



Charles N. Kahn III
President and CEO

June 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1750-P: Proposed Rule: Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year 2022

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule, *FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year FY2022* ("Proposed Rule") published in the Federal Register (86 Fed. Reg. 19480) on April 13, 2021.

FY 2019 CLAIMS

The FAH agrees with CMS that the FY 2019 claims would be the "best available data" to estimate FY 2022 payments and supports its proposal to use FY 2019 claims to calculate the outlier fixed loss threshold and wage index budget neutrality factor. We believe FY 2019

claims are more likely to reflect IPF cases in FY 2022 rather than FY 2020 cases, which were heavily impacted by the intensity of the COVID-19 pandemic, which continues to subside.

WAGE INDEX

“Frontier” Floor

CMS uses a wage index to adjust the labor-related portions of IPF payments under the IPF PPS. Since the inception of the IPF PPS, CMS has used the pre-floor, pre-reclassified acute care hospital wage index in developing a wage index to be applied to IPFs, because there is not an IPF specific wage index available. CMS has previously stated in prior year rulemaking that *“We believe that IPFs compete in the same labor markets as acute care hospitals, so the pre-floor, pre-reclassified hospital wage index should reflect IPF labor costs.”* 83 F.R. 21104, 21110. This observation continues to ring true with our members, whose experience demonstrates that IPFs do compete directly with acute care hospitals for talent.

As CMS has previously acknowledged, however, “under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, *without* taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS.” 83 F.R. at 21110 (*italics added*). This policy acts to disadvantage IPFs when competing with general acute care hospitals, because their payments under the IPF PPS simply do not reflect the economic conditions of these labor markets.

This issue is particularly acute in the “frontier states,” so named by the Affordable Care Act provision that established a floor on the area wage indexes in highly rural states. 42 U.S.C. 1395ww(d)(3)(E). Under that provision, states with a high share of low population-density counties have a “floor” on their area wage index of 1.00. Because CMS does not take this floor into account when applying the IPPS wage index to IPFs, the wage index for an acute hospital can be up to 30% higher than an IPF in the same labor market.

Consequently, IPFs in a frontier state are underpaid relative to general acute care hospitals in the same geographic areas, even though they compete directly for the same employees. This underpayment undermines an IPF’s ability to recruit and retain clinical and administrative staff and offer competitive salaries and benefit packages. To address this inequity, **we urge CMS not to disregard the frontier state “floor” when it applies the acute care hospital wage index to IPFs.** In fact, this same issue was addressed by CMS in the August 6, 2018 final rule, 83 F.R. 38584 where CMS acknowledged the provider comments on this issue and stated the “frontier” floor would be taken into consideration by CMS.

The Secretary has broad authority to implement a prospective payment system for IPFs. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. 106–113, Sec. 124 (1999). The regulations governing the IPF PPS indicate that CMS should “adjust the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an *appropriate* wage index,” 42 C.F.R. § 412.424(d)(1), and that CMS will publish on an annual basis the *“best available* hospital wage index and information regarding whether an

adjustment to the Federal per diem base rate is needed to maintain budget neutrality,” 42 C.F.R. § 412.428(c) (emphasis added). **The regulatory guidance of using an *appropriate wage index* based on the *best available hospital wage index* and information is fulfilled with the use of the frontier state wage index floor of 1.0 to adjust IPF payments in a frontier state in a non-budget neutral manner.**

“Stop-loss”

In addition, we recommend that CMS apply a non-budget neutral five percent cap on decreases to a hospital’s wage index value to help mitigate wide annual swings that are beyond a hospital’s ability to control, and which could otherwise undermine operations.

INPATIENT PSYCHIATRIC FACILITIES QUALITY REPORTING (IPFQR) PROGRAM

The FAH strongly supports the importance of the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program as a means of ensuring the delivery of high quality mental and behavioral health care to Medicare beneficiaries. We respect the continued efforts of CMS to make the program more meaningful and less burdensome for patients and providers and agree with many of your proposals for FY22 and future years. However, we remain concerned about some persistent issues in the IPFQR program that sharply limit its effectiveness in achieving the desired and intended improvement in quality of care. Those issues will frequently figure into our comments below on specific topics, and they include: a measure set that remains dependent upon chart abstraction, a resource-intensive and burdensome process; the absence of relevant experience of care and functional outcome measures; the lack of incentives for providers to adopt EHRs and interoperable health information technology (HIT); and a structure that pays for reporting rather than recognizing value. We look forward to continuing to work with CMS to improve the program, particularly during a time when the demand for mental and behavioral health care continues to increase as our country recovers from the COVID-19 public health emergency (PHE).

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

Overview

Through this RFI, CMS requests information for the stated overarching purpose of making reporting of health disparities within and across its quality program portfolio more comprehensive and actionable for patients, providers, and facilities. CMS focuses on the possibility that enhanced reporting of race-and-ethnicity, dual eligibility, and other demographic and social risk factors could facilitate understanding of health equity gaps that may currently exist in its policies and programs. Specifically, CMS poses a series of questions that are potentially applicable to the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program. The questions are grouped into three concept areas: 1) stratifying quality measure results; 2) improving collection of social risk factor data; and 3) creating a Facility Equity Score. The

agency states that feedback received will inform the creation of a future, comprehensive RFI focused on gap closure.

The FAH welcomes the opportunity to respond to this RFI on behalf of our members, who include hospital-based and freestanding inpatient psychiatric facilities that vary in size, location, and case mix. Our members share a commitment to providing all patients with the best possible care, regardless of their social risk factors.¹ We have long believed that appropriately accounting for social risk is essential for accurately assessing health care provider performance for CMS's public reporting and accountability programs, such as the IPFQR program. Correlations between poor health outcomes and certain social risk factors have been well documented for a number of diseases, although causality has not always been established nor have practicable solutions always been immediately evident. The FAH also believes that when social risk factors affect patient outcomes in ways beyond the control of health care providers, quality measures and related payment adjustments must be carefully designed to avoid unfairly penalizing providers and thereby potentially reducing access to care for at-risk patients.

Stratifying quality measure results

A. General Considerations

CMS currently provides confidential facility-specific performance reports on some measures stratified by dual-eligibility patient status to hospitals that are subject to the Hospital Readmissions Reduction Program (HRRP). The agency describes considering expansion of stratified reporting to other Medicare quality programs and to additional social risk factors beyond dual eligibility. Input is specifically requested about reporting IPFQR program results stratified by race-and-ethnicity as well as by dual eligibility, and about the use of indirectly estimated race-and-ethnicity data during the stratification process.

The FAH generally agrees with CMS that stratification can be a useful tool in identifying and understanding disparities in facility performance when properly designed and implemented. We also agree with CMS that performance data clearly linked to social risk factors should be publicly reported. However, we believe that public reporting should occur only after the data collected have demonstrated a high degree of reproducibility and after a period of confidential reporting to facilities that is sufficient to identify unintended consequences. Transparency dictates that reports to providers explicitly identify measure results that rely on indirectly estimated variables. The inherent sensitivity of behavioral health data is further amplified when reported with stratification for social risk factors; the release of flawed data or premature data release could be catastrophic for patients and providers. Transparency also requires explicit acknowledgement of utilization of indirectly estimated social risk factors when stratified results are publicly reported, and attention must be paid to explaining indirect estimation in a manner comprehensible to patients, families, caregivers, and other members of the public.

B. IPFQR Program Considerations

¹ Social risk factors as used herein includes items sometimes also categorized as demographic variables, sociodemographic status (SDS), socioeconomic status (SES) and social determinants of health (SDOH).

CMS solicits input about stratified reporting of IPFQR program measure data based on dual eligibility, race-and-ethnicity, and disability; using indirect estimation of race-and-ethnicity to generate sufficient data to allow stratification by those variables; informing providers that their performance results are based on indirectly estimated social risk factor data; ensuring accuracy of self-identified demographic information; recognizing and avoiding the use of datasets and methodology containing inherent biases; and suggestions for candidate measures and measure domains.

Before responding to operational questions, the Federation reminds CMS of two features of the IPFQR program that present challenges to nearly every facet of stratified results reporting. First, Medicare's IPF patient population is far more heterogeneous than those of other parts of the Medicare program (e.g., acute and long-term care hospitals) for demographic variables such as age and social risk factors such as substance abuse disorder prevalence. In fact, a previous attempt to stratify IPFQR program reporting by age was terminated for sampling and reliability issues and excess provider burden. Second, IPFs were not eligible for incentive payment funding of EHR systems, and many facilities still lack EHRs and/or suffer from limited health information technology (HIT) interoperability. As a result, the IPFQR program is dominated by chart-abstracted measures, leading to provider burden per measure that is higher than for other Medicare quality programs. Further, the uneven distribution of EHRs across IPFs (e.g., concentrated in facilities that are larger or units of a larger hospital or system) results in the incorporation of inherent bias into the results of measures that depend on HIT for any aspect of collection, reporting, calculation, or analysis.

The smaller IPF patient population compared to that of segments such as IPPS hospitals is more vulnerable to statistical concerns during the stratification process (e.g., numbers of patients in one or more strata may be insufficient for reliable sampling and calculations). Stratification by dual eligibility is less likely to be impaired since that subpopulation is overweighted in the IPF population compared to the general Medicare population. As noted above, stratification by the seemingly simple variable of age previously proved infeasible in the IPFQR program, so stratification by complex or low frequency factors (e.g., disability or social isolation) seems unlikely to be readily implemented. Further, CMS has noted that while dual eligibility was a powerful predictor of social risk and related disparities in the reports provided to the Congress by the Assistant Secretary for Planning and Evaluation (ASPE), its utility as a proxy for multiple risk factors has been questioned by others.² The predictive power of social risk factors on mental and behavioral health patient outcomes compared to the that of the diagnosis requiring treatment is unclear and should be established before stratified reporting is considered for the IPFQR program.

CMS reviews the challenges of standardization of social risk variables, such as the absence of a consensus standard for the granularity levels of race-and-ethnicity to be collected and analyzed, or the variability in dual eligibility that is introduced through differing state eligibility criteria for Medicaid. The FAH notes that small variations may be smoothed out when data are collected and stratified for large groups and subgroups but will continue to impact reliability and utility of results for smaller populations (e.g., IPF patients). Individuals may be

² Alberti PM and Baker MC. Dual eligible patients are not the same: How social risk may impact quality measurement's ability to reduce inequities. *Medicine* 2020;99:38 (e22245).

reluctant to share information about themselves such as race-and-ethnicity, creating higher frequencies of missing data points for variables where self-reported data represent the gold standard; such reluctance may be higher in patients presenting for mental health treatment.

Indirect estimation methodology attempts to fill those data gaps but carries with it any inherent biases of the other data sources which are combined to impute the missing information. The work done by CMS contractors developing indirect estimation algorithms is encouraging but large-scale testing across diverse populations and subpopulations remains to be done. Ensuring data accuracy by external source validation, whether data are self-reported or estimated, could require processes that are likely to be viewed as intrusive such as accessing birth records for adopted individuals. Privacy concerns are substantial for all social risk factor data collection and sharing activities. They also are likely to be heightened in the context of mental and behavioral interventions, perhaps more so when data are indirectly estimated rather than when voluntarily self-reported. The propriety of assent or consent must be explored.

Having considered the foregoing, the Federation is reluctant to endorse stratified analysis and reporting of IPFQR program measure results at this time. We strongly recommend that further exploration of stratification within CMS quality programs remain confined to larger programs and general medical populations such as IPPS hospitals and their patients, where testing of stratified reporting is underway for some measures in the HRRP. Lessons learned from stratified reporting trials in other Medicare settings may be generalizable at least in part to the IPFQR program whereas the reverse transfer seems less likely to occur. In the interim, the IPFQR program measure set should be revised to be more meaningful and less burdensome, and adoption of EHRs and interoperable HIT by IPFs should be incented.

Should CMS persist in pursuing stratified reporting in the IPFQR program, identifying disparities in performance results of the new FAHP measure, if finalized for adoption into the program, could be of value for patients and facilities; since it is a claims-based measure, the added reporting burden would be reduced compared to chart-abstracted measures. The importance of giving attention to safeguarding privacy and minimizing burden during stratified reporting implementation cannot be overstated.

Improving Collection of Social Risk Factor Data

A. Provider Experiences with Social Risk and Demographic Data Collection

CMS states that collection from patients of a specified set of demographic, social, psychological, and behavioral data elements would materially enhance the accuracy and robustness of its methods for identifying and reporting health care disparities. A prerequisite to data collection would be the availability of standardized electronic data definitions whose interoperability would support nationwide data exchange. CMS asks commenters to share their experiences to date, including challenges encountered, in capturing demographic and social risk data elements.

The FAH appreciates the potential value of the dataset described by CMS. Our members' experiences with collecting, sharing and utilizing these data locally are minimal due to the

limited and uneven distribution of EHRs and interoperable HIT among IPFs. We wholeheartedly agree with CMS that additional resources “may be necessary” to create an environment in which all patients feel comfortable responding to all of the questions asked while maintaining individual preferences for non-response to any question(s). In fact, the FAH is totally confident that additional physical, personnel, and financial resources will be necessary for this purpose, and we are extremely concerned about the creation of a substantial and unfunded mandate for IPFs to provide the needed resources.

B. Data Collection at Facility Admission

CMS requests specific input about collecting its desired data, as described above, by facilities at the time of admission using structured, interoperable data standards, for the purpose of quality measurement associated with stratified reporting.

For multiple reasons, the Federation cannot support at this time the concept of data collection of the type and extent as described by CMS to be done by IPFs at the time of admission. Our first and foremost objection is the time and complexity that would be added to an admissions process that is already stressful for patients and families as well as time and labor intensive for facilities. The purpose of the admissions process is to rapidly facilitate the facility’s ability to promptly deliver the clinical care needed by the patient. Delay in providing care to collect additional data, much of which will not change during the admission and which could be collected later (e.g., race-and-ethnicity, housing insecurity), has the potential in and of itself to decrease care quality. The likelihood of patients comfortably answering multiple and sensitive social risk factor questions during the admissions process seems low, and the likelihood of non-response high. The disease process with which a patient presents may materially degrade his or her executive cognitive functions, leading to incorrect answers that will be awarded the validity of self-reported data, and clouding the issue of patient assent or consent to questioning. Facility admissions areas are busy places and may not allow sufficient privacy for social risk factor conversations, and admissions personnel would require substantial initial and refresher training to effectively conduct such conversations. While family members or other caregivers accompanying the patient might be able to provide social risk factor responses for a patient who cannot, their attention needs to be focused on aiding their loved ones to access timely care rather than data collection for quality measurement by CMS.

The Federation recognizes the potential value of widespread demographic and other social risk factor data collection as part of identifying and reporting health disparities across CMS quality programs. However, we do not support such data collection in the IPRQR program until there is a consensus-derived set of standardized and well-defined data elements relevant to psychiatric care and IPFs are meaningfully incented to adopt EHRs and other interoperable HIT.

Creating a Facility Equity Score

CMS states that aggregated results from multiple measures and multiple social risk factors can improve the usefulness of equity results and cites the Health Equity Summary Score (HESS) recently developed by agency contractors. The HESS uses experience of care measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and

clinical measures from the Healthcare Effectiveness Data Information Set (HEDIS), stratified by race-and-ethnicity and dual eligibility, to construct a composite quality performance score for MA plans. The agency describes the possibility of building a Facility Equity Score (FES) modeled on the HESS but modified for use with measures in Medicare Fee-for-Service quality programs for facilities including IPFs. CMS specifically requests input about 1) creating an FES to provide feedback to facilities about multiple measures stratified over multiple risk factors; and 2) how a facility might approach addressing a low score, including the use of improved demographic data (as described in the preceding section).

The FAH agrees that a thoughtfully designed and easily understood FES might provide valuable information to IPFs regarding disparate quality performances for various at-risk populations, and we see no clear reason for CMS not to begin FES development. We note, however, that the HESS developers themselves categorize their work as “proof of concept” rather than as a measure that has proven itself to be accurate, reliable, and actionable through rigorous real-world testing.³ Having examined the information referenced by CMS, the FAH has some reservations about the HESS.

We note that HESS scores for both CAHPS and HEDIS measures were calculable for only 44 percent of 398 MA plans analyzed; HESS scoring for either CAHPS or HEDIS was feasible for 49 percent and 86 percent of plans, respectively. Race-and-ethnicity was self-reported by CAHPS respondents and imputed through indirect estimation for HEDIS measure stratification. Plans for which HESS was unmeasurable were much smaller than measurable plans and the former groups’ black and dually-eligible fractions were smaller components of their overall enrollment. The Federation is not confident that work by CMS to develop an FES modeled on the HESS will bear fruit, when HESS scoring for two risk factors proved feasible for fewer than one-half of MA plans and when HESS scoring was not practicable for smaller entities and those with enrolled populations whose social risk factor distribution patterns differed from the typical plan. We also note the substantial lack of relevance of the CAHPS MA or hospital survey version to IPFs and the complete absence of any meaningful experience of behavioral health care measure in the IPFQR program measure set. Lastly, given the nascent status of the FES, the FAH believes it would be totally speculative and of little real value to CMS for us to comment at this time on interventions an IPF might undertake in response to a low FES.

Development of an FES that is adaptable across the CMS quality portfolio has conceptual merit but will require considerable time and resources to produce a valid and actionable measure. The FAH has no objection to CMS proceeding with FES development, other than the potential diversion of finite resources from other, potentially more productive strategies for identifying disparities and closing the associated health equity gaps. We look forward to commenting further when CMS is able to present a more complete plan for FES development.

³ Agniel D, Martino SC, Burkhart Q, et al. Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score. *J Gen Intern Med* (2019). <https://doi.org/10.1007/s11606-019-05473-x>.

Proposed Addition, Removal, and Retention of IPFQR Program Measures

New Measures

- COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)

This proposed measure would assess the percentage of COVID-19 vaccination coverage in healthcare personnel providing care in IPFs.

The Federation of American Hospitals (FAH) supports the intent of this measure but urges CMS to consider postponing its inclusion in the IPF QRP until the measure specifications have been finalized and the COVID-19 vaccines have been given full FDA approval, not just for Emergency Use Authorization. The underlying evidence for this measure is still emerging, additional vaccines are in development, methods for addressing measure collection challenges related to anticipated “booster” shots may be required, full approval by the National Quality Forum (NQF) has not yet occurred, and feedback from the field is needed to ensure that this measure reflects the most current knowledge and evidence and can be easily collected and reported.

Additionally, this measure would be duplicative at present because CMS already has vaccination status data from hospitals, including IPFs, through HHS’s contract with Teletracking. Further, because we anticipate that this measure will undergo substantial changes within and across reporting years, the FAH does not believe that it should be used for payment decisions, nor should it be publicly reported until the underlying evidence is stable and reporting of the measure has occurred for several years. Ultimately, the FAH generally believes that measures that increase the reporting burden and leverage specifications that are not aligned with other measures should be avoided.

- Follow-Up After Psychiatric Hospitalization (FAPH) for FY 2024 and Subsequent Years

FAH supports the inclusion of this measure, but similar to the MAP that only conditionally supported the measure, we ask that CMS continue to explore a number of issues that are still unresolved, including: concerns with the evidence supporting expansion to substance and alcohol, concerns that the Stark Law may limit a hospital’s ability to ensure necessary substance use disorder (SUD) follow up, concerns that there are limited numbers of SUD providers available, concerns related to the potential for unintended negative consequences for patients, and concerns on the lack of adequate testing of social risk factors in the risk adjustment approach.

Removal of Measures

CMS proposes the removal of four measures beginning with the FY 2024 Payment Determination:

- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a),

- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a),
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), and
- Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576).

The FAH supports removal of these four measures from the IPF QRP as the cost to collect and report each measure outweighs any potential benefits.

Considerations for Future Measure Topics

- Patient Experience of Care Data Collection Instrument

The FAH recognizes the importance of patient experience of care within the quality of care framework and supports the development of a standardized patient experience measure for IPFs. However, the FAH does not believe that the HCAHPS survey is appropriate to evaluate IPFs for several reasons.

In general, the HCAHPS survey requires updating and a complete re-evaluation⁴. It also is intended for patients who are (among other criteria) aged 18 years or older, and who had a non-psychiatric MS-DRG/principal diagnosis at discharge. Although allowing for persons with a secondary diagnosis of psychiatric or substance abuse, the survey was specifically NOT designed to address the unique situation of the behavioral health issues pertinent to psychiatric patients. As a result, a thoughtful review of applicability, evaluation through focus groups on what matters most to inpatient psychiatric patients, and risk adjustment considerations are recommended.

The FAH encourages CMS to explore whether a methodological review is warranted due to the increased transient nature of a significant portion of the psychiatric population given that the survey protocol requires hospitals to initiate the survey “*between 48 hours and six weeks (42 calendar days) after discharge*” and instructs hospitals that “*Patients must not be given the survey while they are still in the hospital.*”

An alternative to mandating a specific survey for patient experience of care would be to identify a limited set of items that must be included in surveys used by providers, such as net promoter surveying as was used by the National Health Service in the United Kingdom. The Net Promoter Score (NPS) is a single item that allows for cross-program comparisons while maintaining a facility’s ability to capture additional patient experience of care data points that are relevant to its specific environment and patient population without undue burden.

There are also patient-, community-, and environmental- level characteristics that factor into a patients experience of care. The FAH encourages CMS to fully explore current research when developing these measures so as to appropriately adjust for the relevant factors. In

⁴ Kahn C, Salzberg CA. The next generation of measuring patient experience. Health Affairs Blog. March 8, 2019. DOI: 10.1377/hblog20190307.766083

addition, the FAH encourages CMS to pursue provider input into the perceived challenges of affecting change on certain measures and the potential burden of data collection and reporting of any future patient experience measure.

- Functional Outcomes Instrument for Use in a Patient Reported Outcomes Measure

The FAH encourages CMS to use a staged approach to measure clinical outcomes focused on evaluating psychiatric treatment and patient improvement in the psychiatric setting, beginning with a broad focus. Specifically, this approach could start with an attestation measure examining how many facilities currently assess outcomes from admission to discharge and gather qualitative information on which standardized instruments and collection protocols are used. This solicitation of information would allow CMS to identify what areas are ripe for potential measurement including those targeting suicide evaluation and reduction, patient experience, patient improvement, and clinical processes that impact significant proportions of psychiatric inpatients. While more complex measures may slow down the rate at which new measures are introduced, the measures themselves will have vastly improved applicability to the field and provide valuable information to IPFs and the individuals they serve.

- Measures for Electronic Data Reporting

The FAH strongly supports the move toward quality measurement derived from electronic health record (EHR) systems and other digital data sources. Regrettably, due to the lack of widespread implementation of EHR systems in IPFs, the FAH believes that the discussion of electronic data reporting is premature for this setting. Because IPFs have not received the same federal funding for implementation of EHR systems that other providers received, a shift to electronic data reporting should not be considered until access to EHR systems is equitable across IPFs.

Form, Manner, and Timing of Quality Data Submission for 2022 and Subsequent Years

- QualityNet System Changes

The FAH supports these changes to simplify and streamline processes.

- Data Submission Requirements

Given the FAH's concerns that the underlying evidence must become more stable and the need for reporting of the COVID-19 Vaccination Coverage Among HCP measure to occur for several years, we believe that public reporting of this measure is premature at this time.

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

The Federation agrees that patient-level rather than aggregate data reporting of chart-abstracted measures as proposed by CMS is appropriate and timely. We also agree with CMS to implement this proposal incrementally, starting with a period of voluntary reporting.

- Data Validation Pilot

The FAH supports the importance of data validation for the IPFQR program as is done for other CMS quality programs. Initiation of data validation should, however, be delayed until patient-level data reporting has been fully implemented and tested for a sufficient period to detect unintended consequences.

The FAH appreciates the opportunity to comment on the Proposed Rule. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

