algorithm for the whole country	Index adapts to local relevance of each domain as it correlates with life expectancy

Table 3 Comparison of various indices potentially being contemplated for purposes related to social risk.

While the agency may be considering other indices, these other tools can pose various challenges. The VVI was developed for health equity specifically, as our research indicated there was a significant need for such an index. Other indices were less insightful in the context of health equity, as they provided little granularity (e.g., the ARHQ SES index provides information by block group) or had too little health care measures included (e.g., the ADI includes only life expectancy/mortality and readmissions). Further, when modeling to fit life expectancy, each index Vizient studied (e.g., those compared in Table 3) had significant opportunities for improvement. As a result, Vizient developed the VVI to better demonstrate the effect of various SDOH domains on community health outcomes and life expectancy.

Further, through our analysis we learned that several indices had insufficient data granularity or did not adapt geographically to provide more actionable and tailored insights. The VVI includes more substantial data granularity, domains of social determinants of health and has a clear health care focus. The VVI includes geospatial adjustments based on local relevance of each domain as it correlates with life expectancy. Thus, should CMS utilize an index, we recommend the VVI be utilized, and we welcome the opportunity to discuss how CMS may best leverage it. Also, we urge CMS to be cautious in utilizing indices that are not designed to serve health equity-related purposes or may not provide sufficiently granular or actionable information related to social risk factors. Again, we emphasize our willingness to work with the agency to help support a thoughtful approach to including health equity performance in the HRRP.

Hospital Value-Based Purchasing (VBP) Program

The ACA established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person and Community Engagement. Typically, the applicable incentive payment percent is required by statute (e.g., 2 percent). In the Proposed Rule, due to the COVID-19 PHE, CMS provides changes to the Hospital VBP program that would prevent the application of the payment reduction. Vizient supports CMS's decision suppress measures and apply a special scoring methodology for FY 2023 so that hospitals do not incur a payment reduction.

In the Proposed Rule, CMS also provides policies to adjust for COVID-19 beginning with the FY 2023 Program Year (Oct. 1, 2022 to Sept. 30, 2023). Vizient appreciates CMS's efforts to better account for COVID-19 and we have similarly implemented a COVID-19 risk adjustment variable within our risk adjustment methodology for patients with a secondary diagnosis of COVID-19. Vizient found the risk adjustment variable we have implemented has quantified the additional clinical impact COVID-19 had on patients who came to the hospital without primarily seeking care for COVID-19. As more information is learned and the pandemic continues, Vizient encourages the agency to consistently monitor the results of any technical changes to identify the best risk adjustment approach.

Hospital-Acquired Conditions (HAC) Reduction Program (HACRP)

HACRP Payment Adjustment

In the Proposed Rule, due to COVID-19, CMS outlines a framework for the FY 2023 program year whereby no HACRP payment adjustments would occur. Vizient encourages CMS to clarify whether data for the FY 2024 program year will be considered for a similar adjustment.

While Vizient understands the agency is anticipating that it will resume calculating measure scores in the FY 2024 program year, in addition to providing certain COVID-19 related risk adjustments, Vizient suggests the agency continue to monitor the data should this risk adjustment be inadequate.

In addition, for the HACRP and other quality programs, Vizient urges CMS to provide additional resources and education to providers regarding the data-related changes and review periods. Vizient has heard from members that there is confusion regarding which data CMS will use and the application of the various pandemic-era policies. More clear information, and potentially additional flexibility, may be needed to support hospitals that identify errors in data and to better understand the implications of these changes moving forward.

Flexibility for Changes that Affect Quality Measures During a Performance or Measurement Period in the HAC Reduction Program

In the Proposed Rule, CMS outlines various measure suppression policies that the agency has provided due to the pandemic. For example, through application of an Extraordinary Circumstances Exception (ECE) policy, all data submitted through Q1 and Q2 of CY 2020 are to be excluded from HACRP performance calculations for FY 2022 and FY 2023. For Q3 and Q4 of CY 2020, CMS also indicated it would suppress CDC NHSN HAI and CMS PSI 90 data from performance calculations for FY 2022, FY 2023 and FY 2024. Vizient encourages CMS to continue to provide outreach and education to ease burdens in tracking the various changes and prevent reporting issues. In addition, Vizient suggests CMS clarify whether retroactive suppression will be considered by CMS for future reporting periods.

Lastly, given the various changes that the HACRP has and will undergo, Vizient notes that it may be an adjustment for hospitals to learn the impact of the reports and changes needed to drive improvement. In addition, there may be unintended consequences to the proposed changes and related data insights that should be monitored and shared, especially if changes to the program may be warranted.

Request for Information: Digital NHSN measures

In the Proposed Rule, CMS seeks feedback regarding the potential adoption in the HACRP and the Hospital Inpatient Quality Reporting (IQR) reporting program of two digital NHSN measures. The two digital measures are the NSHN Healthcare-associated *Clostridioides difficile* Infection Outcome measure and NHSN Hospital-Onset Bacteremia & Fungemia Outcome measure. Vizient notes the importance of taking a gradual approach to the adoption of new measures, and that real-world testing of metrics can help identify unanticipated issues. Thus, Vizient recommends, that the agency provide an implementation period whereby measures could be tested in a real-world setting before officially included in either program.

Regarding digital measures, Vizient notes that there is additional provider burden based on the need to validate algorithmic determinations. While digital measures may reduce manual data collection, we recommend CMS provide measure accuracy and specificity performance so that hospitals do not spend excess time reviewing inaccurately identified cases. Also, the digital measures currently lack measure specificity and accuracy compared with existing reported and evaluated measures. Thus, additional clarity is needed before these measures should be considered for inclusion.

Also, as CMS is aware, there could be duplicative reporting with existing NHSN measures. Should CMS pursue these measures, we encourage the agency to also consider how existing

NHSN measures would be treated, particularly if digital measures would eventually replace existing measures.

Hospital Inpatient Quality Reporting (IQR) Program

For the Hospital IQR Program, CMS proposes to adopt ten new measures, including the Screening for Social Drivers of Health measure[14] and the Screen Positive Rate for Social Drivers of the Health measure.[15] As noted in Vizient's comments to the National Quality Forum, we have several recommendations regarding each measure but applaud efforts to better prioritize health equity.

Screening Measures

Regarding the Screening for Social Drivers of Health measure, Vizient notes our concern that there is no standard definition for "screening" or "social drivers of health" as related to this measure, and limited information is provided regarding the identified social risks. Clear and consistent definitions are critical to collecting data that can be meaningfully used by health care providers to improve outcomes for patients. In addition, defining such terms also supports identification and use of validated screening tools. Without consistency, it will be even more difficult for health systems or CMS to address the patient needs identified during the screen, and it will erode patient trust if it is unclear why the information is collected or what follow-up options exist. Vizient suggests CMS include this measure in the Hospital IQR Program only if the agency defines these terms clearly prior to finalizing the measure's inclusion and works more directly with providers to support consistent screening.

Vizient also notes that prematurely finalizing this measure will limit the utility and comparability of collected data. Standardization is critical for ensuring that patient data collected by health systems can be effectively utilized to address community needs and to ensure that future measures promote community-wide improvements in social drivers of health. A risk of approving this measure without standards is that inconsistent data collection will yield incomplete or unusable data sets, which could make any future analysis for development of new measures to address social drivers difficult. We encourage CMS to work with stakeholders to define and set the standard for data collection to ensure the patient data collected will be used to promote health equity.

Similarly, Vizient is concerned about the inclusion of the Screen Positive Rate for Social Drivers of Health measure given the lack of standardization for data collection for this measure. Vizient reiterates our support of efforts to address health equity and believes screening and data collection are critical steps to help learn more about inequities and patient needs. However, without clear definitions of who to screen or what constitutes a positive screen, it will be difficult to benchmark or meaningfully interpret the data collected. Also, without these definitions, publicly reported data could be misleading. In addition, it is critical that if the agency's policies effectively encourage healthcare systems to ask and collect social

[14] Screening for Social Drivers of Health: Measures the percent of adult inpatients that are screened on the day they are admitted for one type of social risks (i.e., food insecurity, housing instability, transportation needs, utilized needs, and interpersonal violence).
[15] Screen Positive Rates for Social Drivers of Health: Comprised of five measure that aim to include the percent of screened adults who screen positive for each social risk (i.e., food insecurity, housing instability, transportation needs, utilized needs, and interpersonal violence).

needs information, then it is similarly important that patients can be connected to resources based on their responses and that patients understand why social needs information is being collected.

Vizient also notes that this measure does not account for differences by geography, which is critical because a substantial pool of evidence supports the notion that where an individual lives greatly influences health and that a patient's community relates to their social needs. Vizient recommends CMS use a resource, such as the VVI, to provide insights to existing social challenges impacting patients.

Vizient's analyses have shown significant variation in community needs across large geographic areas, as well as within local markets at the zip code level. Vizient notes that accommodations for geographic variation could be achieved through benchmarking using an index of local obstacles to care (e.g., VVI). As provided in Table 3, Vizient has recently reviewed several state and national indices intended to help provide benchmarks for community need. Vizient is willing to work with CMS to leverage our analysis or conduct a similar analysis to evaluate approaches to account for geographic variability in relation to this measure.

Burden

Vizient also notes our concern that the quantity of measures being proposed for inclusion in the Hospital IQR Program may impose excessive burden. While CMS proposes to phase-in measures during the CY 2023 or CY 2024 reporting periods, these changes still impose additional burden on hospitals. We encourage CMS to consider removing measures that may be topped out or measures that may have limited long-term utility. For example, as noted above, the lack of standards for REAL and SOGI data create unnecessary burden for hospitals. This issue is then exacerbated by adding health care equity measures that are more focused on data collection, rather than efforts to drive performance improvement opportunities in the context of the collected information.

Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

In the Proposed Rule, CMS proposes to establish a hospital quality designation related to maternity care that would be publicly reported on a CMS website beginning Fall 2023. CMS provides that the designation would be awarded based on a hospital's attestation of submission of the Maternal Morbidity Structural measure, which was adopted in the FY 2022 IPPS final rule and is designed to determine hospital participation in a state or national Perinatal Quality Improvement collaborative, and implementation of patient safety practices. Vizient supports efforts to improve maternal health but notes that these two factors alone (i.e., hospital participation in a Perinatal Quality Improvement collaborative, and implementation of patient safety practices) may not provide enough information to effectively distinguish hospital quality. This is concerning because less stringent designation criteria may result in the maternal patient population being misled.

Regarding the designation, given that it will be publicly reported and that the criteria appear to be evolving, Vizient encourages CMS to provide a title to the designation that is better reflects the hospital's attestation and scope of that attestation to prevent confusion.

Vizient also recommends that CMS clarify long-term plans regarding the establishment of the designation. Given that Medicare beneficiaries tend to produce relatively few claims for

services related to maternity care, CMS's desired impact with the designation is unclear, although the agency does indicate the designation would "assist consumers in choosing hospitals that have a demonstrated commitment to maternal health…". Vizient remains supportive of efforts to increase transparency but believes that understanding the agency's long-term plans for the designation will lead to more meaningful stakeholder feedback. Further, Vizient notes that many patient-specific factors like coverage and access are likely to heavily impact the patient's choice of hospital.

Medicare Promoting Interoperability (PI) Program

Request for Information: Patient Access to Health Information Measure (Medicare PI Program)

In the Proposed Rule, CMS provides a broad request for information regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the hospital or health care providers. Vizient notes our support of seamless patient access and use of their health information and appreciates that CMS has noted the agency's aim is not to add unnecessary burden on the hospital or health care provider. While Vizient believes the application programming interface (API) and application ecosystem is heading in the right direction, we believe it is premature for FY 2023, for CMS to revisit adding a measure of patient access to their health information. Rather, Vizient encourages CMS to monitor implementation of the CMS Interoperability and Patient Access Final Rule to better understand preparedness and potential provider burden before advancing this measure in the Medicare PI Program.

New Medicare Promoting Interoperability Program Measure Proposals

Among other new measures, CMS proposes to add the "Enable Exchange Under TEFCA measure" to the Health Information Exchange Objective. Under this proposed measure, an eligible hospital or critical access hospital (CAH) could earn credit for the Health Information Exchange Objective by connecting to an entity that connects to a Qualified Health Information Network (QHIN) or connecting directly to a QHIN. Specifically, CMS proposes to add the new measure to Health Information Exchange Objective beginning with the electronic health record (EHR) reporting period in CY 2023. Vizient supports policies the promote information exchange and this proposed, optional measure may help support such information exchange.

Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report Data Elements to Address Any Future Pandemics and Epidemics as Determined by the Secretary

In the Proposed Rule, CMS notes that hospitals and CAHs must be certified as meeting Federal participation requirements (e.g., Conditions of Participation (CoPs), Conditions for Coverage (CfCs)). During the COVID-19 PHE, CMS issued new CoPs to require that hospitals and CAHs report certain COVID-19-related data (e.g., number of staffed beds, supply information, count of patients with COVID-19, inventory of COVID-19-related therapeutics) in the frequency and format specified by the Secretary. In December 2020, CMS expanded these reporting requirements to consider acute respiratory illness (e.g., Seasonal Influenza Virus, Influenza-like Illness, and Severe Acute Respiratory Infection).

Based on the agency's experience throughout the PHE, CMS is considering adopting a more agile regulatory framework to support the response to a future pandemic or epidemic. As a result, CMS proposes to review the hospital and CAH infection prevention and control and

antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements until April 30, 2024. Vizient supports efforts to harness data to help with preparedness and response efforts. During the COVID-19 PHE, hospitals have been strained and undergone rapid changes in the scope and frequency in which data is reported. This effort, as CMS is aware, is incredibly burdensome to hospitals. Further, hospitals are provided little information regarding how data is being used or why specific data points were selected. Vizient recommends CMS provide additional clarity to hospitals on this topic before finalizing the proposed CoPs. Further, we encourage CMS to share how decisions regarding the need to report will be made in the current COVID-19 PHE and future potential PHEs. Lastly, to the extent possible, we encourage CMS to consider opportunities to ease burdens and streamline any reporting requirements. Again, Vizient understands the value in having more robust data available in times of an emergency and for preparedness reasons. However, we also believe it is important that CMS offer greater clarity and support to providers, including financial support, to better ensure that such reporting requirements can be achieved without substantial disruption or strain, as has been the experience during the COVID-19 pandemic.

Request for Public Comments on IPPS and OPPS Payment Adjustments for Wholly Domestically Made NIOSH-approved Surgical N95 Respirators

In the Proposed Rule, CMS indicates that, due to supply challenges during the pandemic, the federal government is interested in encouraging the purchase of "wholly domestically made NIOSH-approved surgical N95 respirators". CMS acknowledges that these wholly domestically made respirators are generally more expensive than foreign made respirators. As a result, in the Proposed Rule, CMS requests comments on a possible payment adjustment, which would be applied in a budget neutral manner, to support a wholly domestic supply chain for NIOSH-approved surgical N95 respirators. Vizient applauds CMS's efforts to consider reimbursement approaches that aim to strengthen the supply chain and recognize providers' increased costs but encourages the agency to consider alternative approaches and products.

Incentivizing Domestic Manufacturers' On-Hand Inventory

Vizient notes that the majority of the surgical N95s used by hospitals are already produced domestically (i.e., United States is the final place of manufacturing; see Vizient's below insights regarding the term "wholly domestically made"). While some surgical N95s are produced near-shore (i.e., Mexico), given that the majority of surgical N95s are produced domestically, a payment adjustment may not have the intended impact for supply assurance. From Vizient's perspective, one of the most significant problems observed during the pandemic was the drastic increase in demand, coupled with the inability of domestic production to "ramp up" quickly enough. While some alternatives were available, each type of surgical N95 must be individually fit tested to work properly, so changing N95 suppliers was challenging for hospitals. Based on this information, Vizient believes that there is an opportunity to incentivize domestic manufacturers to hold more inventory on-hand in the event of another spike in demand. While holding increased product on-hand would require warehousing and rotating product, it would also allow some time for "ramping up" while using additional stock on-hand. Thus, an alternative approach could be for CMS to provide an add-on payment to providers who attest to purchasing surgical N95s through contracts that include terms related to on-hand inventory. Vizient believes this would be a more feasible approach, especially given the success of Vizient's Novaplus Enhanced Supply Program, which prioritizes domestic manufacturing and requires suppliers to keep 90 days of stock on hand, warehoused domestically, to aid in supply assurance.

Information to Inform Future Adjustments
Other than information obtained from hospital cost reports or claims, Vizient encourages CMS to consider inflation and procedure costs to inform future adjustments.

Potential Frameworks
In the Proposed Rule, CMS outlines two potential frameworks to reimburse providers, either (i) a biweekly, interim lump sum payment that would be reconciled as a cost report settlement or (ii) an MS-DRG add-on payment that could be applied to each applicable Medicare IPPS discharge. Vizient notes that both frameworks raise concerns regarding administrative burden, but an MS-DRG add-on payment may be less burdensome since it is part of the billing process. However, Vizient believes additional staff training would be critical to implementing this option to ensure the unique billing code is added to each claim.

Lump-Sum Payment Framework
In the Proposed Rule, CMS requests feedback regarding the appropriateness of using the ratio of Medicare inpatient cases to total inpatient hospital cases for all payers reported on the Medicare cost report to determine Medicare's share of costs for purchased wholly domestically made NIOSH-approved surgical N95 respirators. Vizient believes this approach would be challenging and vulnerable to inaccuracies. For example, Medicare beneficiaries may be admitted as inpatients for reasons that vary from patients with other payers; the service provided can impact the type and volume of supplies that are used. A ratio of cases alone would not account for such variation. This is just one example that Vizient notes as concerning with this approach.

Also, regarding the lump-sum payment framework, CMS asks, "Strictly for purposes of calculating a cost differential in such situations, should a national minimum cost be established for a NIOSH-approved surgical N95 respirator that is not wholly domestically made?". Vizient notes that since the majority of surgical N95s are already domestically made (see below), this would be a challenging methodology to implement. Vizient believes CMS could potentially consider a methodology that relies on manufacturer reporting to inform pricing. Further, there are price differences in different styles (e.g., Duckbill, Molded Cup, Flexing Style) of surgical N95s, adding another element of complexity to this potential approach. Considering quality and style to ensure the appropriate comparison of masks in determining a national minimum cost would be challenging, and CMS would likely benefit from additional stakeholder input.

Claims-based Payment Framework
In the Proposed Rule, CMS outlines a potential claims-based framework for reimbursement, where an MS-DRG add-on payment could be applied. Regarding this approach, CMS asks, "how should Medicare calculate the per claim add-on amount prospectively given the varying costs of NIOSH-approved surgical N95 respirators, and how should it be updated given year-by-year cost changes for NIOSH-approved surgical N95 respirators?". Vizient notes that manufacturer reporting of prices can be important to establishing an add-on payment. Also, as noted in our comments regarding the lump-sum framework, there is a need to ensure similar product comparisons.

Identification of Wholly Domestically Made Surgical N95 Respirators
In the Proposed Rule, CMS notes that the U.S. Government is committing to purchase wholly domestically made PPE in line with new requirements in Section 70953 of the Infrastructure

Investment and Jobs Act. These new contract requirements stipulate that PPE purchased by covered departments must be wholly domestically made—that is, the products as well as their materials and components must be grown, reprocessed, reused or produced in the United States. Such contract requirements rely on other legislative and regulatory frameworks (e.g., Infrastructure Investment and Jobs Act and the Federal Acquisition Regulation) which are less familiar to health care providers. In addition, Section 70953 provides numerous exceptions for availability, and the scope of products impacted by such exceptions may vary from time to time based on procurement determinations in the United States. Vizient is concerned that CMS's reliance on the framework provided in the Infrastructure Investment and Jobs Act overcomplicates purchasing decisions and would disregard current practices related to purchasing. In addition, Vizient is concerned that there may not be enough suppliers in this market to promote competition should a narrow approach to "wholly domestically made" be taken in a future policy.

If CMS continues to encourage hospital purchases of "wholly domestically made" products, Vizient urges CMS to broaden the term "wholly domestically made" to focus instead on products manufactured domestically (i.e., final place of manufacturing within the United States)[16], as this information may be more readily shared by suppliers. Currently, some companies share pedigree information which may help identify the country of origin (e.g., one of Vizient's suppliers places the country of origin on the front of the box); however, sourcing information, particularly information about raw materials, is not consistently shared by suppliers, even if requested. Thus, it may be challenging to identify which products would be eligible to participate in the program. In addition, if only a single supplier can participate in the program, there may be inadequate competition.

Further, Vizient notes that the burden to determine whether a product meets the definition of "wholly domestically made" should not rest on group purchasing organizations (GPOs) or providers, especially due to a lack of transparency. Suppliers may be unable or unwilling to share pedigree information for a variety of reasons, which again poses implementation concerns should a narrow definition of "wholly domestically made" apply. Vizient understands that certain raw materials may be unavailable to source domestically, thus it is unclear which products would qualify and, should CMS consider broadening this effort to support a more resilient supply chain, the agency would be limited only to those products that could meet the requirements specified in Section 70953. For N95s and each subsequent product, it would be challenging to identify qualifying products. Further, if there is limited supply of materials in the United States, the supply chain may not be sufficiently redundant. For example, if only one raw material supplier existed in the United States and had an interruption, all other domestic manufacturers would need to identify alternative sources of raw materials, which could create access issues.

As noted above, to support a more resilient supply chain, Vizient strongly encourages the agency to consider approaches to support more inventory being stored domestically. Alternatively, should CMS continue its current approach, Vizient recommends the agency

[16] For CMS's consideration, Vizient defines products as "Made in the USA" if the final place of manufacturing is within the country's borders. *Final place of manufacturing* is defined as the location where the last significant transformation of the product takes place. *The country's borders* is defined as all 50 states, the District of Columbia and all U.S. territories.

broaden its definition of “wholly domestically made” such that the place of final manufacturing is in the United States.

Vizient also notes our recognition and support of numerous federal efforts that aim to increase supply chain transparency. As these efforts evolve, there may be different approaches to support a more resilient supply chain through payment adjustments to providers.

Budget Neutrality
To the extent possible, Vizient encourages CMS to pursue add-on payments that are not budget neutral, as hospitals truly need additional funds to be sustainable, particularly given increased workforce costs and inflation. While Vizient is sensitive to the need to preserve the Medicare Trust Fund, we are concerned with policies that impose, either directly or indirectly, additional financial strain on hospitals.

Program Integrity Safeguards
Vizient believes it is important for any payment adjustment policy to mitigate price increases for wholly domestically made NIOSH-approved surgical N95 respirators. Given that a large percentage of product is already produced in the United States, should CMS adopt a broader interpretation of “wholly domestically made” as Vizient suggests, it is important that the agency also be cognizant that manufacturers may also attempt to increase prices because providers may be perceived as having margins for these products. Therefore, Vizient suggests CMS consider approaches that result in manufacturers holding more inventory.

Also, Vizient notes the importance of minimizing burdens on providers for compliance and program integrity purposes, especially given the degree of information hospitals already share with CMS.

Domestic Sourcing Threshold
In the Proposed Rule, CMS seeks information regarding approaches to attest compliance as related to a domestic sourcing threshold of 50 percent for wholly domestically made surgical N95 respirators by or for the hospital. Vizient requests CMS clarify this question, as it is unclear whether the threshold is based on dollar amount or number of units. Further, as previously noted, Vizient encourages CMS to clarify the term “wholly domestically made” and, more generally, to consider an inventory-focused policy to address supply chain concerns.

Group Purchasing Organization Purchase of Wholly Domestically Made NIOSH-Approved Surgical N95 Respirators on Behalf of Health Systems
Vizient notes that Group Purchasing Organizations (GPOs) do not typically purchase (i.e., take title to) products. Vizient does not manufacture, label, package, repackage, maintain, inventory, sell, distribute, or control specifications for any product.

Other Types of Respiratory Devices and PPE that Should Be Considered for Payment Adjustments
Vizient urges CMS to consider other types of PPE for payment adjustments given, as previously mentioned, that surgical N95s are already substantially manufactured in the United States. Other products that were challenging to obtain during the pandemic include isolation gowns (these tend to be produced in China, Cambodia, and Mexico) and exam gloves (these tend to be produced in China and Malaysia). Throughout the pandemic, obtaining products from outside the United States was, and continues to be, very challenging. Vizient recommends CMS create incentives to encourage domestic production or increased product

on hand in these categories. However, Vizient reiterates that the supply chain is complex and certain factors such as raw material sources and transparency are critical to consider in supply chain resiliency strategies.

Should CMS also consider payment adjustments for medications, Vizient notes our willingness to share additional insights with the agency.

Request for Information (RFI): Overarching Principles for Measuring Equity and Health Care Quality Disparities across CMS Quality Programs

In the Proposed Rule, CMS describes the agency's ongoing evaluation of opportunities to expand measure stratification reporting initiatives using existing sources of data. In addition, CMS notes that it seeks input on five specific areas that could inform the agency's approach. Vizient applauds CMS for including this RFI in the Proposed Rule because it may help inform a future framework that is utilized across CMS quality programs to assess disparities in healthcare quality, among other efforts.

In addition to Vizient's recommendations in response to the RFI, we encourage the agency to consider various levels that influence inequities, opportunity to improve data collection and standardization, measurement of community social needs and structural inequities, provider care equity assessments and, more broadly, the need for a longer-term plan to collect patient-specific social needs factors and encourage community engagement.

Regarding factors that influence inequities, as shown in Figure 7 and related to work by the National Academics of Sciences,[17] there are various social determinants which can be categorized by level (i.e., systemic, community, institutional, interpersonal and intrapersonal) to help provide greater context to policy approaches. As CMS considers principles to measure equity and healthcare quality disparities across quality programs, the agency should consider a comprehensive measurement approach that accounts for each layer. Also, Vizient encourages the agency to carefully consider which factors are within a provider's control to help develop more targeted policy approaches. A better understanding of each level will lay the needed groundwork to better understand interaction of factors within and between each level.

[17] National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/2462, sourcing, a concept from McLeroy, K. R., D. Bibeau, A. Steckler, and K. Glanz. 1988. An ecological perspective on health promotion programs. Health Education Quarterly 15:351–377.

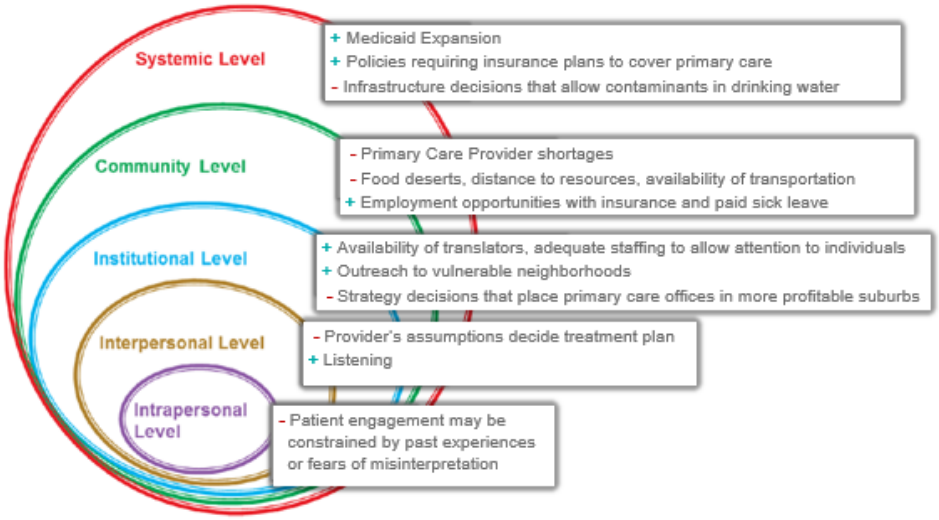

Figure 7 Social ecological model with Vizient-provided examples of constructs impacting a patient's health care journey.[18]

As CMS considers longer-term plans, Vizient also encourages the agency to identify how best to build from other programs, such as the Medicare Shared Savings Program and the Medicare Promoting Interoperability Program. We understand modifications to these, and other programs, would need to undergo rulemaking and benefit from stakeholder input, but do encourage the agency to consider additional opportunities to leverage these programs to support data standardization, measurement and infrastructure. For example, Vizient suggests CMS identify whether opportunities exist to expand the pool of accountable care organization participants to include community leaders or partners to emphasize a more holistic approach to care that better recognizes the role of community stakeholders.

To the extent possible, CMS could leverage insights from the Accountable Health Communities model that is underway, but also include a more robust equity-focused measurement framework and training opportunities. Vizient also appreciates CMS's current proposals to encourage participation in state and local health information exchanges, as this will help improve data capture and share of patient-specific social needs data more consistently. Vizient welcomes the opportunity to provide CMS more detailed information regarding such a longer-term strategy.

Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs

In the Proposed Rule, CMS notes, "By quantifying healthcare disparities through measure stratification (that is, measuring performance differences among subgroups of beneficiaries), we aim to provide useful tools for healthcare providers to drive improvements."[19] Also, CMS provides two approaches (i.e., within-provider disparity method[20] and across-provider disparity

[18] *Id.*
[19] 87 Fed Reg 66 at 20247
[20] The "within-provider" disparity method type of comparison identifies disparities, or gaps in care or outcomes between groups at a hospital. For example, after stratification by dual eligible status, measure results for subgroups of patients served by an individual healthcare provider can be directly compared.

method[21]) that are already used to confidentially provide disparity information to hospitals for a subset of existing measures. Further, CMS indicates that when reported together with overall quality performance, these two approaches may provide detailed information about where differences in care may exist or where additional scrutiny may be appropriate. Vizient agrees that sharing stratified information with hospitals and other providers may help drive improvements.

Vizient similarly shares meaningful information with its hospital members, including stratified information, where appropriate. For example, Vizient's annual Quality and Accountability Scorecard includes a health equity domain where stratified information (stratified by payer, gender and race) is shared with hospital members. For comparison purposes, Vizient provides an interhospital ranking and an intrahospital evaluation on a quarterly basis that provides timely actionable encounter details for hospital review and evaluation. As CMS considers sharing stratified information, we emphasize the need for sharing of actionable and timely information to better help inform hospital decisions.

As CMS is aware, stratification may not be appropriate for all types of measures. Vizient encourages CMS to work with stakeholders in determining which measures should be reported on a stratified basis and for the agency to also consider how hospitals can respond to stratified reporting to help improve quality. Vizient suggests CMS provide resources to hospitals to help them identify key community social determinants of health that may be driving inequities in quality measurement. For example, Vizient utilizes the VVI to develop hospital-specific reports to help identify relationships between health outcomes and community social needs. Based on Vizient's experience in sharing these insights with hospitals, those hospitals have been able to consider more targeted interventions to support patient outcomes. Vizient believes this type of nuanced information may help hospitals better identify and implement interventions.

Lastly, in the Proposed Rule, CMS notes that final decisions regarding disparity reporting will be made at the program level and tailored by setting. Vizient appreciates this more cautious approach to disparity reporting within CMS programs and continues to believe confidential reporting is most appropriate. More broadly, related to CMS programs, Vizient cautions CMS regarding the use of financial penalties in quality programs that utilize stratified information in quality measures, particularly as hospitals may be challenged in identifying interventions based on information gleaned in stratified reports. As noted in Vizient's FY 2020, IPPS comments[22], we believe that when using quality measures to reward or penalize providers, it is critical that the agency consider additional factors impacting patients that are typically outside the direct control of providers. As measurement approaches continue to evolve, in the short-term, Vizient encourages CMS to leverage tools, such as the VVI, and provide resources, including financial support and best practices regarding use of stratified information, to hospitals and other providers.

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[21] The "across-provider" disparity method type of comparison allows for comparisons for specific performance to be better understood and compared to peers, or against state and national benchmarks. For example, this comparison method shows the healthcare provider's performance for only the dual eligible subgroup, but as compared to other healthcare providers' performance for that same subgroup of patients.

[22] Vizient, FY 2020 IPPS Proposed Rule comments, available at: https://www.vizientinc.com/-/media/documents/sitecorepublishingdocuments/public/aboutus/20190624_vizient_comment_letter_cms1716p.pdf

Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting
In the Proposed Rule, CMS provides four principles to help inform prioritization of candidate measures for stratified reporting.

Regarding the first principle, CMS indicates "Programs may consider stratification, among existing clinical quality measures for further disparity reporting, prioritizing recognized measures which have met industry standards for measure reliability and validity". Vizient encourages CMS to clarify "industry standards for measure reliability and validity". For example, it is unclear whether the agency would rely on industry groups or organizations for this determination or develop a framework to evaluate whether a measure has met industry standards. Also, it is unclear at which point CMS plans on considering the appropriate stratification – would stakeholders need to identify those existing clinical quality measures for further disparity reporting or would CMS engage in this process independently? While Vizient has several questions, we agree that there is a need for measures to meet certain reliability and validity standards before stratification, but we further offer that the intention and use of the measure stratification should be to provide the necessary actionable insights that ultimately lead to efforts to reduce health care disparities.

For the second principle[23], Vizient agrees with CMS that, for prioritization purposes, it is important to have evidence that a treatment or outcome being measured is affected by underlying healthcare disparities for a specific social or demographic factor. However, this presupposes that the necessary race, ethnicity, sexual orientation, gender identity and language national data standards have been adequately defined. Vizient notes that given limitations and variability in data collection, Medicare-specific data may be inadequate for analyses. Vizient recommends CMS work with the industry and government stakeholders in developing consistent definitions, standards and processes related to data collection, as this information can have various applications, including in identifying measures to report on a stratified basis.

Consistent with our comments related to stratification, Vizient recommends that CMS select health care disparities measures that focus on provider locus of control. Provider responsible process measures, such as timely administration of antibiotics for sepsis patients, is an example of provider focused locus of control. Measures, such as 30-day readmission to the hospital, include not only provider contributing factors, but also, patient, family support and community factors that influence the patient's experience. Vizient encourages CMS to consider restricting provider assessment to those measures that more closely identify healthcare disparities from which providers can directly change.

[23] 87 Fed. Reg. 66 at 20248, "Programs may consider measures for prioritization that show evidence that a treatment or outcome being measured is affected by underlying healthcare disparities for a specific social or demographic factor. Literature related to the measure or outcome should be reviewed to identify disparities related to the treatment or outcome, and should carefully consider both SRFs and patient demographics. In addition, analysis of Medicare-specific data should be done in order to demonstrate evidence of disparity in care for some or most healthcare providers that treat Medicare patients."

The agency's third principle[24] indicates that the programs may consider establishing reliability and representation standards prior to reporting results. Vizient agrees with the need to establish such standards and recommends that CMS provide additional baseline guidance to programs seeking to establish such standards to support consistency.

Also, regarding the third principle, CMS notes that programs may also consider prioritizing measures that reflect performance on greater numbers of patients, as this may help ensure that the reported results of the disparity calculation are reliable and representative. Vizient supports CMS's efforts to focus on measures that have high volume, and, as a result, would have more reliable and representative results. However, we also note that this also depends on data being collected accurately.

The fourth principle that CMS provides is that after completing stratification, programs may consider prioritizing the reporting of measures that show differences in measure performance between subgroups across healthcare providers. Vizient agrees with providing information in the context of a subgroup but believes the value of such information will be largely dependent on how subgroups are identified. Vizient welcomes the opportunity to further discuss subgrouping approaches with CMS.

Lastly, we encourage the agency to clarify how CMS programs would apply these principles. As currently provided, it is unclear when in the regulatory (or subregulatory) process programs would rely on these principles and if stakeholder feedback would be obtained. Vizient encourages CMS to include opportunities for stakeholder feedback within the principles. In addition, given that these principles may apply across CMS programs, we encourage CMS to provide additional information regarding the monitoring of application of these principles to support consistency and transparency.

Principles for Social Risk Factor (SRF) and Demographic Data Selection and Use
In the Proposed Rule, CMS notes the following data sources and advantages and disadvantages of each for disparity reporting: patient-reported data; CMS administrative claims data; area-based indicators of social risk (e.g., AHRQ's SES Index, CDC/ATSDR Social Vulnerability Index, and HRSA's ADI); and imputed data sources (e.g., Medicare Bayesian Improved Surname Geocoding (MBISG) method (currently in version 2.1), which combines information from administrative data, surname and residential location to estimate race and ethnicity of patients at a population level).

Vizient agrees that an array of data sources may be used for disparity reporting. Generally, regarding each of these sources, we emphasize the need to better standardize data and to set standards that reflects the diverse U.S. population. For example, as a starting point and consistent with USCDI, Vizient encourages broader utilization, including through potentially more stringent CEHRT requirements, of the CDC recommended race and ethnicity code list CDC-Race-Ethnicity-Background-and-Purpose. We recommend that for longer-term plans, CMS consider using a combined race and ethnicity list as identified by the Institute of

[24] 87 Fed. Reg. 66 at 20248, "Programs may consider establishing statistical reliability and representation standards (for example, the percent of patients with a SRF included in reporting facilities) prior to reporting results. They may also consider prioritizing measures that reflect performance on greater numbers of patients to ensure that the reported results of the disparity calculation are reliable and representative."

Medicine's report on Race, Ethnicity, Language Data: Standardization for Health Care Quality Improvement.[25] Also, we encourage CMS to work with other government agencies, such as the Office of Management and Budget, to revise outdated standards related to race and ethnicity data.[26] Vizient encourages CMS to consider standardization approaches to better harmonize information collected across a range of sources, such as harmonizing claims data fields with USCDI data elements. While "gender" may exist as a field on claims, the options to complete gender vary and claims data may also lack REaL and SOGI data.

Regarding patient-reported data, Vizient emphasizes the role of trust when patients are asked to share personal information. Further, additional training and a more standardized approach to asking certain information may be beneficial, such as for collecting REaL and SOGI data.

In addition, and consistent with feedback related to the Hospital Readmissions Reduction Program, Vizient offers feedback for CMS's consideration regarding area-based indicators of social risk, including a comparison table (Attachment 1) that details and compares critical aspects of various indices including the VVI. Vizient has unique insights regarding these indices as we carefully analyzed each of these resources, and others, before deciding to develop the VVI.

Consistent with prior comments, Vizient urges CMS to use an index designed for health equity purposes as is considers approaches to measure social risk. While the agency notes that certain indices (e.g., Area Deprivation Index (ADI)) "may be considered as an efficient way to stratify measures that include many social risk factors", these tools can also present various challenges. The VVI was developed for health equity specifically, as our research indicated there was a significant need for such an index. Other indices were less insightful in the context of health equity, as they provided little granularity (e.g., the ARHQ SES index provides information by block group) or had too little health care measures included (e.g., the ADI includes only life expectancy/ mortality and readmissions). Further, when modeling to fit life expectancy, each index Vizient studied was a poor fit. As a result, Vizient developed the VVI to better demonstrate the effect of various SDOH domains on life expectancy.

In addition, unlike other indices, the VVI includes geospatial adjustments based on local relevance of each domain as it correlates with life expectancy. We urge CMS to be cautious in utilizing indices that may not provide sufficiently granular or actionable information related to social risk factors. Vizient welcomes to the opportunity to discuss how CMS may leverage the VVI.

Lastly, as CMS considers health equity measurement approaches, Vizient suggests the agency also consider measures specific to health equity (rather than considering social risk factors in the context of current measures) and structural inequities (e.g., disenfranchisement,

[25] Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Content last reviewed April 2018. Agency for Healthcare Research and Quality, Rockville, MD. Available at: https://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html.
[26] Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997.

incarceration rates, local school funding, wealth, segregation of people, and segregation of opportunity).[27,28]

Request for Information: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

In the Proposed Rule, the agency indicates that CMS policies and programs can help accelerate nationwide connectivity through TEFCA by health care providers and other stakeholders. In addition to improved care coordination, reduced burden and greater efficiency in care delivery, another benefit to widespread information exchange under TEFCA is the overall reductions of gaps in care. However, Vizient notes that not all providers are similarly situated to engage connectivity through TEFCA. For example, providers in rural areas may need additional support and resources, and thus, may have greater burden from an implementation perspective. As CMS considers modifications to policies and programs, it is imperative that the agency not presume a level of preparedness and that meaningful steps are taken to support providers who are not as well positioned to connect through TEFCA.

CMS notes there may be opportunities for the agency to incentivize exchange under TEFCA through other programs that incentivize high quality care or through program features in value-based payment models. Vizient prefers an incentive-based approach and discourages CMS from imposing penalties should a hospital or other provider not exchange information under TEFCA.

Regarding concerns about enabling exchange under TEFCA, Vizient notes that it should be made clear to providers by EHR system vendors that systems are TEFCA compliant. Further, as TEFCA engagement and exchange increases, it is imperative that costs to providers, including potential charges from EHR vendors, are stable and reasonable.

Request for Information: Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

As part of CMS's efforts to move to fully digital quality measurement in CMS quality reporting and value-based purchasing programs, the agency is seeking input on the transition to digital quality measurement. CMS notes the critical role of standardized data for EHR-based measurement (which is based on the FHIR standard) in this transition. While specific program requirements related to providing data for quality measurement and reporting would be addressed in future rulemaking, Vizient appreciates CMS's efforts to gain stakeholder feedback before proposing changes to hospital quality programs and responds to several questions provided by CMS.

In the Proposed Rule, CMS seeks feedback regarding what challenges or considerations are needed should digital quality measures (dQMs) use data from non-EHR sources. Vizient

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[27] Hardeman, Homan, Chantarat, Davis, and Brown. Improving The Measurement Of Structural Racism To Achieve Antiracist Health Policy Health Affairs 41, NO. 2 (2022): 179–186, available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01489

[28] Groos, Maya; Wallace, Maeve; Hardeman, Rachel; and Theall, Katherine P. (2018) "Measuring inequity: a systematic review of methods used to quantify structural racism," Journal of Health Disparities Research and Practice: Vol. 11 : Iss. 2 , Article 13. Available at: https://digitalscholarship.unlv.edu/jhdrp/vol11/iss2/13

believes that challenges would include assuring quality and validation of patient-reported data. In addition, there is a need to standardize, including how data is collected and then connected with data from various sources.

Vizient believes there is an opportunity to leverage FHIR APIs to decrease reporting burden and support implementor readiness as FHIR APIs allow standardized data to be pulled from different sources for specific patients and populations. As a result, there should be fewer data gaps in care and reduced redundancy in care. Vizient also notes that FHIR APIs are currently being used by applications that are implemented both inside and outside of electronic medical record systems to assist in provider workflows.

CMS also requests feedback regarding approaches to combine data needed for measure score calculation for measures that require aggregating data across multiple providers (e.g., risk-adjusted outcome measures) and multiple data sources (e.g., hybrid claims-EHR measures). Vizient notes that FHIR APIs from various health systems and providers can be accessed for specific patients by payers (or other stakeholder types) to aggregate the standardized data for those patients. This can occur even though patients may receive care from various health systems and have information spanning a range of data sources. However, this aggregation can be limited by the type of data currently required to be standardized via FHIR. Implementation guides are helpful and leading to expansion of available data elements, and thus, we encourage ongoing review and publication of implementation guides, especially as more data sources are utilized.

Request for Information: Current Assessment of the Impact of Climate Change on Outcomes, Care and Health Equity

In the Proposed Rule, CMS seeks comment on how hospitals, nursing homes, hospices, home health agencies, and other providers can better prepare for the harmful impacts of climate change on their patients, and how CMS can support them in doing so. Vizient appreciates CMS's efforts to gain insights from stakeholders and the agency's aim to provide support.

To help hospitals reduce the impacts of climate change, Vizient supports our members in a variety of ways. For example, Vizient helps members identify environmentally responsible vendor partners and helps members establish or augment their sustainability programs.[29] In addition, Vizient actively participates in working groups established by the National Academy of Medicine's Action Collaborative on Decarbonizing the U.S. Health Sector.[30]

As CMS considers approaches to support hospitals in preparing for climate change, we recommend the agency identify and share various positive examples and best practices so that hospitals may learn from one another's journey. Vizient has learned that there is a wide range of approaches being considered by our hospital members regarding climate change, and that members are at different stages in planning and/or implementation. Further, hospitals

[29] Vizient, Environmentally Preferred Sourcing, available at: https://www.vizientinc.com/our-solutions/supply-chain-solutions/supply-chain-programs/environmentally-preferred-sourcing

[30] National Academy of Medicine, Action Collaborative on Decarbonizing the U.S. Health Sector, available at: https://nam.edu/programs/climate-change-and-human-health/climate-collaborative-members/

may have unique considerations based on their circumstances, such as geography, which impact their assessment, planning and implementation efforts.

Also, Vizient notes that efforts to respond to climate change are evolving and require ongoing commitment and long-term changes. Thus, any support provided to hospitals should also consider long-term needs, including funding options.

One need that is more consistent among Vizient members is the need for alternative or additional funding to support assessment, strategy and implementation of climate-related efforts. Vizient encourages CMS to consider whether additional funds or resources, including sharing of information learned via this RFI, can be made available to hospitals and health systems. Further, should CMS collaborate with other federal agencies, such as the Internal Revenue Service, we encourage the agency to work collaboratively to identify opportunities to provide education on leveraging community benefit funds for climate change purposes. Should such opportunities be identified, this information should be shared with hospitals.

Lastly, while CMS has not alluded to CMS-specific requirements in this RFI, Vizient proactively notes our concern with CMS-imposed climate change-related mandates or penalties. Rather, Vizient reiterates the need for hospitals to be provided meaningful support and incentives to enable an effective response to climate change.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the FY 2023 IPPS Proposed Rule. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In closing, on behalf of Vizient, I would like to thank CMS for providing the opportunity to respond to this Proposed Rule. Please feel free to contact me, or Jenna Stern at jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

Shoshana Krilow
Senior Vice President of Public Policy and Government Relations
Vizient, Inc.

799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

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Attachment 1. Index Comparison

	Area Deprivation Index	Distressed Communities Index	Social Vulnerability Index	Intercity Hardship Index	Child Opportunity Index	AHRQ Socioeconomic Status Index	Vizient Vulnerability Index
Data granularity	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code × Census Tract × Block Group	✓ County • Zip Code possible ✓ Census Tract • Block Group possible	• County possible • Zip Code possible • Census Tract possible • Block Group possible	× County ✓ Zip Code ✓ Census Tract × Block Group	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code ✓ Census Tract ✓ Block Group
Timeliness	Updated in 2015 and 2019	Updated annually	Updated every two years	Not provided at the national level; algorithm available	2010 and 2015	Updated in 2015 and 2019	Updated annually
Social Determinants of Health Domains	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation ✓ Social Environment ✓ Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing ✓ Health Systems ✓ Transportation ✓ Social Environment ✓ Physical Environment × Public Safety (in development)
Health Care Focus	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence ✓ Readmissions ✓ ED utilization ✓ Maternal Health
Measurement Focus	17 components 2 components account for almost all of the variation (income and housing) Intended to predict mortality, but a poor fit to life expectancy (r^2 0.25)	7 components 2 components account for almost all of the variation (income and housing) Intended to describe economic differences; poor fit to life expectancy (r^2 0.31)	14 components in 4 domains, 2 components account for almost all of the variation (income and education) Intended for disaster management planning; poor fit to life expectancy (r^2 0.20)	6 components 2 components account for almost all of the variation (income and education) Intended to describe economic differences; poor fit to life expectancy (r^2 0.14)	29 components in 3 domains no serious issues with partial correlations Reports a moderate relationship to life expectancy (r^2 0.43)	7 components no serious issues with partial correlations Intended to describe economic factors related to health care access; poor fit to life expectancy (r^2 = 0.30)	19 components in 8 domains. All are significant in different locations Intended to describe differences in life expectancy (r^2 0.63)
Geospatial Adjustments	Single index algorithm for the whole country	Single index algorithm for the whole country. Small zip codes excluded	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country, but with state or local standardization options	Single index algorithm for the whole country	Index adapts to local relevance of each domain as it correlates with life expectancy

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