June 17, 2022

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 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)

On behalf of the over 84,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2023 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule published in the *Federal Register* on May 10, 2022.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of surgical care is furnished in the inpatient hospital setting, the College has a vested interest in the IPPS and related hospital quality improvement efforts. With our more than 100-year history in developing policy recommendations to optimize the delivery of surgical services, lower costs, improve program integrity, and make the U.S. healthcare system more effective and accessible, we believe that we can offer insight to the Agency's proposed changes to the IPPS. Our comments below are presented in the order in which they appear in the rule.

PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS

Proposed Changes to Specific MS-DRG Classifications

Physicians use the International Classification of Diseases, 10th Revision (ICD-10) coding system to report diagnoses and procedures for Medicare hospital inpatient services under the MS-DRG system. The ICD-10 coding system includes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. CMS annually reviews stakeholder requests to update MS-DRG

facs.org

CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

classifications to better align with ICD-10 coding and reporting guidelines and major diagnosis categories (MDCs).

MDC 06 (Diseases and Disorders of the Digestive System): Appendicitis

CMS received a request to add ICD-10-CM diagnosis code K35.20 (*Acute appendicitis **with** generalized peritonitis, without abscess*) to the same MS-DRG codes assigned for ICD-10-CM diagnosis code K35.32 (*Acute appendicitis with perforation and localized peritonitis, **without** abscess*). Currently, K35.20 is assigned to MS-DRGs 338, 339, and 340. ICD-10-CM code K35.20 currently groups to MS-DRGs 341, 342, and 343 (*Appendectomy without Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC,* respectively) and K35.22 is assigned to MS-DRG codes 338, 339 and 340 (*Appendectomy with Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC,* respectively).

The requestor asserted that the current difference in MS-DRG assignment for diagnosis codes K35.20 and K35.22 suggests that localized peritonitis is more severe or requires an additional level of care over and above that for generalized peritonitis, and stated that both localized and generalized peritonitis—when treated in conjunction with an appendectomy—require the same level of patient care, including: aspiration of purulent fluid or exudate at the surgical site, direct inspection or imaging of the abdomen to look for possible abscess, use of intravenous antibiotics, and prolonged inpatient monitoring. The requestor added that generalized peritonitis can be thought of as a progression of the localized peritonitis condition and that patients progress from localized to generalized peritonitis, and not vice versa.

ICD-10-CM diagnosis code K35.32 currently groups to MS-DRGs 338, 339, and 340; however, diagnosis code K35.20, which describes a generalized, more extensive form of peritonitis, does not. ICD-10-CM diagnosis code K35.20 is the only ruptured appendicitis code not included in the list of complicated principal diagnosis codes for MS-DRGs 338, 339 and 340, and the requestor indicated that it is clinically appropriate for all ruptured/perforated appendicitis diagnosis codes to group to MS-DRGs 338, 339 and 340.

CMS noted that this topic has been previously discussed in FY 2019 and FY 2021 IPPS rulemaking. In FY 2021, the Agency stated that because diagnosis code K35.20 is described as "without abscess," it should not be added to the list of complicated principal diagnoses for MS–DRGs 338, 339, and 340. **The ACS wishes to highlight that both diagnosis codes K35.20 and K35.22 indicate "without abscess" and that the difference between these two diagnoses is *generalized* versus *localized* peritonitis.** In this proposed rule, CMS acknowledged that appendectomy diagnosis codes were a part of the agenda for the March 2022 ICD-10 Coordination and Maintenance Committee (C&M) meeting. As such, CMS proposes to maintain current MS-DRG assignments until final decisions are made by the Centers for Disease Control and Infection (CDC) National Center for Health Statistics (NCHS), which is charged with updating the ICD-10-CM system, regarding the potential changes to the appendectomy ICD-10 diagnosis codes.

The ACS opposes CMS' proposal to maintain the current MS-DRG assignment for diagnosis code K35.20. We agree with the requestor that all ruptured/perforated appendicitis

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

diagnosis codes should group to MS-DRGs 338, 339 and 340 and believe that the condition described by code K35.20 can be associated with risk of postoperative abscess formation and extended length of hospital stay, thereby warranting classification as a complicated diagnosis. **We urge CMS to reassign code K35.20 from MS-DRGs 341, 342, and 343 to MS-DRGs 338, 339, and 340 immediately for FY 2023.** We are disappointed that CMS continues to delay clinically logical reassignments, which have been repeatedly requested by stakeholders over the past several years, while waiting for the CDC NCHS to potentially finalize new or revised appendectomy diagnosis codes addressed during the March 2022 C&M meeting.

MDC 07 (Diseases and Disorders of the Hepatobiliary System and Pancreas): Laparoscopic Cholecystectomy with Common Bile Duct Exploration

CMS received a request to review the MS-DRG assignment for ICD-10-PCS procedure code 0FC94ZZ (*Extirpation of matter from common bile duct, percutaneous endoscopic approach*) when reported with an ICD-10-PCS procedure code for laparoscopic/endoscopic cholecystectomy. The applicable procedure codes are listed in the table below.

ICD-10-PCS Code	Code Description
0F544ZZ	Destruction of gallbladder, percutaneous endoscopic approach
0F548ZZ	Destruction of gallbladder, via natural or artificial opening endoscopic
0FB44ZZ	Excision of gallbladder, percutaneous endoscopic approach
0FB48ZZ	Excision of gallbladder, via natural or artificial opening endoscopic
0FT44ZZ	Resection of gallbladder, percutaneous endoscopic approach

The requestor noted that, when a laparoscopic common bile duct exploration (C.D.E.) and gallstone removal is reported with procedure code 0FC94ZZ in conjunction with one of the laparoscopic/endoscopic cholecystectomy procedures codes in the table above, the resulting assignment is MS-DRGs 417, 418 and 419 (*Laparoscopic Cholecystectomy **without** C.D.E. with MCC, with CC, and without CC/MCC,* respectively). This MS-DRG assignment does not recognize that a C.D.E. was performed. However, when procedure code 0FC90ZZ (*Extirpation of matter from common bile duct, open approach*) is reported with any one of the above listed laparoscopic/endoscopic cholecystectomy procedure codes, the resulting assignment is MS-DRGs 411, 412, and 413 (*Cholecystectomy **with** C.D.E. with MCC, with CC, and without CC/MCC,* respectively) which appropriately recognizes that a C.D.E. was performed. The requestor questioned why—when reported with a laparoscopic cholecystectomy—C.D.E. with gallstone removal performed using an open approach (procedure code 0FC90ZZ) is properly grouped, but laparoscopic C.D.E and gallstone removal (procedure code 0FC94ZZ) is not properly grouped.

CMS agreed with the requestor's statement that the current MS-DRG assignment does not recognize performance of a C.D.E. when performed laparoscopically, and proposes to redesignate procedure code 0FC94ZZ from a non-operating room (O.R.) procedure to an O.R. procedure with alignment to MS-DRGs 411, 412, and 413 in MDC 07 to appropriately reflect when this procedure is performed and improve the clinical coherence of the patients assigned to these MS-DRGs. **The ACS agrees that the procedure described by code 0FC94ZZ typically requires the resources of an O.R. when performed with a laparoscopic cholecystectomy, and we also**

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

agree with the requestor and CMS that the current MS-DRGs assigned to this procedure do not reflect the performance of a common bile duct exploration. Therefore, we support the Agency's proposal regarding changes to the O.R. designation and MS-DRG assignments for procedure code 0FC94ZZ.

However, this proposal only addresses one specific procedure code in an entire family of cholecystectomy with C.D.E. procedure codes. While the MS-DRG assignments create a decision tree that bifurcates cholecystectomy (without regard to approach) into those with and without C.D.E., the laparoscopic cholecystectomy grouping only recognizes the procedure "**without** C.D.E." Given that the "**with** C.D.E." cholecystectomy grouping does not recognize approach, we assume that all laparoscopic cholecystectomies **with** C.D.E. are assigned to that DRG grouping, and it is only laparoscopic cholecystectomies **without** CDE that split off from the non-approach-specific cholecystectomy family. **We believe there may be an opportunity to further refine these MS-DRGs in future rulemaking and encourage CMS to conduct a comprehensive review of the ICD-10-PCS procedure codes describing cholecystectomy with C.D.E. to determine if their MS-DRG assignments appropriately reflect the work, resources, and intensity of such procedures.**

Operating Room (O.R.) and Non-O.R. Issues

In this proposed rule, CMS addresses requests submitted by stakeholders regarding changing the designation of specific ICD-10-PCS codes from non-O.R. to O.R. procedures or changing the designation from O.R. procedures to non-O.R. procedures. For each requested procedure code change, the Agency considers whether the procedure would typically require the resources of an operating room; whether it is an extensive or a non-extensive procedure; and to which (if any) MS-DRGs the procedure should be assigned.

Non-O.R. Procedures to O.R. Procedures

- Diagnostic and Therapeutic Endoscopic Procedures Performed on Thoracic and Abdominal Organs. CMS received a request to change the designation of all ICD-10-PCS procedure codes that describe diagnostic and therapeutic percutaneous endoscopic procedures performed on thoracic and abdominal organs, from non-O.R. to O.R procedures. The requestor stated thoracoscopic and laparoscopic procedures are always performed in the operating room under general anesthesia. The Agency indicated that additional time is needed to fully examine the numerous ICD-10-PCS codes in the classification that describe diagnostic and therapeutic percutaneous endoscopic procedures performed on thoracic and abdominal organs, as there are over 19,000 ICD-10-PCS codes in the classification that describe procedures performed using a percutaneous endoscopic approach.

  A "percutaneous endoscopic" approach is defined as:

  > *Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure. The access location for this approach is the skin or mucous membrane with visualization instrumentation being used to reach the operative site*.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

While we do not dispute that there may be over 19,000 ICD-10-PCS codes that describe procedures performed using a percutaneous endoscopic approach as indicated by inclusion of the numeral "4" as the fifth character in the ICD-10-PCS code, this list can be whittled down substantially by considering only the numerals in the fourth position for thoracic and abdominal organs. K35.20 and K35.22 indicate "without abscess" and that the difference is generalized versus localized peritonitis **Even with a smaller list utilizing the code criteria above, we cannot think of a thoracoscopic or laparoscopic procedure that would not require general anesthesia and be performed in an O.R. As such, we strongly urge CMS to assign O.R. status to any ICD-10-PCS code with the numeral "4" as the fifth character that additionally has a numeral in the fourth character that corresponds to a thoracic or abdominal organ.**

- Open Drainage of Subcutaneous Tissue and Fascia. In the FY 2022 IPPS final rule, CMS redesignated 22 codes that describe the open drainage of subcutaneous tissue and fascia—which were previously designated as O.R procedures—as non-O.R. procedures. The applicable 22 codes are listed in the table below.

ICD-10-PCS Code	Code Description
0J900ZZ	Drainage of scalp subcutaneous tissue and fascia, open approach
0J910ZZ	Drainage of face subcutaneous tissue and fascia, open approach
0J940ZZ	Drainage of right neck subcutaneous tissue and fascia, open approach
0J950ZZ	Drainage of left neck subcutaneous tissue and fascia, open approach
0J960ZZ	Drainage of chest subcutaneous tissue and fascia, open approach
0J970ZZ	Drainage of back subcutaneous tissue and fascia, open approach
0J980ZZ	Drainage of abdomen subcutaneous tissue and fascia, open approach
0J990ZZ	Drainage of buttock subcutaneous tissue and fascia, open approach
0J9B0ZZ	Drainage of perineum subcutaneous tissue and fascia, open approach
0J9C0ZZ	Drainage of pelvic region subcutaneous tissue and fascia, open approach
0J9D0ZZ	Drainage of right upper arm subcutaneous tissue and fascia, open approach
0J9F0ZZ	Drainage of left upper arm subcutaneous tissue and fascia, open approach
0J9G0ZZ	Drainage of right lower arm subcutaneous tissue and fascia, open approach
0J9H0ZZ	Drainage of left lower arm subcutaneous tissue and fascia, open approach
0J9J0ZZ	Drainage of right hand subcutaneous tissue and fascia, open approach
0J9K0ZZ	Drainage of left hand subcutaneous tissue and fascia, open approach
0J9L0ZZ	Drainage of right upper leg subcutaneous tissue and fascia, open approach
0J9M0ZZ	Drainage of left upper leg subcutaneous tissue and fascia, open approach
0J9N0ZZ	Drainage of right lower leg subcutaneous tissue and fascia, open approach
0J9P0ZZ	Drainage of left lower leg subcutaneous tissue and fascia, open approach
0J9Q0ZZ	Drainage of right foot subcutaneous tissue and fascia, open approach
0J9R0ZZ	Drainage of left foot subcutaneous tissue and fascia, open approach

For FY 2023, CMS received a request to reconsider this change in designation. The requestor stated that open procedures for the drainage of subcutaneous tissue and fascia are indeed typically performed in the O.R. under general anesthesia and involve making incisions through the subcutaneous tissue into fascia for therapeutic drainage, breaking up of loculations, and irrigation. CMS disagreed with the requestor and stated that the Agency believes procedures involving the

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | facs.org

open drainage of subcutaneous tissue and fascia can now be safely performed in the outpatient office setting. As such, CMS proposes to maintain the non-O.R. designation for these 22 procedure codes.

> In the FY 2018 IPPS proposed rule, the same 22 ICD-10-PCS codes for open drainage were identified by a commenter as not requiring the resources of an O.R.[1] However, other stakeholders opposed changing the designation of these codes from O.R. to non-O.R. procedures. The stakeholders indicated that such procedures were invasive, performed on deep subcutaneous tissue and fascia, and most often furnished in the O.R. setting under general anesthesia. Stakeholders also noted that the primary objective of these procedures was to incise through the skin into the subcutaneous tissue and fascia in order to drain and clean out an abscess or hematoma. Furthermore, stakeholders highlighted that CMS disagreed with a separate recommendation in the FY 2018 IPPS proposed rule to reclassify open extraction of subcutaneous tissue and fascia as non-O.R. procedures, and for the same reasons, open drainage of subcutaneous tissue and fascia should not be changed from an O.R. procedure to a non-O.R. procedure. In response to the issues raised by these stakeholders, CMS determined in the FY 2018 IPPS final rule that it was appropriate to maintain the designation of the 22 procedure codes as O.R. procedures.[2]
>
> **The ACS disagrees that these 22 ICD-10-PCS procedures do not typically require the resources of an O.R. and can be safely performed in the non-O.R. setting.** We find the Agency's rulemaking on this issue between FY 2018 and FY 2023 to be contradictory and believe that the rationale to designate such codes describing the open drainage of subcutaneous tissue and fascia as O.R. procedures (as presented to CMS by stakeholders for the FY 2018 IPPS) remains the same: the intent of these procedures—which are more complex and resource intensive than ICD-10-PCS codes describing open drainage with a drainage device (e.g., procedure code 0J9N00Z)—is not to place a drainage device, but instead to incise and drain not only subcutaneous tissue but also the fascia in order to reach the infection in the subfascial space. There is no safe way to effectively drain an infection involving the subfascial plane without the resources of an O.R. **Therefore, we do not support CMS' proposal to maintain the non-O.R. designation for the above 22 ICD-10-PCS codes and request that these codes be redesignated as O.R. procedures for FY 2023.**

OPENING COMMENTS TO CMS HOSPITAL QUALITY REPORTING PROGRAM PROPOSALS

To be successful in improving care and creating an environment for patients to understand value in the care they seek, quality must be more than a set of disjointed metrics used in payment programs. In complex care, it takes a well-orchestrated team to deliver the outcomes safely, affordably, adequately, and equitably. As a team, quality programs should inform patients about their expected outcomes and the safety indicators needed to avoid

[1] Centers for Medicare & Medicaid Services. (2017). Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates [Proposed Rule], 86 F.R. 25070.
[2] Centers for Medicare & Medicaid Services. (2017). Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates [Final Rule], 82 F.R. 37990.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | facs.org

preventable harms. We must move away from thinking about measures in a transaction and instead think of measurement of conditions or populations—asking the question, what is needed to give the best care to a population for a given condition?

As part of this solution, the ACS has put forth the concept of domain-specific quality programs. This solution is different from the current types of CMS measures; domain-specific programs incentivize team-based care to organize around the patient to meet the challenges of a condition. Measures are included in the domain-specific quality programs, too. Rather than simply addressing individual clinical issues in isolation, what is needed is a holistic approach with the goal of reframing the entire care pathway and aligning all the team members to better serve the needs of a population. Within each domain-specific quality program, standards are drawn from Donabedian's structure, processes, and outcomes quality model.[3] The standards address all six Institute of Medicine domains (safe, effective, patient-centered, timely, efficient, equitable) and are comprehensive across the full spectrum of care, which has proven to be an effective way to conceptualize quality of care.

This framework for structure and process measures goes beyond the typical National Quality Forum (NQF) singular structural element or process by focusing on the challenges of bringing all aspects of care into a well-aligned system or program, including care delivery, coordination, data, and data-driven improvement activities. Together, these become a patient-centered program of care. When the components are properly tied together, care becomes well-coordinated, complex aspects of care are more reliably delivered, harms are minimized, and outcomes are optimized.

Currently, CMS quality programs consist of a large, extremely costly universe of measures in multiple different payment programs. They often lack the consideration for focusing a surgical team in a patient-centered way. Such sporadic measurement creates a massive amount of burden and overhead, similar measures often provide different or conflicting quality signals, and therefore have limited impact on improving the quality of overall care—this is especially evident in the Merit-based Incentive Payment System (MIPS) program.[4,5] As a result, these efforts fail to create accountability to patients for the care they receive. Measuring a surgeon with sporadic metrics and disjointedly measuring anesthesia services, pathology, radiology, and facility care with disparate measure sets does not align with care delivery. The development of individual measures and the subsequent combination of these measures into payment incentive programs may be useful for fee-for-service payment. However, value-based payments need a more condition, patient-type approach. CMS must consider how to best support a programmatic approach as they look to transition to digital quality measures (dQMs). Instead of emphasizing the aggregation of data with dQMs that focus on single metrics, data can be used to comprehensively track patients' progress over the lifecycle of care, better inform clinicians and

[3] Donabedian, A. (2005). Evaluating the quality of medical care. *The Milbank Quarterly*, *83*(4), 691-729. https://doi.org/10.1111/j.1468-0009.2005.00397.x

[4] Casalino, L. P., Gans, D., Weber, R., et al. (2016). US physician practices spend more than $15.4 billion annually to report quality measures. *Health Affairs*, *35*(3), 401-406. https://doi.org/10.1377/hlthaff.2015.1258

[5] Glance, L. G., Thirukumaran, C. P., Feng, C., Lustik, S. J., & Dick, A. W. (2021). Association Between the Physician Quality Score in the Merit-Based Incentive Payment System and Hospital Performance in Hospital Compare in the First Year of the Program. *JAMA*, *4*(8): e2118449. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2782631

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

patients to facilitate shared decision-making, and offer actionable information that supports a "quality program" framework.

This programmatic approach also offers useful information that patients will find beneficial when deciding where to seek care. **An important standard to apply in evaluating payment quality incentives is their effectiveness in providing patients with knowledge of where to find high quality care in their community.** Twenty years of NQF and CMS initiatives in quality have not produced reliable public knowledge or a public-facing website that informs patients about where to get the care they need for the *condition* they have. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are the prerequisites for a valid depiction of the value of care. In assessing the effectiveness of our measures, we wonder if the patient had this information, would it enable them to easily find information on a website for the types of care they seek, for a safety and equitability profile, and for personal goal attainment.

Lastly, moving forward, we encourage CMS to consider how it can restructure programs to be more focused on incentivizing and motivating hospitals to institute and maintain high quality care. While we understand that this is generally the intent, we are concerned (in the current programs where hospitals' performance is evaluated on siloed outcome and processes that do not track to the modern delivery system) there is a focus on penalty avoidance without seeing any true correlation to improvements in quality. **From the ACS perspective, the mindset needs to be changed from one of penalty avoidance to one that rewards hospitals for implementing and maintaining the elements of quality programs that are built around care for specific conditions, align with the team-based nature of care delivery, apply improvement cycles, and can provide useful information that supports patients when they must determine where to seek medical care.**

HOSPITAL READMISSIONS REDUCTION PROGRAM

The Hospital Readmissions Reduction Program (HRRP) requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. The reduction is based on a hospital's risk-adjusted readmission rate during a 3-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG).

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

In the FY 2018 IPPS/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule, CMS finalized updates to the HRRP payment reduction methodology, including a policy to stratify hospitals into one of five peer groups based on their proportion of beneficiaries who are dually eligible for Medicare and full Medicaid benefits, which serves as a proxy for beneficiaries' social risk. This policy allows CMS to make separate comparisons of hospitals with differing proportions of dually eligible beneficiaries in determining a hospital's payment adjustment factor

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

under the HRRP. However, it does not directly measure or account for disparities in health care quality between beneficiary groups with heightened social risk versus groups with less social risk.

In the FY 2018 final rule, CMS also introduced confidential reporting of hospital quality measure data stratified by dual eligibility status. The following two complementary methods are used to calculate disparities in condition/procedure-specific readmission measures, which CMS believes more directly measures disparities in health care quality between dually eligible and non-dually eligible beneficiary groups than the HRRP's peer grouping methodology:

- **Within-Hospital Disparity Method** measures the differences in outcome rates between dual-eligible and non-dual eligible patients within an individual hospital. The method seeks to answer the question, "Will dual eligible patients in one hospital have worse health outcomes than non-dual eligible patients in the same hospital?"
- **Across-Hospital Disparity Method** compares performance across hospitals by calculating a hospital's outcome rate for dual eligible patients only. Hospitals can use these results to compare their performance for dual-eligible patients to other hospitals, their state, and the nation. [6]

The agency is now seeking comment on these and other approaches to incorporate performance for socially at-risk populations in the HRRP. CMS' objective is to encourage providers to improve health equity and reduce health care disparities without disincentivizing hospitals to treat socially at-risk beneficiaries or disproportionately penalizing hospitals that treat a substantial proportion of socially at-risk beneficiaries. Although the HRRP currently relies on dual eligibility status as a proxy for social risk, CMS is interested in feedback on additional variables, measures, or indices that can help hospitals identify socially at-risk populations, as discussed below.

The ACS commends CMS for clarifying that their goal is to encourage providers to improve health equity and to not disincentivize hospitals to treat socially at-risk populations. As we have stated in the past, we also commend CMS for continuing to emphasize issues related to social determinants of health (SDOH) in their quality programs. However, there is evidence that demonstrates that safety-net hospitals consistently score lower on performance measures, such as readmissions, and therefore are a target for penalties in programs such as HRRP.[7] This suggests that the current peer grouping methodology is not working as intended. We appreciate CMS' interest in more directly measuring disparities in health care quality, but remind CMS that as part of this process, it is critical to take a closer look at how current CMS measures, including HRRP measures, disproportionally impact safety-net hospitals. **For CMS to achieve their stated goal, it is critical that hospitals that treat larger proportions of socially at-risk patients are supported rather than penalized. The system should offer these hospitals greater, not fewer, resources to help them improve the services provided to patients who need additional support.**

[6] Centers for Medicare & Medicaid Services. (2021). Frequently asked questions for Disparity Methods. https://qualitynet.cms.gov/files/6148891ae615c5002265f811?filename=2021_Disp_Method_FAQ_V2.0.pdf

[7] Zuckerman, R., Joynt Maddox, K. E., Sheingold, S. H., et al. (2017). Effect of a hospital-wide measure on the Readmissions Reduction Program. *The New England Journal of Medicine*, 377:1551-1558. https://doi.org/10.1056/NEJMsa1701791

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

CMS also seeks comment on the addition of one or more indices used to identify socially at-risk populations and measuring degree of risk. Specifically, CMS seeks proposals for other indices or modified indices that capture multiple dimensions of social risk and that have demonstrated relations to health outcomes or access to health care resources. CMS intends to add these additional indices to the HRRP along with dual eligibility as factors for stratifying data. CMS also discusses various indices that could be helpful in identifying socially at-risk populations and measuring the degree of risk—examples include the University of Wisconsin School of Medicine and Public Health and Health Resources and Services Administration's (HRSA) Area Deprivation Index (ADI), the Agency for Healthcare Research and Quality's (AHRQ) Socioeconomic Status (SES) and the CDC's Social Vulnerability Index.

The ACS strongly supports these efforts to evaluate various SES indices to identify socially at-risk populations and the degree of their risk. The ACS has analyzed SES indices for sensitivity in ACS National Surgical Quality Improvement Program (NSQIP) and other ACS registries. The findings indicated that for surgery, ADI is the most sensitive SES index currently available. However, it is important to note that ADI and the other SES indices are developed by combining American Community Survey data points (housing, education, job, income, transportation, etc.), which does not consider the outcome to be predicted. In that regard, these indices are generic for assessing risk. A better approach would be to construct an index (e.g., using regression) that is tuned for predictive strength with respect to the outcome of interest, which in this case is hospital readmissions.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

Proposed Scoring and Payment Methodology for the FY 2023 Program Year Due to the COVID-19 Public Health Emergency (PHE)

CMS is proposing a special rule for FY 2023 scoring under the Hospital Value-Based Purchasing (VBP) Program. Under the special rule, CMS would calculate measure rates for all measures in the FY 2023 program, but for measures that it has proposed to suppress or those for which it has finalized suppression due to the impact of COVID-19 on data, CMS would not use measure rates to generate achievement and improvement points. This means that achievement and improvement points, as well as a domain score, could only be calculated for remaining measures in the Clinical Outcomes domain and the Efficiency and Cost Reduction domain. As a result, CMS has determined that it cannot award Total Performance Scores (TPS) to hospitals for FY 2023 performance. CMS acknowledges that this proposal will have implications for physicians who qualify for facility-based scoring within the MIPS. Under facility-based measurement, eligible clinicians may receive a MIPS quality and cost performance category score based on the TPS of the hospital where they practice. If this scoring policy is finalized for FY 2023, facility-based scoring would not be applied to MIPS eligible clinicians who qualify during the Calendar Year (CY) 2022 performance period, similar to a policy adopted by CMS last year.

The ACS appreciates CMS' efforts to minimize the impact of the COVID-19 pandemic on hospitals and health care practices by suppressing measures and easing reporting requirements across many CMS quality programs. **These policies have helped healthcare practices avoid payment penalties while they overcome the many challenges presented by the pandemic,**

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | facs.org

such as staffing and supply shortages and limited resources. At the same time, we are very supportive of efforts to better align facility and physician-level quality improvement programs and request that CMS continue to work with stakeholders to identify additional opportunities to ensure cross-program credit and alignment.

OVERARCHING PRINCIPLES FOR MEASURING HEALTHCARE QUALITY DISPARITIES ACROSS CMS QUALITY PROGRAMS – REQUEST FOR INFORMATION (RFI)

It is well established that SDOH factors impact quality of care. Patients with certain social risk factors may experience lack of access to health care services, limits on resources, lack of preventative care, poor early detection, and limited chronic care maintenance, which can contribute to care inequities, and ultimately result in worse overall outcomes in surgical care. In recent years, CMS has highlighted its commitment to achieving equity in healthcare outcomes for beneficiaries. CMS plans to do this by supporting healthcare providers' quality improvement activities to reduce health disparities, enabling beneficiaries to make informed decisions, and promoting healthcare provider accountability for healthcare disparities.[8] To achieve this, the CMS believes that it is important to consistently measure differences in care received by different groups of beneficiaries, and notes that this can be achieved by methods to stratify quality measures (i.e., calculating measure results for specific groups or subpopulations of patients).

In the proposed rule, CMS outlines various efforts that they implemented over the past decade that aim to identify and reduce healthcare disparities, such as implementing the CMS Disparity Methods for confidential reporting of stratified data. CMS expresses interest in continuing to evaluate opportunities to expand its measure stratification reporting initiatives using existing sources of data, with the goal of providing comprehensive and actionable information on health disparities to support quality improvement efforts. This includes examining the possibility of reporting disparities in care based on additional social risk factors and demographic variables associated with historic disadvantage in the healthcare system and examining disparities using stratified healthcare quality measures across a variety of care settings.

As CMS works to advance the use of measurement and stratification tools to address disparities and advance equity in healthcare, they ask for stakeholder input on five specific areas to inform their approach. **The ACS commends CMS for its continued commitment to closing the health equity gap and agrees that creating goals and principles to guide these efforts is essential. As the ACS, we witness the many dimensions of inequities in surgical care and seek to use all our resources to help the nation overcome the barriers of inequities.**

Our feedback on the principles and the questions posed in the RFI are discussed in the following sections.

[8] Centers for Medicare & Medicaid Services. (2016). CMS Quality Strategy. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Qualityinitiativesgeninfo/downloads/cms-quality-strategy.pdf

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | facs.org

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

CMS discusses how they have focused on illuminating healthcare disparities by reporting stratified results of existing quality measures by dual eligible status in two complimentary ways—the "within-provider" disparity method and the "across-provider" disparity method.

- **"Within-Provider" Disparity Method** - this method identifies disparities, or gaps in care or outcomes between groups, such as dual eligible or non-dual eligible groups, at a hospital. After stratification by dual eligible status, measure results for subgroups of patients served by an individual healthcare provider can be directly compared. This method can be used for most measures that include patient-level data for most care settings and, according to CMS, is a helpful means by which to quantitatively express disparities in care at the provider level.
- **"Across-Provider" Disparity Method** - a healthcare provider's performance on a measure for only dual eligible patients (or any particular social risk factor) is compared to other healthcare providers' performance for that same subgroup of patients. This approach allows for comparisons for specific performance to be better understood and compared to peers, or against state and national benchmarks.

CMS notes that alone, each approach may provide an incomplete picture of disparities in care for a particular measure, but when reported together with overall quality performance, they may provide detailed information about where differences in care exist or where additional scrutiny may be appropriate. The Agency also acknowledges the need to ensure that measurement bias is avoided in all disparity reporting methods.

In our comments to the "Closing the Health Equity Gap in CMS Hospital Quality Programs – RFI" in the FY 2022 IPPS proposed rule, we asked CMS to first state the goals they wish to accomplish before CMS takes steps to identify quality measures and stratify performance. **We thank CMS for responding to our call for the identification of goals. Once the goals can be defined, then all efforts can be aligned around what is necessary to continue to move us closer to achieving the goals. As CMS continues to develop its strategy for measuring healthcare disparities, we ask the Agency to take a comprehensive look at how its policies can enrich hospitals that care for the most complex patients.** Hospitals that care for complex patients with various social risk factors are faced with many challenges to achieve good patient outcomes. These challenges may be exacerbated by perverse incentives that reduce their already strained resources. There is a critical need to better measure inherent disparities to bring attention and investment to under-resourced areas and populations, and then change the payment system so that it is accountable for the results of every individual.

As the ACS has stated in previous comments, we think when setting goals for advancing equity and addressing disparities, it will be important to take a phased approach. From the ACS' perspective, the cycle of this work should be as follows:

1. **Shine a light on the problem.** CMS should continue to focus on ways to reliably define and identify the multifactorial challenges that impact Medicare beneficiaries. They

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

should not be incentivizing hospitals based on performance until the challenges can be reliably and validly identified, and the metrics used in the quality reporting programs are tested to ensure they are providing actionable information that drives improvement.

2. **Reward innovation.** CMS should take steps to reward those who have proven their ability to define and identify factors that present greater challenges for at-risk patient groups and are using their resources in innovative ways to address the problems. Their methods should be shared to help inform efforts, including research.
3. **Research and development.** Research and development will drive the advancement of these efforts. This is the stage where the problems and solutions can be tested to ensure that desired outcomes to advance equity can be achieved.
4. **Socializing solutions.** To continue to drive change, it is critical that the health care community socializes their experiences. Sharing solutions that have worked, along with methods that have not worked, will help the broader healthcare community as it continues to discover how to best address healthcare disparities.

It is important that we do not rush this process when hospital payment is affected—it will take time to achieve impactful solutions and while more work is being done to advance health equity, we are still in the discovery phase. We also suggest that in addition to the hospital-to-hospital and provider-to-provider comparisons, CMS should be stratifying and comparing metrics based on conditions and/or procedures. A condition-specific comparison would help identify if complex care is the same or different across patient groups. From our perspective, having the ability to drill down to more conditions and procedures would be most informative and impactful, and present opportunities to motivate improvements in care within service lines that deliver complex care to patients with social risk factors. We suggest exploring conditions beyond AMI, COPD, HF, THA/TKA, and CABG. As CMS explores different stratification methods, it is also important that they continue to test the measures to ensure they have enough statistical power to truly show differences in care, recognizing that different statistical thresholds might be more appropriate depending on the measure or scenario. This is especially important when measuring disparities on the level of the provider. Once measures are stratified, measures should be tested on a measure-by-measure basis.

Finally, it is important that at the root of these efforts, CMS continues to ask themselves how they will help patients seek out trusted care that will meet their needs. Reporting on patient experience will reflect whether patients felt they were treated respectfully, whether they felt their voice was heard and personal goals understood, and if they experienced a trusting relationship with the care team. Inclusion is a much-needed area of development in health care and could encompass a patient's feeling of receiving care that is sensitive to their culture, beliefs, language, race, ethnicity, sexual orientation and gender identification, personal circumstances, and so on. Inclusion can also comprise whether patients feel they are in an environment where they are understood, have a feeling of trust, and can be connected to community-based organizations or other resources that may be necessary to optimize their goals of care. Transparently publicly reporting these measures can help patients seek out care based on their personal circumstances and values.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

Guiding principles for selecting and prioritizing measures for disparity reporting across CMS Quality Reporting Programs

CMS plans to expand its efforts to provide stratified reporting for additional quality measures. CMS expresses the aim to standardize approaches, when possible, but acknowledges that decisions about how to identify and prioritize measures for possible stratification should be made at the program level to ensure results, provide the most actionable data, and limit potential bias. To help inform prioritization of the next generation of candidate measures for stratified reporting, CMS is soliciting feedback on several systematic principles under consideration that they believe will help prioritize measures for disparity reporting across quality programs.

- Prioritize Existing Clinical Quality Measures
- Prioritize Measures with Identified Disparity in Treatment or Outcomes for the Selected Social or Demographic Factor
- Prioritize Measures with Sufficient Sample Size to Allow for Reliable and Representative Comparisons
- Prioritize Outcome Measures and Measures of Access and Appropriateness of Care

In general, the ACS supports CMS in their work to create a strategy around prioritizing measures. It is extremely important that CMS identify the measurement methodologies and measures where they can make the most impact and take time to properly implement these approaches, instead of moving forward with many changes quickly that may be unsuccessful. As CMS works to create their strategy for prioritization, we suggest that the agency explore how to incorporate equity in a way that is integrated in the care cycle, instead of selecting siloed measures that are used to determine payment.

From the ACS' perspective, quality should be viewed programmatically and must include components that evaluate the structures, processes, and the interdependencies that are in place to achieve patient goals. Patient experiences and measurable outcomes are also used to inform care and identify gaps. Similarly, the identification of social needs and SDOH should be foundational pieces of the quality program. Implementing structures and processes that enable regular assessments of a patient's social needs should be standard across all dimensions of care. First, we should explore the necessary resources and tools that put hospitals in the best position to screen and assess patients. Once hospitals can identify needs, they can be evaluated based on the processes in place to take the actions needed.

In addition, CMS should explore the potential stratification of measures that have "topped out" performance or have recently been removed because of topped out performance. By stratifying these measures, CMS can evaluate if there are differences in performance across certain populations that could demonstrate an ongoing gap in care. If CMS can identify gaps in care through stratification efforts, this should be considered as a criterion for maintaining these measures in the programs.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

Principles for Social Risk Factor and Demographic Data Selection and Use

In the proposed rule, CMS refers to the World Health Organization (WHO), which defines social risk factors as "non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." While it is widely known that these factors play a role in health outcomes, the availability of standardized and self-reported data on social risk factors and demographics is limited. The Agency refers to multiple efforts to develop data standards for collecting self-reported patient social risk and demographic data (the gold standard) and discusses the advantages and disadvantages of the available data sources. As CMS evaluates patient-reported sources of these data, they share the following sources of social risk and demographic data for consideration as variables to report within stratified measure results:

- Billing and Administrative Data
- Area-based Indicators of Social Risk Information and Patient Demographics
- Imputed Sources of Social Risk Information and Patient Demographics

The ACS commends CMS for the resources it has invested in identifying ways to promote health equity and agrees that identifying means to improve the health care of certain populations who are underserved should be a top priority of the agency and the entire U.S. health care system.

Data sources that are currently in use, such as billing and administrative data, can serve as proxies, but they will not be able to provide the proper level of detail and context that gets to the heart of the issues that patients face. These broad approaches will be helpful in giving us a general sense of the needs within a population. **As the ACS has stated in the past, the lack of standardization in demographic and SDOH data presents a major challenge in addressing needs. We agree that to achieve more widespread collection, aggregation, and tracking of SDOH data, improvements in collection methodologies and standardization are necessary across the entire healthcare system. In the same way that emphasis has been put on standardization of clinical information data in the medical record, SDOH information should also be consistently collected and maintained as part of the patient's medical record.** The ability to collect accurate and real-time SDOH data and put these variables in the hands of the clinician at the bedside could drastically change care delivery across the phases of care. Having these data would allow clinicians to tailor care based on SDOH from how they conduct screening, prevention, and early intervention to preoperative planning to postoperative recovery and post-discharge management.

Identification of Meaningful Performance Differences

In CMS' work to examine ways to report healthcare disparity data (or the results of quality measure stratification), they also will consider different approaches to identify meaningful differences in performance. CMS asks for feedback on the benefits and limitations of the following possible disparity reporting approaches.

- Statistical Differences – The Agency believes that statistical testing can be helpful when trying to reliably group results, using confidence intervals, creating cut points based on

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

standard deviations, or using a clustering algorithm. However, they recognize that these groupings may be statistically different but not meaningfully different.

- Ranking Ordering and Percentiles – CMS envisions that health care providers could be ranked based on their performance on disparity measures to allow comparison between their performance and other similar healthcare providers.
- Threshold Approach – In this system, CMS could group healthcare providers based on their performance using defined metrics, such as fixed intervals of results of disparity measures, indicating varying levels of performance.
- Benchmarking – This approach would compare individual results to other state or national averages or other group averages. CMS states that this approach, especially if combined with a ranked or threshold approach, could give providers more information on how they compare to the average care for a patient group.

As mentioned earlier, evaluating a facility's ability to identify the problem should be the first step in measuring performance. Since further research is required to decipher the best methodologies and variables for identifying and addressing social needs, hospitals should not be measured or compared based on their ability to reverse negative trends. Instead, **we think it is critically important to find ways to highlight and recognize the facilities that can accurately identify social needs and have taken steps to provide services and resources to reverse trends. From the ACS' perspective, we are too premature in these efforts to reward or penalize facilities based on their performance on measures that are stratified for SDOH variables.**

In the current state, CMS should use its resources to share information with healthcare providers and determine what metrics provide information that spurs action and improvements in care. As we have stated previously, in general, an important standard to apply in evaluating payment quality incentives is their effectiveness in providing patients with knowledge of where to find high quality care in their community. When considering meaningful performance differences this should be key—what information do patients value and how will that information reliably help them seek equitable care? Finally, when CMS determines that performance-based comparisons are appropriate across their programs, it must not adopt a one-size-fits all approach to applying statistical standards or other methodologies for identifying meaningful differences in performance. Statistical standards and approaches are specific to the use case.

Guiding Principles for Reporting Disparity Results

CMS describes the advantages of confidential reporting, which is a process that is typically used for newly adopted measures in CMS quality programs to give healthcare providers time to familiarize themselves with their performance, the calculation methods, and to begin improvement activities before the results are publicly reported. CMS asks for comment on the benefits of confidentially reporting all stratified measure results that are adopted into a quality reporting program before the results are publicly reported.

The ACS supports CMS' strategy to initially share stratified measure results through confidential reports. However, CMS should not publicly report outcomes until the measure science for reporting outcomes in at-risk patient populations is further developed. Instead, when publicly reporting SDOH information, CMS should report a facility's ability to identify and address the

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

social needs of the patients. **The ACS is supportive of reporting structural measures that show facilities have processes in place to support patients, such as programs for underinsured patients to receive prevention, screening, and early detection. We reiterate our belief that public reporting must include information that will be most valuable and informative for patients as they try to select facilities and clinicians that will be able to meet their needs and provide them the best care.**

CONTINUING TO ADVANCE TO DIGITAL QUALITY MEASUREMENT AND THE USE OF FHIR IN HOSPITAL QUALITY PROGRAMS – REQUEST FOR INFORMATION

In the FY 2022 IPPS/LTCH rule, CMS stated their aim to move fully to digital quality measurement in CMS quality programs and value-based purchasing programs. In this RFI, CMS continues to build on their goals and strategies to achieve the move toward digital quality measurement. They specifically focus on data standardization activities related to leveraging and advancing standards for digital data and approaches to transition to Fast Healthcare Interoperability Resources (FHIR) electronic clinical quality measure (eCQM) reporting in the future. In following sections of this RFI, CMS states that they envision quality measurement as only one use case for digital data in a learning health system where standardized digital data can support multiple use cases, including quality measurement, quality improvement efforts, clinical decision support, research, and public health. The Agency also clarified that they plan to transition to dQMs incrementally, by beginning with the uptake of FHIR Application Programming Interface (API) technology and shifting to eCQM reporting using FHIR standards.

To reiterate our past comments in response to the RFI in the FY 2022 IPPS/LTCH proposed rule, the ACS is supportive of using digital tools to capture the full scope of patient data. Leveraging digital tools to support the generation and management of knowledge can inform patient care and quality improvement efforts. However, we remain concerned that **the current structure of CMS programs force physicians to chase metrics for payment purposes instead of implementing quality programs that leverage digitally derived knowledge to drive continuous quality improvement. CMS continues to evaluate the necessary steps to transition to digital quality measures, but the Agency should not focus solely on how to advance to digital quality measures that only account for single isolated metrics.** Single metrics offer little value to patients when they are seeking high-quality care and little value to physicians for driving quality improvement cycles. Creating a digital framework to aggregate data for single metrics will make it easier and less burdensome to collect data, but if the measurements do not drive meaningful quality improvement cycles or appreciate the comprehensive patient journey and patient goals, we are left with the same disaggregated measure problem we have now and are trying to fix. Instead, **we suggest focusing this transition on utilizing digital tools to enhance more comprehensive quality improvement programs that have been proven to drive improvements in care.**

Digital services should be leveraged by building knowledge around a patient's care pathway through aggregation of clinically relevant data on open standards-based platforms that can ingest data from numerous sources. These digital services are nascent and hold great promise to enhance knowledge sharing around care to enable the following services:

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

1. Clinical decision support (CDS) that may inform the care team about clinical guidelines, standards, and pathways available as a digital service through platforms that are not constrained by proprietary efforts from electronic health records (EHRs).
2. Capabilities that can gather condition or procedural cohort data for outcomes reporting and complete assessments of a care team's conformance with a predetermined care plan, such as clinical guidelines or standards-based care.
3. Data aggregation and analytics for near real-time observations as part of an improvement event, research, etc. including expanding sample sizes in randomized clinical trials (RCTs).
4. Quality metrics that payors are interested in for incentive programs in a patient-centered manner.

Open architecture platforms are essential to expand medical knowledge management and optimize care. By using open standards-based platforms, data can be leveraged from a variety of data sources, such as health information exchanges (HIEs), clinical data, public health registries, EHRs, personal devices, commercial payer databases, and more to allow for a more complete picture of the patient and their healthcare needs. Having access to the full scope of patient information opens the door for shared and coordinated care across providers and facilities and increased ability to track patients' outcomes and recovery long term. This architecture can meet and exceed payor needs for quality metrics, as well as enrich clinical knowledge. However, retooling the healthcare industry for digitally supported knowledge enhancements takes considerable capital investment. If Medicare continues to distract the health informatics development and operations (DevOps) by focusing merely on metrics tied to payment activities, these capital needs to support better outcomes will be delayed. **We continue to encourage CMS to think more broadly about the underpinnings of digital healthcare so that the four aspects of care outlined above—CDS, cohort analytics, clinical research, and payor quality metrics—are similarly recognized when making capital investments in quality of care.**

Redefined Definition of Digital Quality Measures (dQMs)

Based on previous feedback, CMS clarifies that dQMs are quality measures organized as self-contained measure specifications and code packages that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, laboratory systems, prescription drug monitoring programs (PDMPs), instruments (e.g., medical devices and wearable devices), patient portals or applications (e.g., for collection of patient-generated data such as a home blood pressure monitor, or patient-reported health data), HIEs, registries, and other sources. CMS seeks comment on the refined dQM definition and on potential considerations or challenges related to non-EHR data sources. **The ACS thanks CMS for acknowledging that dQMs should be designed to incorporate multiple sources of patients' health information.** Important patient data that can support clinical decision making and quality improvement efforts can be found in various sources beyond a local EHR instance, and the ability to aggregate data from all sources of patient data will allow for more accurate and detailed tracking to inform patient interventions and improve outcomes. **As we stated in our introductory comments in this RFI and described in**

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | facs.org

the opening comments on page 6, we suggest that CMS change its emphasis from aggregating data with dQMs that focus on single metrics to developing a definition for digital services that can be applied to support a "quality program" framework.

Data Standardization Activities to Leverage and Advance Standards for Digital Data

In the FY 2022 IPPS/LTCH final rule, CMS stated that they are considering implementing eCQM quality reporting via FHIR-based APIs based on standardized interoperable data. As mentioned above, CMS states that they envision quality measurement as only one use case for digital data in a learning health system where standardized digital data can support multiple use cases, including quality measurement, quality improvement efforts, clinical decision support, research, and public health. **The ACS agrees that standardization will be crucial to the success of the transition to digital quality measurement, and we thank CMS for acknowledging that digital services and standardized data have uses cases across many aspects of healthcare delivery.** As we have stated in the past, there are other sources of patient data in standardized formats aside from FHIR that will also be useful to quality measurement, such as operative and pathology reports using structured data capture (SDC) and Enhanced Recovery protocols. CMS should consider ways to incorporate these data in digital quality measurement in the future.

CMS also discusses the need for standardization across implementation guides (IGs), value sets that organize the specific terminologies, and codes that define clinical concepts. Based on previous feedback, CMS states that they will continue to focus on leveraging the interoperability requirements for standardized APIs in certified health IT, set by the Office of the National Coordinator for Health Information Technology (ONC) 21st Century Cures Act final rule, including data elements for quality measurement that are consistent with the United States Core Data for Interoperability (USCDI) standard. The Agency seeks comment on the following IGs, additional IGs they should consider, and other data and reporting components where standardization should be considered to advance the learning health system.

- U.S. Core Implementation Guide
- Quality Improvement Core (QI) Implementation Guide
- Data Exchange for Quality Measures (DEQM) Implementation Guide
- Quality Measure (QM) Implementation Guide
- Clinical Guidelines (CPG) Implementation Guide

Standardizing IGs will be important in the transition to dQMs, but the IG will only be effective if the measure or guideline it is implementing is effective. The IG provides standards for the measure structure, metadata, logic and other clarifying definitions and details necessary for implementation. Therefore, if the dQM itself does not better inform patients, the standards, structures, logic, etc. within the IG that supports the measure may be right for the measure, but the overall goal of better quality and value of care will not be achieved. It is very important that CMS evaluate the information and overall impact of the quality measure inventory before fully transitioning to dQMs. DQMs should be designed to aggregate data across multiple digital sources to enhance accountability across the entire clinical team and drive improvements in care, not to merely meet the objectives of a payment incentive program.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

We commend CMS for exploring how they should be leveraging Health Level 7 (HL7) standards and IGs—HL7 has taken steps to expand the availability of IGs and this is a great step towards interoperability. However, the ACS reminds CMS that the goal should be to optimize these resources for better care that is safe, affordable, and equitable as they work towards dQMs. As HL7 continues to add IGs to their library, we suggest that they specify what the IG brings to overall care. This will help prioritize what IGs are being built to align with goals for quality improvement programs and can evaluate if they are achieving this goal.

CMS also asks for stakeholder input on other relevant data that require standardization. To align with CMS' efforts to advance health equity and reduce disparities in healthcare, we emphasize the need for standardization in SDOH and demographic data. Improving the collection methodologies and standardization of these data is just as important as standardizing clinical data points. In many instances these data are not widely collected, and if they are, there is variation in how it is identified, classified, and what fields are used in EHRs and other systems. Giving physicians real-time SDOH data that can be bi-directionally exchanged with all members of the care team will support open communication pathways to align care around the patients' goals. If physicians have access to accurate information about patients' social needs, they will be better prepared to provide high-quality care to all patients.

We envision opportunities for these data to be integrated into clinical workflows through CDS modules that physicians can access in their EHRs or other platforms. CDS algorithms could evaluate the patient's electronic health information (EHI), including other risk variables, to trigger follow-up reminders and alerts for certain medications or interventions specific to the patient's medical and social needs.

The cancer journey is a pertinent example that illustrates the usefulness of data standardization in sharing knowledge and treatment planning across the care team and the timeline involved. Cancer treatments and prognosis are often determined by treatment options which depend on clinical information used to determine the stage of the cancer (Stage I, II, III or IV). The clinical information may rely on clinical exam, lab results, imaging, and operative reports. Structured data capture tools exist in standardized formats and are available to clinicians on open platforms. Adopting these as industry standards—such as the Tumor, Nodes, Metastases (TNM) classification of cancer staging or structured surgical pathology reports and structured surgical operative reports—would provide shared knowledge that would be invaluable to the cancer treatment teams. These clinical standards are held by the clinical societies who developed them based on scientific evidence. We encourage CMS to recognize these as enrichments to the digital ecosystem and to encourage FHIR-based adoption of these artifacts for inclusion in physician workflows in EHRs. It is also important to keep in mind that while EHRs provide the tools for workflows, it is the clinical expertise that should govern the content and context for standards related to clinical care. **The data needed for shared knowledge will always evolve and should be governed by those with the appropriate expertise–clinicians for clinical content and context, and technology engineers for workflow architecture.**

Figure 1 shown on page 33 is a limited representation of a cancer patient under treatment by a care team. Each physician has explicit roles to play and coordinate with the other physicians. The primary care physician, once informed of a cancer diagnosis, refers the patient to medical

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

(represented by the green boxes) and surgical (represented by the blue boxes) oncologists. The purple boxes indicate areas of co-management and shared decision-making. EHRs are narrowed workflow solutions that are used to capture a transaction and perhaps where eCQMs will be implemented. Coordinated care requires platform solutions that are beyond instances of an EHR and better represent care and provide the team with a full sense of the patient and their care journey.

The Object Management Group (OMG) subgroup, Business Process Modeling (BPM+) Health, enables human-readable and machine-readable clinical algorithms for process tracking, decision management, and case reporting. Implementation of these OMG resources are a means for expressing the intersections of care teams in such complex care environments, especially those which involve conditions treated by many clinicians with more than a few visits.

Approaches to Achieve FHIR eCQM Reporting

CMS considers the transition to FHIR-based eCQM reporting the first step to dQM reporting and outlines the activities that they believe will be necessary to achieve this. The Agency asks for feedback on near term and future plans needed to report FHIR-based eCQMs and future dQMs. From the ACS perspective, a phased-in approach is necessary to make this transition, thus we urge CMS to take the necessary time to ensure that the transition to dQMs is done in a way that is safe and effective. They must allow opportunities to test the efficacy and impact of the measures, gather stakeholder feedback, and implement processes to iterate the measures until they achieve the desired goal of informing improved patient care.

We also agree that CMS must eventually acknowledge dQMs that expand beyond the current inventory and structure of traditional eCQMs. Currently, most eCQMs focus on using claims and payer data to evaluate singular processes and outcomes. As we have discussed throughout our comments, measures that only evaluate isolated or rare event rates and disconnected processes will not push our system towards higher quality care and improved value in the modern healthcare delivery system. If CMS only focuses on eCQMs in their first phase of dQM implementation, CMS will be limited and will not realize the many opportunities that other dQMs offer. Instead, we recommend that CMS pursue the eCQM transition while simultaneously beginning to accumulate the functionalities and processes for gathering the data needed to support quality programs.

A quality program incorporates elements of structure, process, outcome, and patient experience measurement across the full cycle of care for a condition or following a procedure that can be applied to better evaluate the entire clinical team. It is important to define the condition-specific program, its data needs, and how the data are used in improvement cycles—not just a sporadic, single measure that is not tied to a full quality program. Quality programs purposefully assemble explicit bits of data that are used to inform, monitor, and drive change. Today's methods of sporadically gathering data across a broad array of conditions only serve limited purposes, such as payment, and do not reflect how data is being exchanged and used in healthcare. Measuring a physician based on six to ten quality measures that are not linked to a condition or used in a quality improvement exercise will serve payment, not patients. **Therefore, it is extremely important to also explore ways that these data can be leveraged to support activities that**

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

identify a condition, define its complete program for improvement, find gaps or problems, determine opportunities to improve, and monitor improvement cycles for their effectiveness.

ADVANCING THE TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT – REQUEST FOR INFORMATION

Section 4003(b) of the 21st Century Cures Act, enacted in 2016, required the Department of Health and Human Services (HHS) to take steps to advance interoperability for the purposes of ensuring full network-to-network exchange of patient health information. Specifically, Congress directed the ONC to "develop or support a trusted exchange framework, including a common agreement among health information networks nationally." Since then, HHS has pursued development of the Trusted Exchange Framework and Common Agreement (TEFCA) with goals of: establishing a universal policy and technical floor for nationwide interoperability; simplifying connectivity for organizations to securely exchange information to improve patient care, enhance the welfare of populations, and generate health care value; and enabling individuals to gather their health care information.

In 2022, ONC released the Trusted Exchange Framework, a set of non-binding principles for health information exchange and Common Agreement Version 1, a contract that advances those principles. CMS states that they are considering other ways to advance information exchange under TEFCA. They are interested in opportunities to encourage exchange under TEFCA through CMS regulations for certain health care payers, including Medicare Advantage, Medicaid Managed Care, and Children's Health Insurance Program (CHIP) issuers. CMS is also considering future opportunities to encourage information exchange under TEFCA for payment and operations activities such as submission of clinical documentation to support claims adjudication and prior authorization processes.

The ACS strongly supports the importance of TEFCA and the implementation and widespread adoption of these exchange networks. They present countless opportunities for clinicians and other stakeholders to enhance patient care and augment healthcare knowledge. In recent years, the ACS has emphasized that a shift from EHRs to shared knowledge across platform technology that feeds into data lakes and leverages available web services through channels enhanced by TEFCA is the future of healthcare delivery. By implementing data lakes to store the full depth of clinical knowledge and through opportunities to develop logic to better organize and present those data to physicians (instead of only utilizing the information held by a single EHR), quality of care and access to high-quality care will be improved for patients. The ability to reach across care teams and to coordinate care, inform and engage patients, track social determinants, etc. are all enhanced by fully realizing the functionalities that can be built at the HIE and TEFCA level. For example, data lakes can hold hubs of information about individual patients, conditions, and about individual clinicians that treat patients with specific conditions. By incorporating certain capabilities and logic within the data lake, physicians can have real-time access to data that can give them better insight into their success rates for surgical treatments on their patients with chronic conditions or dual-eligible patients, for example. They might also be able to pull down data that helps them understand their practice profiles for pain management in geriatric surgical patients and any associations to postoperative delirium, confusion, or falls.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

These and many more aspects of care cannot be tracked in a single EHR system and require the ability to aggregate and utilize data on a larger scale.

Expansive opportunities are also present for specialty societies and other stakeholders. Organizations with clinical expertise can enhance the applied sciences because more content and context will be available when long-term knowledge is broadly available and exchanged. This can better support the development of many services, such as standards for care, care pathways, and guidelines supported by widespread data about real-time patient care. This also can create opportunities for research and development in many important clinical areas. By leveraging HIEs and TEFCA and integrating exchange with data lakes hosted by specialty societies, these activities can take place closer to real time while being supported with expansive knowledge, as compared to current practices that access data in single EHRs or registries. **Given the many use cases, we urge CMS to explore opportunities to offer federal support for HIEs that leverage data lakes to fully recognize their potential.**

In addition, we ask CMS to explore the concept that other non-clinical documents can be exchanged between Qualified Health Information Networks (QHINs) and their participants. We envision that QHINs could create a library of documents that would fulfill specific request types. Currently, exchanges do not take a query, construct data elements into a document, and make these documents available to exchange participants. The ability to organize and share information about non-clinical variables, such as the inventory of medical supplies, medications, etc. could be helpful for resource planning, understanding capacity, and population health at the local level.

CMS also asks stakeholders to share their concerns about enabling exchange under TEFCA. They ask about potential increases in burden, or other financial or technical barriers, and ways CMS can reduce these barriers. As the availability of clinical data and knowledge increases, the depth of information about individual patients will exceed individual human capacity and can overwhelm the clinical team. Managing this much information—true big data—requires teams with highly specified roles, oversight, shared accountability, and a redesign of the practice of medicine. When care is limited, simple, and only requires a few visits, these data are not as critical, and care can be easily managed. However, when a multi-morbid patient with a complex illness, such as a malignancy, enters the picture, the shared co-management environment will outperform the traditional transactional, one-stop-at-a-time medicine. It is the coordinated efforts of each role player doing their part and supporting each other that leads to optimal care. Leveraging data across time and settings will allow for care team redesign and business models that have more alignment with the modern care model.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

Under the Hospital Inpatient Quality Reporting (IQR) program, hospitals must meet requirements for reporting specific quality information to receive the full market basket update for that fiscal year. Hospitals that do not meet the reporting requirements will receive a two-percentage point reduction in that year's inpatient hospital payment update factor.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

New Measures Being Proposed for the Hospital IQR Program Measure Set

Proposed Hospital Commitment to Health Equity Measure Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination and for Subsequent Years

CMS is proposing to adopt the Hospital Commitment to Health Equity measure for the CY 2023 IQR reporting period/FY 2025 payment determination and for subsequent years. The Hospital Commitment to Health Equity measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges. The measure includes five attestation domains and elements within each domain that a hospital must affirmatively attest to for the hospital to receive credit for that domain. Hospitals would be required to submit information for this measure once annually using a CMS-approved web-based data collection tool available within the Hospital Quality Reporting (HQR) System.

From the ACS' perspective, the introduction of the Hospital Commitment to Health Equity measure takes a step toward moving federal quality programs forward, especially when seeking to drive hospitals toward inclusivity and health equity. It has proven difficult to reliably measure health care disparities due to current inconsistencies in demographic data collection and availability, a shortage of resources in facilities to track patients over time, and more. **Structural composite measures like this serve as a good starting point to ensure that hospitals have the proper structures and processes in place to move towards a culture of inclusivity. The ACS commends CMS for developing and introducing this measure that intends to assess how a hospital promotes an organizational culture of equity-focused leadership, its commitment to robust demographic data collection, and the active review of disparities in key quality outcomes.**

Structural measures are a key component to a comprehensive quality program and the ACS thanks CMS for acknowledging the value of these measures. As we have been advocating through multiple comment letters and meetings over numerous years, the ACS supports comprehensive quality programs built around the team-based nature of patient care delivery, providing patients with the information they need to meet their health goals, and driving surgical teams toward improvements in care and a culture of excellence. To accomplish these objectives, **a quality program must include components that evaluate the structures, processes, and the interdependencies that are in place to build toward patient's goals, be informed by measurable outcomes, and incorporate patient experiences**. Attestation that key structures and processes are in place can assure the right care is applied for the right indication. These components are part of ACS Quality Programs, which are referred to as verification or accreditation programs where care is verified for a specific condition by the ACS.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

Proposed Adoption of Two Social Drivers of Health Measures Beginning with Voluntary Reporting in the CY 2023 Reporting Period and Mandatory Reporting Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years.

The proposed measures are as follows:

1. *Proposed Screening for Social Drivers of Health Measure*
   This measure assesses the percentage of patients admitted to the hospital who are eighteen years or older at the time of admission and are screened for food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. The measure is being proposed for voluntary reporting beginning with the FY 2023 reporting period and mandatory reporting beginning with the FY 2024 reporting period/FY 2026 payment determination and subsequent years. Providers could use a self-selected screening tool and collect these data in multiple ways to accommodate the populations they serve. CMS clarifies that the intent of this measure is to promote adoption of health-related social needs (HRSN) screening by hospitals. They also encourage hospitals to use the screening as a basis for developing their own individual action plans (which could include navigation services), as well as opportunities for initiating and improving partnerships between healthcare delivery and community-based services.
2. *Proposed Screen Positive Rate for Social Drivers of Health Measure*
   This measure requires the reporting of the number of patients that screened positive for social drivers for each domain. The measure is being proposed for voluntary reporting beginning with the CY 2023 reporting period, followed by mandatory reporting on an annual basis, beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years. CMS notes that adoption of this structural measure would encourage hospitals to track prevalence of specific HRSNs among patients over time and use the data to stratify risk as part of quality performance improvement efforts.

The ACS supports CMS' efforts to increase screening for social drivers of health, however we see a missed opportunity to drive hospitals towards putting actions in place to support patients who screen positive for certain social risk factors. CMS should not simply evaluate who conducts screenings, and if a patient screened positive for certain social drivers, but whether the hospital has action plans in place to address the risk factors. When patients screen positive for one of the domains, processes should be in place to share that information with an interdisciplinary care team to organize around the patient and coordinate to optimize care, communication, follow-up, and tracking of the patient following treatments.

As part of these proposals, CMS describes their methodology for selecting the five domains to be included in the screening tools. The effect of social drivers is experienced at the local level, and many factors—such as, geographic location, available resources, and populations characteristics—can play a role in the prevalence of social drivers and their impact on healthcare outcomes and delivery. Therefore, **the ACS supports flexibility in the selection of screening tools. Flexibility should be allowed until we can better understand SDOH and their impact before standardizing screening tools across care settings, geographic locations, and patient**

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

populations. Moving forward, CMS should evaluate the impact of SDOH on health outcomes that they continue to evaluate and adjust the domains for social drivers.

Additionally, we seek clarity as to why there are two different measures: Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. It would seem reasonable to include this as one measure where hospitals screened and reported the results. To make these measures more valuable, the ACS encourages CMS to work with measure developers to develop a measure that focuses on the actions that were taken following a positive screen. Eventually, the two proposed measures, and a third designed to evaluate the follow-up action, could be combined into a single metric with stratification of the results for screened positive versus those who did not.

Finally, the title of the measure, "screen positive," is misleading. From a patient's perspective screening positive for social factors intuitively would be a positive, whereas in this measure, it is indicating complexities that required additional resources. Considering how patients might seek care, the measure title is important if this is to be publicly reported in the future.

Proposed Hospital-Level, Risk Standardized Patient-Reported Outcomes (PRO) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #3559)

CMS proposes to add the THA/TKA patient reported outcome performance measure (PRO–PM), which reports the hospital-level risk-standardized improvement rate (RSIR) in patient reported outcomes following elective primary THA/TKA for Medicare fee for service (FFS) beneficiaries aged 65 years and older, to the Hospital IQR Program. More specifically, the measure outcome is the risk-standardized proportion of patients undergoing elective primary THA/TKA who meet or exceed a substantial clinical improvement threshold between preoperative and postoperative assessments on two joint-specific PRO instruments. Substantial clinical improvement would be measured by achieving a pre-defined improvement in score on joint-specific PRO instruments measuring hip or knee pain and functioning, from the pre-operative assessment (data collected 0 to 90 days before surgery) to the post-operative assessment (data collected 300 to 425 days following surgery). The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data.

In response to comments submitted during 2022 rulemaking, CMS proposes a phased implementation approach, with two voluntary reporting periods in CY 2025 and 2026 reporting periods prior to mandatory reporting beginning with the CY 2027 reporting period/FY 2028 payment determination. The Agency proposes to provide hospitals with their THA/TKA PRO-PM results in confidential feedback reports during the two voluntary reporting periods occurring in 2025 and 2026. CMS also proposes to publicly report which hospitals choose to participate in voluntary reporting and/or the percent of preoperative data submitted by participating hospitals for the first voluntary reporting period, and their percent of preoperative and postoperative matched PRO data submitted for subsequent voluntary reporting periods. The THA/TKA PRO-PM results and response rates would be publicly reported on the Compare tool or its successor website, beginning with the first mandatory reporting period for the FY 2028 payment

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

determination. Hospitals would receive confidential feedback reports prior to public reporting that detail results from the reporting period.

The ACS strongly supports the use of condition-specific functional patient-reported outcome measures (PROMs) in CMS programs. These measures are useful tools to more accurately measure the success of certain procedures based on outcomes that are important to the patients, while also supplying the clinical team with information essential to the patient's recovery. **Utilizing PROMs gives the patient the opportunity to indicate whether the operation or intervention was successful based on why the patient sought care and whether the treatment was able to deliver results on the initial goals of care. This information should then be expressed publicly in a way that is meaningful to patients seeking care so they can apply their own judgment to their needs.**

Given our continued support for the incorporation of PROMs in CMS programs, the ACS supports the inclusion of the *Proposed Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* measure. Using joint-specific PROMs to measure hip or knee pain and function following a THA and TKA procedure can be effective in measuring a patient's postoperative goals. THA and TKA procedures are unique from some other surgical procedures (such as cancer surgeries) because the improvements in a patient's joint-function and the presence of pain can be clearly tracked through the preoperative and postoperative phases of care. Utilizing PROMs that focus solely on patients' postoperative goals and outcomes becomes more complicated when measuring outcomes in other specialties such as oncological care, where improvement metrics are influenced by many other factors that are unique to the specific patient's condition. In these other instances, there are not always metrics that can be universally applied to all patients that undergo these treatments. In these cases, PROMs may be more focused on the patient's experience while receiving treatment. It is the ACS' hope that condition-specific functional PROMs will become more commonplace in other surgical specialties, as they are appreciated by both the patient and the surgical team in assessing value. We encourage CMS to promote research that furthers the use of PROMs in other surgical conditions to better drive toward patient goals of care. This should include identifying ways to increase patient activation in the PROM process to enhance response rates and more meaningfully inform the entire care team.

Expanding the use of PROMs in CMS programs will reflect a transition to a more patient-centric program by assessing outcomes that matter most to patients. It will also be critical to incorporate these types of measures across CMS programs, including clinician-level programs such as MIPS and/or MIPS Value Pathways (MVPs), to ensure the patient-centric approach to care delivery. As the ACS has stated in the past, CMS could create alignment for PROMs at the clinician and facility level by measuring whether the facility has the infrastructure to implement a specific PROM, and then assess the clinician based on their adherence to a quality improvement plan that is designed to follow up on the responses to the same PROM.

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

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

The Hospital IQR Program adopted the Maternal Morbidity Structural measure in the FY 2022 IPPS/LTCH PPS final rule. The Maternal Morbidity Structural measure captures via attestation whether hospitals are: (1) Currently participating in a structured state or national Perinatal QI Collaborative; and (2) Implementing patient safety practices or bundles as part of these QI initiatives. For FY 2023, CMS is proposing to publicly report this measure on CMS Care Compare website. If finalized, this would be the first hospital quality designation by HHS or CMS that specifically focuses on maternal health. In future rulemaking, CMS intends to propose a more robust set of criteria for awarding the designation that may include other maternal health-related measures that may be finalized for the Hospital IQR Program measure set in the future.

When proposed last year, the ACS supported the intent and direction of the perinatal quality improvement initiative with the Maternal Morbidity measure. Structural measures are the first step needed to build the foundation for maternity care nationally. However, with the lack of national maternity care standards coupled with the undoubtedly great variation in state QI collaboratives, this measure will need to be further developed. Therefore, we strongly recommend CMS work toward the development of a true, comprehensive quality program for maternity care—or a programmatic maternity measure. A programmatic measure should be developed first by defining the patient care journey, and next by selecting condition-specific elements for national standards that are verified by clinical experts to create a program. Programmatic measures consist of structural and process measures, which address all six Institute of Medicine domains (safe, effective, patient-centered, timely, efficient, equitable), and is comprehensive across the full spectrum maternal care.

This programmatic approach also offers useful information that patients will find beneficial when deciding where to seek care. **An important standard to apply in evaluating payment quality incentives is their effectiveness in providing patients with knowledge of where to find high quality care in their community.** In assessing the effectiveness of measures, we recommend asking the question—if the patient had this information, would it enable them to easily find the type(s) of care they seek, such as if the facility delivers safe and equitable care, and whether it has been successful in attaining patients' personal goals for their condition?

Therefore, we strongly support a programmatic measure that provides public assurance for patients seeking maternity care and one that can help them choose which hospital best suits the care they seek. To achieve this, it is critical that CMS develop a more robust designation to report on CMS Care Compare. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are the prerequisites for a valid depiction of the value of care.

MEASURE RECENTLY SUBMITTED BY THE ACS TO CMS: *Programmatic Geriatrics Surgery Measure* (MUC 2022-032)

The ACS recently submitted a new type of measure—a programmatic measure for geriatric surgical care, titled *Geriatrics Surgery Measure.* This measure was submitted for consideration in

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

the CMS facility-level quality programs, including the IQR. This programmatic measure differs from traditional structural or process measures commonly used by CMS, which are usually singular structural components, or a simple process tied to a transaction/patient visit. It builds on the Hospital Commitment to Health Equity Measure framework for a more comprehensive program of care.

The challenges with the classical structure or process measures are that care is not a single structural element or process. Instead, it is the collection of all these components orchestrated across the continuum of care for the entire team in a patient-centered manner. Together, these become a patient-centered program of care. When the components are properly tied together, care becomes well-coordinated, complex aspects of care are more reliably delivered, harms are minimized, and outcomes are optimized. The elements in the program are focused on care delivery, coordination, data, and data-driven improvement activities.

A measure focused on geriatric surgical care is critical for the aging U.S. population, where older adults are the fastest-growing demographic in the country. Currently, over four million high-risk operations (procedures with a mortality rate over one percent) are performed on adults over 65 annually.[9] Hospitals are increasingly faced with older patients who have complex medical, physiological, and psychosocial needs that are often inadequately addressed by the current healthcare infrastructure. Despite this growing need, our healthcare system has not comprehensively rethought care for the complex geriatric population since the creation of Medicare more than 50 years ago.

A programmatic facility-level geriatric measure is part of what is needed to rethink care for the older adult population. This solution is different from the current types of CMS measures. This programmatic measure incentivizes team-based care organized around the geriatric surgical patient to meet the challenges unique to geriatric surgical patients. Although existing quality metrics have improved both the rate and reporting of clinical outcomes (e.g., falls, appropriate use of anticoagulants, etc.) that are important to older individuals, these measures can be narrow in scope and may have limited long-term effectiveness due to ceiling effects. Rather than simply addressing individual clinical issues in isolation, optimizing care for older patients with multifaceted vulnerability profiles will require a holistic approach with the goal of reframing the entire care pathway to better serve the needs of this unique population. The *Geriatrics Surgery Measure* was developed with the Modified Delphi method, receiving input from more than fifty organizations, including the ACS. The multistakeholder group identified clinical frameworks based on evidence and best practices that provide goal-centered, clinically effective care for older patients. As a result, this programmatic measure consists of structural and process measures which address all six Institute of Medicine domains (safe, effective, patient-centered, timely, efficient, equitable) and is comprehensive across the full spectrum of geriatric surgical care.

This programmatic approach also offers useful information that patients will find beneficial when deciding where to seek care. An important standard to apply in evaluating payment quality

[9] Schwarze, M. L., Barnato, A. E., Rathouz, P. J., et al. (2015). Development of a list of high-risk operations for patients 65 years and older. *JAMA,150*(4), 325-331. https://doi.org/10.1001/jamasurg.2014.1819

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

incentives is their effectiveness in providing patients with knowledge of where to find high quality care in their community. Twenty years of NQF and payer actions in quality have not produced reliable public knowledge or a public-facing website that informs patients about where to get the care they need for the *condition* they have. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are the prerequisites for a valid depiction of the value of care. In assessing the effectiveness of our measures, we wonder if the patient had this information, would it enable them to easily find information on a website for the types of care they seek, such as if the facility delivers safe and equitable care and has a reputation for attaining patients' personal goals. We look forward to working with CMS on the implementation of this measure and future measures that follow this framework, with the goal of also aligning programmatic measures with measures in other payment programs, including MIPS/MVPS.

CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM

Electronic Prescribing Objective: Proposed Changes to the Query of Prescription Drug Monitoring Program Measure and Technical Update to the E-Prescribing Measure

In past years, CMS has finalized that the *Query of Prescription Drug Monitoring Program (PDMP)* measure would remain optional and eligible for bonus points due to the COVID-19 Public Health Emergency and lack of widespread availability of PDMPs across the country. However, despite these ongoing challenges, CMS proposes to require the current *Query of PDMP* measure, beginning with the CY 2023 EHR reporting period. CMS also proposes updates to the measure description and two new exclusions, which if finalized would go into effect in the CY 2023 EHR reporting period. Proposed updates to the measure specifications include:

- Expand the *Query of PDMP* measure beyond just Schedule II opioids to include Schedule II, III, and IV drugs. The revised measure would read: "For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a PDMP for prescription drug history."
- The query of the PDMP for prescription drug history must occur prior to the electronic transmission of an electronic prescription for a Schedule II opioid or Schedule III or Schedule IV drug.

CMS also proposes the following exclusions:

1. Any eligible hospital or critical access hospital (CAH) that does not have an internal pharmacy that can accept electronic prescriptions for controlled substances that include drugs from Schedules II, III, and IV, and is not located within ten miles of any pharmacy that accepts electronic prescriptions for controlled substances at the start of their EHR reporting period; and
2. Any eligible hospital or CAH that cannot report on this measure in accordance with applicable law.

As stated in our past comments, the ACS suggests that CMS maintain this as an optional measure. While we understand that much progress has been made to integrate PDMPs into

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

the clinician's EHR workflow, without widespread data exchange capabilities it could be challenging to electronically report due to the additional documentation and verification with an external system. This creates unnecessary documentation burden for clinicians. We challenge CMS to consider how PDMPs can be optimized with knowledge engineering. Knowledge engineering solutions would be extremely helpful in tracking and analyzing narcotic prescribing practices and a patient's risk for Opioid Use Disorder (OUD). For example, a physician would input prescribing information for a certain patient into the patient's record, which could be sent directly from their EHR to the PDMP. Then the PDMP, through analytics built within the PDMP, could review the patient's record within the system and flag any variables that would signal the patient's risk for overuse or OUD. These analyzed data and any other variables the physician requests would then be sent back to the physician at the point of care to support clinical decision-making. A system such as this, could optimize PDMP's ability to exchange meaningful knowledge for better clinical care.

Health Information Exchange (HIE) Objective: Proposed Addition of an Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS discusses the opportunities presented by the implementation of TEFCA in the *Advancing the Trusted Exchange Framework and Common Agreement RFI.* To offer providers more opportunities to earn credit for the HIE objective under the Medicare Promoting Interoperability (PI) program, CMS proposes to add an additional measure through which an eligible hospital or CAH could earn credit for the HIE objective by connecting to an entity that connects to a QHIN or connecting directly to a QHIN. This new measure, *Enabling Exchange Under TEFCA* measure would be reported by attesting "yes/no" to the following attestation statements. If a facility attests "yes" they would earn the total points allotted for the HIE Objective.

- Participating as a signatory to a Framework Agreement, (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website) (in good standing that is not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (Place of Service (POS) 21 or 23), and all unique patient records stored or maintained in the EHR for these departments, during the EHR reporting period in accordance with applicable law and policy.
- Using the functions of Certified Electronic Health Record Technology (CEHRT) to support bi-directional exchange of patient information, in production, under this Framework Agreement.

The ACS has been a strong supporter of the TEFCA efforts for many years. From the ACS perspective, the Framework will offer benefits to both patients and providers. Widespread exchange with QHINs open doors to greater access and exchange of important clinical data that can be applied across the entire healthcare spectrum. **We applaud CMS for taking steps to incentivize bi-directional exchange with QHINs. With these data, providers can longitudinally track patients' comorbidities, risk factors, and past treatments, regardless of where the patient was treated, to better inform care decisions.** We also see opportunities in

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

the near future for these networks to be leveraged to generate knowledge that supports the development of digital tools, such as CDS, that can be applied to achieve more patient-centric healthcare delivery.

The ACS appreciates the opportunity to provide feedback on this proposed rule and looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Mujumdar, Chief of Regulatory Affairs, at vmujumdar@facs.org, or Jill Sage, Chief of Quality Affairs, at jsage@facs.org.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director

WASHINGTON OFFICE | 20 F Street NW, Suite 1000, Washington, DC 20001 | T 202-337-2701 | F 202-337-4271 | E-mail: ahp@facs.org | *facs.org*

Figure 1. ***Cancer Care Process Map***