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President and CEO

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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: FY 2023 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update and Quality Reporting-Request for Information (CMS-1769-P)**

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, DC 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 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System-Rate Update and Quality Reporting-Request for Information (“Proposed Rule”) published in the Federal Register on April 4, 2022. The FAH’s comments will focus on concerns with the rate of inflation proposed by the IPF market basket, the proposed wage index stop-loss of 5 percent, and the Requests for Information (RFIs) on future rate refinement (and corresponding technical report), as well as, quality reporting and health equity.

**MARKET BASKET UPDATE**

For FY 2023, CMS proposes to update the 2016-based IPF market basket to reflect projected price increases according to the IHS Global Inc.’s (IGI) 4th quarter 2021 forecast with historical data through the 3rd quarter of 2021. Using that forecast, the proposed IPF market

basket for FY 2023 is 3.1 percent. Using data from the same period, CMS estimates an offset to the IPF market basket for total factor productivity of 0.4 percentage points<sup>1</sup>. Consequently, CMS proposes an IPF PPS update of 2.7 percent for FY 2023. For hospitals that do not successfully submit quality data under the IPFQR program, the update is reduced by 2.0 percentage points to 0.7 percent. For the final rule, CMS will use updated data for the market basket and total factor productivity.

For FY 2023, CMS proposes to update the 2016-based IRF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2021 forecast with historical data through the 3rd quarter of 2021. Using that forecast, the proposed IRF market basket for FY 2023 is 3.2 percent. Using data from the same period, CMS estimates an offset to the IRF market basket for total multifactor productivity of 0.4 percentage points. Consequently, CMS proposes an IRF PPS update of 2.8 percent for FY 2023 for hospitals that submit quality data.

The FAH has serious concerns that the proposed market basket forecast is neither accurately nor adequately capturing the unique factors influencing the hospital and health care market today in general, and the market in which IRFs compete specifically. The scope and scale of the COVID-19 pandemic is unprecedented in our times with the constant barrage of challenges and pressures that hospitals have and continue to face. Chronic, preexisting nurse and caregiver shortages have exploded during the pandemic fueled by increased demand and workforce burnout from, among other factors, quarantines, surges, and stress.

Hospitals have had to weather an unrelenting cascade of market pressures during the COVID public health emergency (PHE), compounded by historically high, spiraling inflation, as detailed in an April 2022 report<sup>1</sup> by the American Hospital Association:

- According to data from the Bureau of Labor Statistics, hospital employment is down approximately 100,000 from pre-pandemic levels. At the same time, hospital labor expenses per patient through 2021 were 19.1% higher than pre-pandemic levels in 2019.
- Driving the growth in labor expenses has been an increased reliance on contract staff, especially contract nurses, who are integral members of the clinical team. In 2019, hospitals spent a median of 4.7% of their total nurse labor expenses for contract travel nurses, which skyrocketed to a median of 38.6% in January 2022.
- Contract staff agencies have increased the rates they bill hospitals significantly. In fact, hourly billing rates that hospitals pay staffing firms for contract employees increased 213% compared to pre-pandemic levels and led to a 62% profit margin for contract staff agencies, i.e., the difference between what the firms charge hospitals and what the firms actually pay the contract employees.
- Drug expenses also increased dramatically, 36.9% on per patient bases, compared to pre-pandemic levels. As a share of non-labor expenses, drug expenses grew from approximately 8.2% in January 2019 to 10.6% in January 2022.

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<sup>1</sup> [Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems](#), American Hospital Association, April 2022.

- Higher economy-wide costs have important effects on hospital and health system prices. In April 2021, BLS reported that the CPI-U had the largest 12-month increase since September 2008. Additionally, consumer prices rose by a historic 8.5% in March 2022. Despite persistent cost pressures, hospital prices have seen consistently modest growth in recent years. According to BLS data, hospital prices have grown an average 2.1% per year over the last decade, about half the average annual increase in health insurance premiums.

These inflationary cost pressures for IRFs and all of America’s hospitals do not seem to be captured in IHS Global’s (IGI) estimate of 3.2 percent for IRF market basket inflation for FY 2023. We are concerned that the 4-quarter rolling average and methods used to estimate inflation in IRF spending are not capturing the readily-evident pandemic-initiated shocks to the health care market that are significantly driving up costs, especially labor, across the spectrum of hospital inputs. **We urge CMS to consider these pandemic triggers that do not seem to be reflected in the market basket forecast and use its broad authority under section 1886(s) of the Social Security Act (the Act) to further increase IPF rates to better adjust FY 2023 payments to IPFs to account for inflation.** Section 1886(s)(2)(A) of the Act specifies that “any update to a base rate for days during the rate year for a psychiatric hospital or unit” be reduced for total factor productivity. The specification of “any update” implies the Secretary has broad authority to determine data used to determine an inflation update as long as it is net of the reduction in productivity specified in a different section of the statute.

Secondly, it is noteworthy that CMS and IGI estimates for the FY 2021 and FY 2022 market basket inflationary increases were underestimated as well as shown in the table below:

Inpatient Psychiatric Facility PPS	FY 21	FY 22
Market Basket Update In Final Rule	2.2	2.7
FY21 Actual/ FY22 Most Current MB Estimate*	2.9	3.9
Difference	0.7	1.2

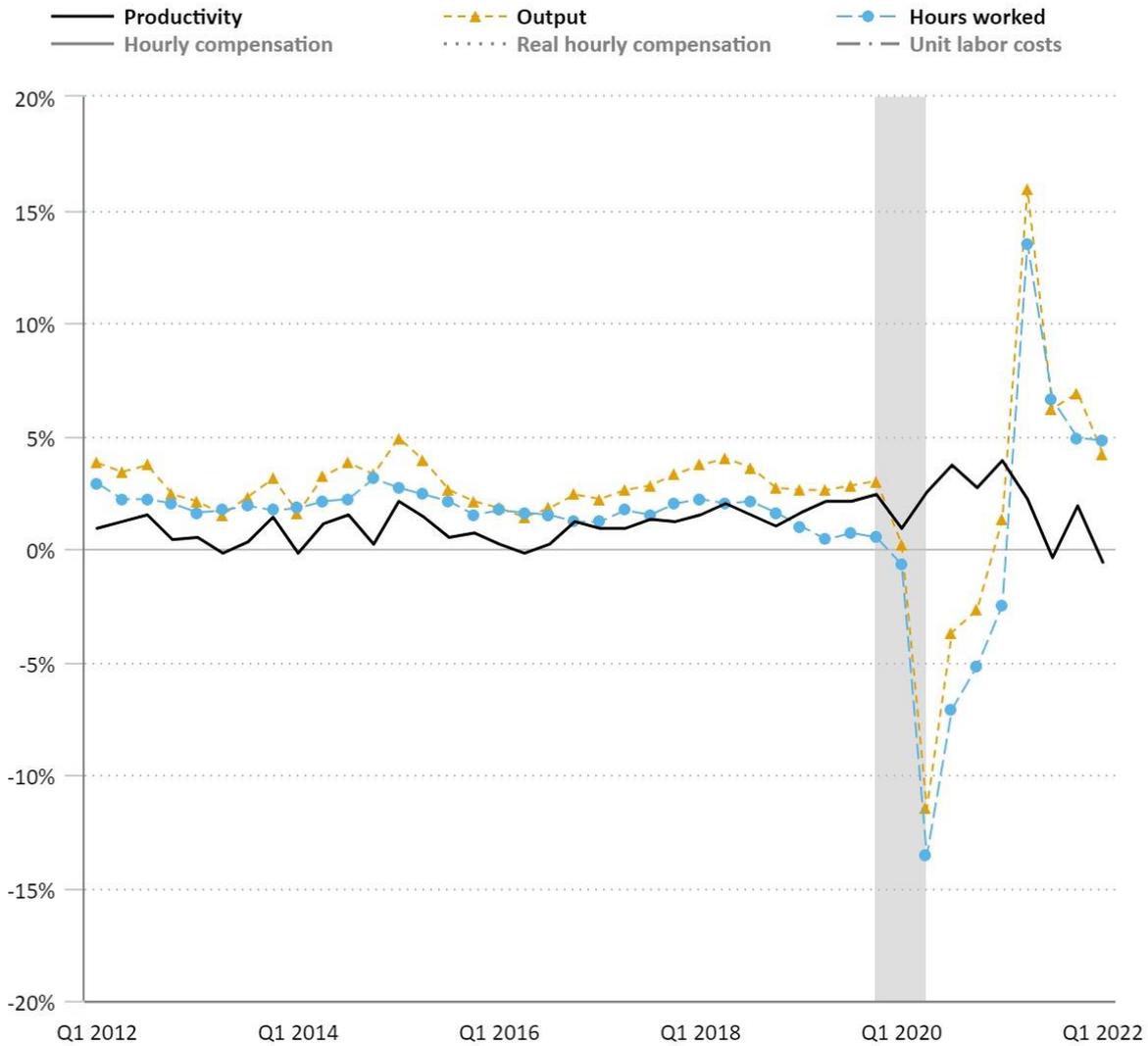
\*Source: IHS Global Inc. 2021q4 Forecast  
 Historical Data through 2021Q3  
 Released by CMS, OACT, National Health Statistics Group, dnhs@cms.hhs.gov

As this table reflects, market basket updates to IPFs in FY 2021 and FY 2022 are currently estimated to underinflate the base IPF rate by 1.9 percent. This means that the base rate for FY 2023 is 1.9% too low – further compounding the inadequate FY 2023 rate increase.

Third, the FAH is also concerned that the IPF update for FY 2023 includes a reduction for private non-farm multifactor productivity growth of 0.4 percent. The COVID-19 pandemic has had a profound impact on US productivity and most estimates of labor productivity highlight uncharacteristic reductions. In fact, from the first quarter 2021 to the first quarter 2022, nonfarm business sector labor productivity decreased 0.6 percent, reflecting a 4.2-percent increase in output that was outpaced by a 4.8-percent increase in hours worked. This is the largest over-the-

year decline since the fourth quarter of 1993, when the measure also declined 0.6 percent. The chart below highlights the dramatic impact of COVID on US productivity<sup>2</sup>.

**Labor productivity (output per hour), and related measures, percent change from same quarter a year ago, 1st quarter 2012–1st quarter 2022**



Click legend items to change data display. Hover over chart to view data.  
 Shaded area represents a recession as determined by the National Bureau of Economic Research.  
 Source: U.S. Bureau of Labor Statistics.



<sup>2</sup> BLS, May 2022: <https://www.bls.gov/opub/ted/2022/nonfarm-business-labor-productivity-down-0-6-percent-from-first-quarter-2021-to-first-quarter-2022.htm>

Further CMS' own Office of the Actuary documented the disconnect between using the private non-farm total factor productivity growth measure and a hospital-specific measure<sup>3</sup>. While this annual productivity offset is based on a provision of the Affordable Care Act of 2010 and required by law, we urge CMS to consider the appropriateness of this reduction and the further slide in payment adequacy the reduction could lead to for IPFs.

In light of this once-in-a-generation convergence of inflationary and COVID-19 pandemic forces, the FAH recommends CMS consider its update for IPF PPS payments to ensure that the FY 2023 rate reflects a more realistic measure of inflationary pressures, is applied to a base rate that more accurately incorporates actual inflation during the pandemic, and recognizes the disconnect with expectations for providers to be at least as productive as the 10-year average during a pandemic which has had a profound impact on ability for hospitals to increase productivity. **We urge CMS to consider its regulatory authority to modify this adjustment or make a PHE related exception in its application for the FY 2023 update.**

## **WAGE INDEX**

For FY 2023 and future years, CMS proposes a permanent cap of 5 percent on reductions to the wage index for any reason. CMS believes providers generally experience fluctuations in the wage index annually of less than 5 percent. Thus, the proposed cap would generally affect few hospitals and minimize the required budget neutrality adjustment while also addressing concerns about instability in payments from year to year.

CMS proposes that the 5 percent cap would apply regardless of the circumstances causing the decline. Under this proposal if a wage index is calculated with the application of the 5 percent cap, the following year's wage index would not be less than 95 percent of the IPF's capped wage index in the prior year. CMS further proposes that a new IPF would be paid the wage index for the area where it is geographically located for its first full or partial FY with no cap applied.

The FAH appreciates CMS' recognition of how disruptive volatile drops in the area wage index can create significant challenges for IPFs and, as we recommended in our previous comments, the FAH supports a non-budget neutral stop-loss to minimize annual reductions in the area wage index value to help mitigate wide annual swings that are beyond a hospital's ability to control, and which could otherwise undermine operations. CMS is not proposing to apply the stop-loss for a new IPF in an area where the stop-loss would otherwise apply. While we understand the rationale for this approach, we are concerned that this will create an unnecessary inequity in Medicare payments for IPFs in the same market and we would encourage CMS to apply the same wage index value for new and existing IPFs under this policy.

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<sup>3</sup> Spitalnic et al., *Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies* (February 22, 2016) <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf>

## **RATE REFINEMENT AND CORRESPONDING TECHNICAL REPORT**

### **I. General Observations**

CMS notes the existing IPF PPS model continues to be generally appropriate in terms of effectively aligning IPF PPS payments with the cost of providing IPF services, and the FAH agrees. While the FAH agrees there are some adjustments supported by the data analysis in the technical report, the FAH does not believe incorporating all identified technical adjustments would be appropriate.

It's important to note that COVID-19 has had a significant impact on hospitals' overall costs, and IPFs are no exception. It is likely IPFs will continue to experience higher costs due to increasing labor costs, additional disease control processes, and other changes for the foreseeable future. These costs would not be reflected in 2018 data. For this reason, relying on the technical report for any future adjustments may not be advisable given the significant changes hospitals have experienced since 2018.

**The FAH urges CMS to only incorporate refinements to the IPF PPS model that are strongly supported in the data as well as supported by well-founded payment policy. CMS should only adopt payment methodology refinements that will continue to support high-quality care and improved access for Medicare beneficiaries, particularly considering the expanding need for mental health care and the continued cost burdens IPFs face related to the pandemic.**

### **II. Consolidating Age Groups**

Based on reviewing 2018 data, the technical report suggests that reducing the patient age groups from 9 to 7 by consolidating the age 45 – 49 and age 50 – 54 into a single group and also consolidating the age 70 –74 and age 75 –79 into a single group. When reviewing the data, the analysts observed these groups had identical factors; therefore, it would be administratively easier and supported by the data to combine the age groups. **The FAH supports decreasing the patient age groups from 9 to 7 by consolidated categories that effectively have identical factors in the contractor's analysis.**

### **III. Comorbidity Adjustments**

The technical report generally did not find that the data supports adding new comorbidities to the adjustment factor. After analyzing whether the IPF PPS model should include homelessness and pregnancy as identified comorbidities, the data did not support that either condition significantly increases costs. Additionally, analysis of the 2018 data shows that five of the comorbidity groupings are not statistically significant. When considering which factors should be incorporated in calculating a payment adjustment, the FAH believes CMS should only include adjustments that are strongly supported by the data and public policy.

**The FAH agrees with the technical report that homelessness and pregnancy should not be included as a comorbidity grouping because the data does not support that these**

**comorbidities have a significant impact on costs. The FAH urges CMS to only include comorbidity groupings if they are strongly indicated in the data.**

#### **IV. Teaching Status Adjustment**

Teaching hospitals receive an adjustment to their per diem rate to reimburse them for the additional costs incurred of training psychiatric residents in their facilities. These teaching hospitals are vital to supporting the mental healthcare safety net because most of the country is currently located in a mental health professional shortage area, impacting 149 million people. Based on analysis of the 2018 data, the technical report supports increasing the teaching status adjustment variable from 0.5150 to 0.9486. This increase should significantly improve reimbursement for teaching hospitals, and it is much needed. **The FAH supports increasing the teaching status adjustment to further support training efforts in order to increase the number of practicing mental health practitioners.**

#### **V. Social Determinants of Health and Equity**

See below in the section on IPF Quality Reporting Program.

#### **VI. Length of Stay Adjustment**

The report prepared by CMS' contractor observes that shorter lengths of stay are more common and generally have higher relative costs than longer lengths of stay. Additionally, when updating the regression analysis using 2018 data, the technical report suggests increasing the adjustment for shorter lengths of stay accordingly, with rather large increases for stays less than seven days. While the FAH agrees the majority of IPF stays are generally shorter stays, we are concerned that significantly increasing the per diem adjustment for shorter stays, particularly the first day, would create improper financial incentives. With higher reimbursement for the earlier days, this change could have the unintended consequence of incentivizing providers to discharge a patient earlier than is clinically indicated because a new patient in that bed would effectively generate a higher reimbursement yield for each inpatient encounter. This potential consequential behavior would be inconsistent with care mandates IPFs should follow for patient wellbeing. Additionally, length of stay during the COVID-19 PHE has dropped as IPFs take care to limit COVID exposure to patients. The analysis of 2018 data may miss key length of stay patterns and changes during COVID and should be considered in a future model.

**If CMS were to consider incorporating a per diem adjustment related to length of stay, the FAH urges CMS to balance the results of the technical report with clinical care policy considerations to ensure the payment methodology is consistent with Medicare payment goals of aligning payment with resources expended to treat beneficiaries. It is important that the IPF PPS model does not incentivize discharging patients early in order to take advantage of the higher reimbursement for short stays and COVID practice changes should be considered before any policy change.**

#### **VII. Outlier Policy**

The technical report's analysis of the outlier data identifies that fewer IPF cases qualify as outliers under the current 2 percent outlier target than CMS originally estimated for the IPF PPS model. Unlike medical/surgical outliers, psychiatric outliers generally are not more costly because of increased acuity. Based on discussions with our members, the FAH believes psychiatric outliers are typically the result of patient placement challenges. Often, for IPFs, the length of these outlier stays is a result of too few discharge options. Many facilities are unable to discharge patients because there are no appropriate step-down levels of care available in many communities, which results in longer stays. Thus, the outlier adjustment does not directly address the root cause of this issue.

**The FAH does not support decreasing IPF PPS payments generally in order to increase the outlier target because this would inappropriately decrease base rates for all facilities while failing to address the cause of extended stays. We do not support increasing the outlier target rate beyond 2 percent.**

## VIII. DSH Adjustment

When preparing the original IPF PPS model, CMS chose not to incorporate a DSH adjustment because the result would be a decrease for most facility payments, which is inconsistent with the goals of a DSH adjustment.<sup>4</sup> The technical report, using 2018 data, shows a similar negative relationship between the per diem cost and DSH status. The majority of hospitals would experience decreased payments if CMS incorporates a DSH adjustment. As hospitals continue to face financial difficulties in the wake of COVID-19, particularly with increasing wage costs, it would not be well-founded payment policy to incorporate a DSH adjustment if it results in decreased reimbursement for the majority of providers when both empirical and anecdotal evidence do not fully support this payment change.

**For the same reasons CMS declined to adopt a DSH adjustment when designing the IPF PPS model, the FAH urges CMS not to adopt a DSH adjustment now. CMS should only incorporate a DSH adjustment if the data fully supports and illustrates a positive relationship between the facilities' increased costs and DSH status.**

## IX. Rural Location Adjustment

The technical report suggests decreasing the rural location adjustment from 1.17 to 1.11; however, the impact of using 2018 data is practically negligible when the analysts remove the occupancy control variables. Reducing payments to rural hospitals would be destabilizing and would not represent well-founded payment policy.

Rural hospitals are the primary points of care and access for many Medicare beneficiaries who cannot travel to urban areas for mental health services. They are a fundamental component of the behavioral health safety net, and Medicare reimbursement should support these facilities to ensure beneficiaries have continued access. Millions of Americans live in communities that do not have essential health care services, particularly mental health care. Many of these patients

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<sup>4</sup> Prospective Payment System for Inpatient Psychiatric Facilities, Centers for Medicare & Medicaid Services, 69 Fed. Reg. 66922, 66958 (Nov. 15, 2004).

already have significant barriers to receiving the care they need. Rural hospitals provide critical access points for patients in their own and neighboring communities.

Despite the important role they serve, year over year, we see more rural hospitals closing.<sup>5</sup> In fact, around 181 rural hospitals have closed since 2005, with 138 closures occurring since 2010.<sup>6</sup> Rural hospital closures are not only detrimental for a community's physical and mental health care but also result in increased unemployment because hospitals are often large employers for rural areas. Particularly with the rural hospitals' increasing labor costs and low wage index, it is important to continue to support strong rates for these facilities.

In reviewing the technical report, it was notable that once the analysts removed the occupancy controls, the rural adjustment was comparable to the current adjustment. The FAH believes that due to their unique circumstances, it may not be appropriate to apply the occupancy control factors when assessing appropriate rates for rural facilities. Most rural IPFs have far fewer beds than the average urban IPF, which means smaller census changes have a much larger proportional impact on the facility's occupancy rate. But the rural facility will not experience significantly lower costs due to this same occupancy rate change. Rural facilities are more sensitive to occupancy rate changes than the larger urban facilities. The technical report does not discuss much on the intent of using occupancy rates as a control factor. However, to the extent one intent of the occupancy control factor is to assess the efficient use of resources, a lower occupancy rate in a rural facility is not necessarily indicative of an inefficient use of resources. Rural IPFs frequently provide the *only* source of mental health care in their communities. It is vital to ensure these access points remain open for those populations. As such, it may be best to assess the potential changes to the rural location adjustment without applying the occupancy control variables.

Additionally, COVID-19 has both increased the need for mental health care while also significantly impacting hospitals' costs and processes going forward. **The FAH cautions CMS on relying too heavily on refinements that may be indicated in the 2018 data that CMS would then apply to a post-COVID environment.** Rural hospitals have been especially hard hit by the COVID-19 pandemic and have experienced an even greater drain on their limited resources. It is possible an analysis based on 2018 data has generally limited applicability post-COVID, but this impact could be even more pronounced for rural facilities. **In sum, the FAH does not support decreasing the rural location adjustment.**

## **IPF QUALITY REPORTING QUALITY REPORTING PROGRAM**

### **Overarching Principles for Measuring Equity and Health Care Quality Disparities Across CMS Quality Programs – Request for Information (RFI)**

CMS requests input into key principles and approaches to be considered as the agency further develops its strategy for advancing health equity across its programs, including the IPF

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<sup>5</sup> E.g., CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM, *The Crisis in Rural Health Care*, available at <https://ruralhospitals.chqpr.org/> (last accessed May 18, 2022).

<sup>6</sup> CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIV. OF NORTH CAROLINA, *Rural Hospital Closures*, available at <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last accessed May 18, 2022).

Quality Reporting Program.<sup>7</sup> CMS describes health equity as *the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes*. This RFI focuses its attention to enhancing quality measurement and performing stratified data analyses as tactics for recognizing, understanding, and reporting healthcare outcome disparities. Additionally, CMS solicits input about health equity measures for future adoption that are potentially applicable, specifically to the IPF Quality Reporting Program (QRP).

The FAH welcomes this opportunity to respond to this Equity Measurement RFI on behalf of our members who include hospital-based and freestanding inpatient psychiatric facilities that vary in size, location, and case mix. We have long believed that appropriately accounting for social risk must be explicitly embedded in the framework for each of the agency's public reporting and accountability programs, including the IPF QRP, in order to accurately and meaningfully assess provider performance. Evidence of associations between numerous social risk factors (SRF)<sup>8</sup> and disparate health outcomes among Medicare beneficiaries continues to accumulate, although the extent and reproducibility of evidence varies with disease and SRFs studied. Causality has proven challenging to establish, and practicable solutions for resolving disparities have not always been identifiable.

CMS repeats throughout the RFI its intention to tailor its disparity measurement and reporting approaches to reflect the contextual and structural variations across its quality programs. The FAH fully concurs, and we believe the necessity for tailoring is nowhere more apparent than for the IPF QRP. Disparity analysis in this Program is confounded by patient and facility attributes that differ from those encountered in other CMS quality programs. Separation of SRF effects from primary clinical diagnoses may be especially difficult for patients with behavioral health issues.

The distribution of demographic and social risk factors among IPF patients is dissimilar when compared to those of Medicare patients treated in most other settings. Medicare beneficiaries are a smaller subpopulation in IPFs versus other facilities. The dually eligible proportion is larger, so that variations across states in Medicaid eligibility is a potential source of subtle bias. The range of patient age is much wider so that comparing age disparities across CMS programs is problematic when the IPF QRP is included in the analysis. Additionally, the frequency of substance abuse diagnoses is considerably higher in the IPF population; the sensitivity of this and other behavioral diagnoses must be considered in the contexts of data collection and public reporting of disparities as well as legal restrictions about sharing such

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<sup>6</sup> Described at <https://www.cms.gov/cms-strategic-plan>.

<sup>8</sup> The terms social risk factors (SRF), sociodemographic or socioeconomic status (SDS or SES), and social determinants of health or social drivers of health (SDOH) are often used interchangeably in health equity discussions to refer to non-clinical factors known to negatively affect patient outcomes.

information. Interventions targeting disparities that are applicable, appropriate, and practicable in the behavioral health setting are likely to differ from those for other CMS programs.

The FAH recommends that CMS proceed cautiously and deliberately when designing and implementing quality measure changes and payment revisions intended to reduce disparities in order to avoid the perverse consequence of reducing access to care for at-risk patients by unfairly penalizing providers who care for these patients. Even when data are extensive and highly congruent, causative SRFs may be beyond the ability of providers to control or mitigate. We also recommend that burden, operational capabilities, and available resources be comprehensively assessed before measure sets are expanded or payment policies modified. Imposed burden often is disproportionately higher for IPF QRP participants, as the Program's measures are predominately chart-abstracted and many facilities lack electronic health records (EHRs) and other health information technology (health IT) resources.

## **1. Cross-Setting Framework to Assess Health Care Quality Disparities**

### **Identification of Goals and Approaches for Measuring Health Care Disparities and Using Measure Stratification Across CMS Quality Reporting Programs**

CMS reviews its Within-Facility and Between-Facility Disparities Methods and asks for input about their use to generate reports for providers about their performances on selected IPF QRP measures. The reports would present data that are facility-specific and stratified for selected demographic or social risk factors through the application of one or both disparity methods.<sup>9</sup>

CMS states that the within-facility method is suitable for use with most measures that include patient-level data. We note that facilities are not required to submit patient-level data for chart-abstracted measures to the IPF QRP until program year FY 2024. These measures constitute a greater proportion of the Program's measure set than is true for other CMS quality programs. Therefore, the FAH recommends that stratified reporting of IPF QRP measures be deferred until facilities have had sufficient time to acquire experience with patient-level data submission and any related CMS operational issues are resolved. CMS could proceed sooner with using stratification for claims-based measures but this would exclude the measures for which self-reported data – the gold standard – are most likely to be available.

We further recommend delaying stratified reporting to IPFs until CMS gains more experience with application to several of its larger programs (e.g., acute-care hospitals, skilled nursing facilities) to allow for transfer of lessons learned when appropriate. Finally, given the greater heterogeneity of demographic social risk factors among IPF patients than in other settings, the FAH recommends that the optimal first action by CMS should be to conduct a trial of confidential, stratified, disparities reporting to a representative sample of IPFs, using a well-established social risk factor such as dual-eligibility status as applied to performance on an existing measure. Multiple opportunities for feedback from stakeholders should be part of the trial's design. A trial-first strategy would generate valuable lessons for IPFs and CMS and allow

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<sup>9</sup> 2020 Disparity Methods Updates and Specifications Report, prepared for CMS by the Yale Center for Outcomes Research and Evaluation. Available at <https://qualitynet.cms.gov/inpatient/measures/disparity-methods/resources#tab3>.

issues identified to be remedied prior to large-scale reporting, conserving finite resources and mitigating burden for facilities and the agency.

### **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting**

Principles under consideration by CMS include the use of measures that are: existing, validated, and reliable clinical measures; outcome measures for which some evidence of disparities exists among Medicare beneficiaries; measures for which adequate sample sizes are available; measures broadly representative of providers and outcomes; and measures of appropriate access and care.

The FAH believes that all of the principles being considered by CMS have merit. We agree with CMS that modifications may be needed based on the demographic or social risk variable being examined, each quality program's structure, and the intended use of a given measure. We have described above several features of the IPF QRP and the attributes of patients and facilities that deserve consideration when selecting and prioritizing measures for disparity reporting (e.g., uneven distribution across facilities of EHRs and other health IT resources limits the practicality of measures dependent upon EHRs).

The FAH recommends that CMS also consider as guiding principles the following: 1) measures for which CMS already has data sources containing potentially relevant demographic or social risk factors (e.g., zip code or dual-eligibility status); 2) measures for which self-reporting of data are inherent in the measure, such as experience-of-care surveys and patient-reported outcome performance measures (PRO-PM); 3) measures for which CMS can calculate performance results timely and provide feedback promptly to providers, as aging data quickly become irrelevant; 4) expansion beyond clinical measures to resource use measures, as providing appropriate and equitable care to at-risk patients may necessitate increased resource use (e.g., unplanned readmissions) that could cause what otherwise appears to be poor resource use performance; and 5) measures that are likely to align with collection and reporting requirements of states and other third-party payers as a means of minimizing provider burden that also will strengthen the validity and reliability of measure results. Finally, we note that the IPF QRP currently lacks a patient's experience-of-care measure, a significant gap when attempting to assess disparities in the IPF setting, and we strongly encourage CMS to develop such a measure. Our members believe that an experience measure would be a "game changer" for the IPF QRP.

### **Principles for Social Risk Factor and Demographic Data Selection and Use**

CMS notes the challenges of selecting from the myriad factors for which associations with disparities have been suggested and the limited availability of high-quality (i.e., self-reported) data sources for certain variables. Practical barriers to the number of variables to be studied also must be taken into account, including reporting burden created for providers and optimal allocation of finite provider and CMS resources. CMS describes proxy variables (e.g., neighborhood indices) and tools (imputation for missing data) for possible use when self-reported data are scarce.

The FAH strongly recommends that CMS begin disparity analyses and stratified reporting with demographic and social risk variables for which CMS already has large data sets (e.g., Medicare enrollment and claims data) containing potentially relevant information (e.g., diagnoses, dual-eligibility status). We note 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 such as Medicare-only IPF patients. We further recommend that all variables to be analyzed for disparities be required to have clear, standardized definitions that are used consistently across CMS quality programs.

The FAH recognizes that patients may be reluctant to share sensitive personal information, contributing to the challenge of missing data points for the gold standard, self-reported data. Reluctance may be more common among patients presenting for mental health treatment. When self-reported data availability is particularly limited, we support the judicious use of some of the substitute variables being considered by CMS, such as neighborhood-based variables (e.g., Area Deprivation Index, Census Bureau's Community Resilience Estimates).

The FAH does not support the use of imputed data techniques to replace missing demographic data, at least until considerably more data become available about data imputation efficacy and accuracy when used in CMS quality programs. The assumptions of the imputation technique may introduce unanticipated biases into the original data set. We believe CMS resources are better invested into enhanced efforts for collection of self-reported data than into expanding techniques for data imputation. We strongly encourage the agency explore alternative sources of social risk factor data in other HHS initiatives and other federal programs. Finally, we suggest that CMS explore establishing a needs assessment process through which variables with high face validity for potential disparities -- but lacking standardized definitions, credible self-reported sources within CMS data sets, and/or suitable proxy variables -- could be identified, analyzed, and refined for future use in a transparent manner (e.g., sexual orientation/gender identity). This process could be particularly valuable for the IPF QRP wherein the distribution of social risk factors is often atypical in comparison to other CMS programs.

### **Identification of Meaningful Performance Differences**

CMS intends to balance standardizing its analytic approaches wherever possible with retaining flexibility to make adjustments as appropriate for contextual variations between its individual quality programs (e.g., between the IPF QRP and the home health QRP). The agency describes a wide range of techniques being considered for use to identify meaningful performance differences from stratified measure results.

IPF facilities and patients are less numerous compared to several other Medicare segments (e.g., IPPS hospitals and skilled nursing facilities) introducing increased vulnerability to statistical concerns during the stratification process (e.g., insufficient sample size in one or more strata). As we noted earlier, stratification by the seemingly simple variable of age previously proved infeasible in the IPF QRP so that stratification by complex or low frequency factors (e.g., gender identify) seems impractical in this Program. Stratification by dual eligibility is less likely to be impaired since that subpopulation is overweighted in the IPF population

compared to other settings. 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 must be considered when choosing analytic approaches and establishing criteria for meaningful differences for use in the IPF QRP. The differences in the IPF patient population from other Medicare segments are also likely to impact analytic standardization, as certain methods may not be adaptable to the IPF QRP.

The FAH strongly recommends that the actionability of specific data comparisons for IPFs be routinely considered during data analyses regardless of statistical method chosen. When multiple comparisons are performed some statistically significant associations inevitably will emerge, but not all will be worthy of time and resource investment by IPFs to explore, particularly when exploration would depend heavily on health IT capabilities. Cut points, defined thresholds, ranked ordering, and benchmarking should be approached with particular care until disparity analysis and reporting has matured and a substantial amount of experience with its use has accrued for CMS and providers. These approaches all carry the risk of creating subgroups that could be inappropriately characterized as practicing discrimination. Labeling of providers as discriminatory, even though unintentional, when based on poorly chosen statistical methods and/or inappropriate application of stratified reporting results could cause long-term and nearly irreparable harm to beneficiaries, providers, and the Medicare program.

### **Guiding Principles for Reporting Disparity Measures**

CMS notes that statute requires public reporting of results from many of its quality programs, but stratified reporting is seldom mandated. Outside of mandatory reporting, CMS believes that both overall and stratified results routinely should be reported together. The agency suggests that confidential reporting to providers is especially beneficial when new programs and measures are being introduced. CMS observes that public results reporting allows market forces to incent improvement by providers to remain competitive.

The FAH believes that confidential reporting to providers is entirely appropriate for measures and initiatives involving stratification for demographic and social risk factors. Results reporting should be accompanied by a review and correction process, and be subject to data validation. Properly structured provider-only reporting should create an environment that facilitates the detection of unintended consequences or confusing results before any public reporting of these sensitive data occurs.

Transition to public reporting should be planned and implemented in a deliberate and unhurried manner, and only after the data collected have demonstrated a high degree of reproducibility and after a period of confidential reporting that is sufficient to identify unintended consequences. The FAH believes it to be essential for CMS to structure public reporting of disparities comparison results in a way that avoids the risk of further disadvantaging providers who serve populations and areas with limited resources (e.g., IPFs located in low-income and rural communities). Also, prior to public reporting, we urge CMS to undertake focus groups to test messaging and understanding of disparities data, so that the results reported are clear and actionable for patients, families, and caregivers. Finally, the FAH recommends that

privacy protection be the foundational principle on which CMS bases decisions about disparities reporting. The importance of privacy safeguards for patients and facilities cannot be overemphasized, particularly in the context of care for behavioral health disorders and the IPF QRP.

## **2. Approaches to Assessing Drivers of Health Care Quality Disparities in the IPF QRP**

### **Performance Disparity Decomposition**

CMS discusses a statistical technique, regression decomposition, used to attribute the relative contributions of several factors to an outcome that is different (disparate) across two or more groups. An illustrative example is presented using this technique to analyze IPF spending differences between patients who are or are not dually eligible. A portion of the differential spending remains unexplained, which CMS states could be due to social risk factors beyond those included for analysis or to a “distinctive pattern of care decisions” made by providers (i.e., discrimination) when caring for dually eligible and non-dual patients. CMS suggests that regression decomposition could be applied to disparate measure results throughout its quality programs for which potential contributing factors are available in the agency’s databases and references an article published about the Blinder-Oaxaca methodology for decomposition.<sup>10</sup>

The FAH acknowledges the intrinsic appeal of a statistical technique that could quantify the relative contributions of multiple specified social risk factors to a health care outcome disparity. We are deeply concerned, however, about the potential application of the Blinder-Oaxaca methodology by CMS for Medicare disparity analyses anytime in the near future for multiple reasons.

The simplified example presented in the RFI bears no similarity to the complex examples discussed in the reference article by Rahimi and Nazari, creating doubt about the actual transferability of the method from mathematical theory to credible, real-world health equity analyses. The cited article has not been peer-reviewed. Its bibliography, though stretching back to 1973, contains very few reports from health care delivery settings, with most citations linking to mathematical or nonmedical papers. Even more disturbing, Rahimi and Nazari repetitively characterize the unexplained component of the decomposition as attributable to discrimination, though do mention in passing that it may instead represent as yet unidentified social risk factors. The potential for decomposition method results to be misunderstood and be substantively misrepresented (e.g., categorizing unexplained differences as discrimination) is large and disquieting, particularly if confidential results inadvertently were to become public.

The FAH cannot support regression decomposition for any use other than experimental by CMS in disparity analyses at this time. Should the agency wish to revisit adoption of this analytic tool for use across its quality enterprise as something other than a research tool for internal use only, CMS should return to stakeholders with a body of evidence that credibly and transparently addresses the adaptation of Blinder-Oaxaca decomposition to Medicare disparities

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<sup>10</sup> Rahimi E, Hashemi Nazari S. A detailed explanation and graphical representation of the Blinder-Oaxaca decomposition method with its application in health inequalities. *Emerg Themes Epidemiol.* 2021;18:12. <https://doi.org/10.1186/s12982-021-00100-9>.

data analysis. The evidence must include readily understood – but not oversimplified -- simulation and modeling examples and results using actual deidentified Medicare data from several quality programs. A plan that details how results would be used internally by CMS and perhaps someday shared publicly must also be presented with special attention to how misrepresentation of providers as discriminatory would be avoided.

## **Measures of Health Care Equity Applicable to the IPF QRP**

### **Health Equity Summary Score (HESS)**

CMS offers the HESS as an equity measure already in development for use in other programs that is potentially transferable to the IPF QRP. This composite measure was conceived for scoring Medicare Advantage (MA) plans on care delivered to their racial/ethnic and dually eligible patient subgroups that aggregates facility performance on selected HEDIS clinical measures (e.g., breast cancer screening) with experience-of-care survey results (MA CAHPS). The HESS was designed for reporting to plans and the public as a star rating (1-5 stars scale).

The FAH views the HESS as having limited utility for use in the IPF QRP. As we have previously commented<sup>11</sup>, we recognize the appeal of a single metric for facility equity performance and its potential use for evaluating progress towards closing the equity gaps in CMS programs. However, the FAH remains concerned by the challenges encountered by the measure developers as reported in the reference article cited by CMS in this RFI.<sup>12</sup>

We especially note that smaller health plans and those with less typical demographic distribution patterns were seldom evaluable by the HESS. Given the less typical distribution of demographic and social risk variables in the IPF patient population, a HESS-like measure seems much less likely to be applicable to IPFs than to other Medicare programs whose populations demonstrate typical distribution patterns. We are troubled that CMS does not describe or provide additional references about its ongoing experiences using the HESS. We additionally note the agency’s statement in this RFI that “a version of the HESS is in development for the Hospital Inpatient Quality Reporting (HIQR) program. The FAH recommends that CMS defer consideration of a HESS-like measure for IPFs until the HIQR measure is adopted and its track record can be assessed.

Finally, we are concerned that the HESS is moving forward towards implementation in at least two CMS programs even though the HESS does not appear to currently meet the criterion of adhering to high scientific acceptability standards as described in this RFI by CMS for its equity measures. We do support continued exploration of “HESS-type” measures but strongly urge that modeling, simulation, and beneficiary comprehensibility trials occur and testing results be shared fully and transparently with stakeholders before any such measures move further

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<sup>11</sup> The Federation of American Hospitals. FY 2022 IPPS Comment Letter to CMS. June 28, 2021. Retrieved from <https://www.fah.org/wp-content/uploads/2021/06/FY-2022-IPPS-Proposed-Rule.FAH-comment.062821.pdf>

<sup>12</sup> Agniel D., Martino S.C., Burkhart Q., Hambarsoomian K., Orr N., Beckett M.K., James C., Scholle S.H., Wilson Frederick S., Ng J., Elliott M.N. (2021). Incentivizing excellent care to at-risk groups with a health equity summary score. *J Gen Intern Med*, 36(7):1847-1857.

forward through rulemaking for the IPF QRP or other Medicare programs. We stand willing to work with CMS in development of a realistic and fair summary score.

### **Degree of Hospital Leadership Engagement in Health Equity Performance Data**

A structural measure for health equity, the Hospital Commitment to Health Equity (HCHE) measure, was recently taken through the pre-rulemaking process by CMS in anticipation of the measure being proposed for adoption into the Hospital Inpatient Quality Reporting (HIQR) Program during FY 2023 inpatient hospital rulemaking. CMS describes the measure and asks whether it could be adapted for the IPF QRP. Designed as an attestation-only measure, the HCHE measure requires a hospital to attest to each of five domains of organizational commitment to health equity: strategic plan, SDOH data collection; disparities analysis; quality improvement activities; and leadership involvement. The hospital must attest affirmatively for all domains, and thereby to all of their contained queries, to receive measure credit.

The FAH has general and IPF-specific concerns about this measure. For example, we note that during pre-rulemaking the Measures Application Partnership's (MAP) Hospital Workgroup observed that evidence for a linkage between the measure and improved health outcomes had not been established. The purpose and value of collecting data for a measure that has no demonstrable linkage to better outcomes are unclear to us. The burden imposed on providers to create documentation to support affirmative attestation responses for each of the measure's elements is not justifiable for a measure with unclear purpose and value. Further, the measure has not yet been formally proposed for adoption into the HIQR Program, so that CMS has not yet had the opportunity to review and reflect on stakeholder comments about the measure.

We also note that several elements would be extremely problematic for IPFs, such as the requirement for entry of social risk factor information collected from patients as structured interoperable elements using certified electronic health record technology (CEHRT). Due to funding issues,<sup>13</sup> many IPFs still lack CEHRT capabilities and this substantial IPF subset would be unable to attest affirmatively to this item and thereby to the measure's data collection domain. Successful attestation would reflect monetary (CEHRT funding) rather than equity-related factors. Since the HCHE measure is "all or none" – that is, there is no partial credit option – these IPFs would fail the entire measure based on their lack of CEHRT, even if they satisfied all of the remaining elements.

We do not support adoption of an HCHE-type measure into the IPF QRP before 1) a linkage between the HIQR HCHE measure and improved health outcomes is shown by CMS or is documented in peer-reviewed publications; 2) sufficient experience is accrued with HCHE measure implementation and use in the HIQR Program to identify and resolve operational

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<sup>13</sup> IPFs were not eligible to receive the incentive payments to purchase and implement CEHRT that were made available through the HITECH Act of 2009.

challenges for CMS and providers as well as unintended consequences; and 3) the measure is appropriately respecified to allow reporting by all IPFs.

### **Health Equities RFI Conclusion**

The FAH remains supportive of the vital work being done by CMS related to health care disparities and inequities as represented by this Equity Measurement RFI. Application of methods for identifying and reporting disparities within CMS programs remains a worthy goal to which we and our members recommend a deliberative, consistent, coordinated approach be taken by the agency. Some of the tools and methods described in this RFI appear promising for use in CMS programs including the IPF QRP. The FAH remains fully committed to working with CMS, HHS, and others on additional principles, tools, and methods that seem likely to be feasible, practicable, and lead to improved health outcomes, particularly in the IPF setting.

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The FAH appreciates the opportunity to offer comments on the FY 2023 IPF PPS proposed rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

