June 17, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, MD 21244-1850

RE: CMS-1771-P; FY 2023 IPPS Proposed Rule

Dear Administrator Brooks-LaSure:

We, the undersigned organizational members of The Academy Advisors, appreciate the opportunity to provide the following feedback in response to the **FY 2023 Inpatient Prospective Payment System Proposed Rule** (CMS-1771-P: 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 Programs 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).

The Academy Advisors is a group of clinically integrated delivery networks that pursue innovative care efforts throughout our communities. Our health systems serve more than 36 million patients annually in 28 states across the country. Our comments, provided below, focus on two key areas of proposed changes within the FY 2023 IPPS Proposed Rule: quality program modifications and health equity-related initiatives. The Academy Advisors believes that our member health systems are the Administration's ideal partner in the creation and implementation of meaningful and sustainable quality improvement initiatives, as well as in the planning, analysis, and execution of innovative interventions to address health disparities in communities across the country.

Our organizations share the Centers for Medicare and Medicaid Services' (CMS) deep commitment to improving healthcare quality. We commend the Administration for their recognition that the COVID-19 pandemic continues to affect health system performance in the Medicare quality reporting programs. Looking beyond 2023, we hope to work closely with CMS to build a sustainable framework for quality measurement that reflects the ongoing challenges brought by new COVID variants and continues to drive meaningful improvement in care quality for every patient across the country.

The Academy Advisors also commends the Administration for their recognition of health disparities and applauds CMS for their ongoing efforts to evaluate appropriate initiatives to reduce these inequities. The Academy Advisors coalition and our member organizations are committed to reducing health disparities in our individual communities and are dedicated to supporting the Administration in nation-wide efforts to create equity in the U.S. healthcare system.

As part of our ongoing commitment to addressing health disparities, our organizations have partnered separately in the creation of the Health Equity Alliance. The goal of the Alliance is to develop and disseminate best practices across member health systems to accelerate progress toward equitable patient care. In reviewing the information enclosed in the FY 2023 IPPS Proposed Rule and the Requests For Information (RFIs) included therein, we recognize that your team(s) at CMS might benefit from understanding more about what our organizations are currently doing to collect data, analyze outcomes, and address inequities. We encourage the agency to meet with our organizations to better understand current market approaches and explore where we believe the agency can offer organizational, financial, and other support so that we are all working together to achieve common goals.

Our comments are organized below by topic.

Proposed Changes to Payment Rates Under the IPPS

While the majority of our comments below focus exclusively on the proposed quality program modifications and health equity-related initiatives, The Academy Advisors would be remiss not to share with CMS our concern that the proposed FY 2023 net 3.2% payment update is sincerely inadequate.

In addition to the challenges rendered by the ongoing pandemic, our organizations are also faced with financial pressures brought by hyper-inflation and extreme labor and supply cost increases. At the same time, health systems are also contending with Medicare sequestration and other payment policies set to expire. Combined with the IPPS market basket proposal, and the proposed DSH payment cuts, many organizations could see a net decrease in payments between 2022 and 2023.

An adequate payment update is necessary not only for health systems to continue caring for patients, but is also critical to sustain quality improvement efforts and investments in programs and services to reduce health disparities. All of our comments below rely on health systems' financial sustainability. The Academy Advisors urges CMS to use the full extent of its authorities to ensure health systems can continue to provide care in their communities across the country and partner with CMS in our shared goals for quality improvement and health disparity reduction.

Proposed Changes to the Medicare Hospital Quality Incentive Programs

The Academy Advisors' organizational members share the Administration's unwavering commitment to improving care quality and safety for every patient in every community we serve. Throughout the COVID-19 pandemic our organizations were challenged constantly to develop, modify, and implement new and updated safety and quality protocols as community spread and caseload surges created massive changes in typical operations.

In one example of health system commitment to quality and safety, AdventHealth, based in Altamonte Springs, Florida, was able to achieve improvements in outcomes for patients with COVID-19 by adopting numerous new protocols and tools, such as the creation of a Clinical Performance Dashboard. While clinical leaders are not new to the development of dashboards, a fundamental shift occurred in AdventHealth's design principles during the pandemic. Instead of just tracking outcomes, such as length of stay for COVID-19 patients, AdventHealth focused on creating actionable data and accountability on the fundamental clinical processes driving the outcomes of interest, such as compliance with standardized order sets, appropriate utilization of Remdesivir, and referrals to a home monitoring program for eligible patients. AdventHealth also developed a dedicated COVID-19 management model to accelerate clinical transformations. This model was subsequently recommended by the Joint Commission to its accredited organizations as an effective model to provide clinicians with opportunities to collaborate, lead, and innovate.

In another example, Carilion Clinic, head-quartered in Roanoke, Virginia, saw improvement in hospital-acquired infection (HAI) outcomes over the last two years. Carilion was able to accomplish this feat by restructuring and escalating their daily huddle to include the review of every patient with a central line and foley catheter to promote best practices and create awareness of unique patient risks for development of a device related infection. This practice resulted in two of Carilion's COVID ICUs with zero CAUTIs in 2021 while also achieving exceptional CLABSI outcomes. Also impactful, was the implementation the HAI Leadership team early in the pandemic. The HAI Leadership team meets biweekly and includes participation by Executive Vice Presidents, Vice Presidents, the Chief Nursing Officer, Chief Quality Office, Infection Control, and Chief Medical Informatics Officer to accomplish rapid cycle improvements and removal of barriers to support front line team members.

At a high level, The Academy Advisors agrees with the FY 2023 IPPS proposals related to the Medicare hospital quality incentive programs. We commend CMS for recognizing that the innumerable and unpredictable challenges brought by the pandemic continue to affect health system performance in the Medicare quality reporting programs and may create an unfair misrepresentation of health systems' commitment to quality care. We also agree with the inclusion of new health equity metrics in the Inpatient Quality-Reporting Program. Our key recommendations, outlined below, focus on the future of the quality reporting programs. We wish to work with CMS to create a strategy that allows for fair and meaningful measurement of quality initiatives while recognizing the long-term impact of the pandemic.

Hospital-Acquired Condition (HAC) Reduction Program & Hospital Value-Based Purchasing (VBP) Program

The Academy Advisors commends CMS' proposal to suppress all six measures in the Hospital Acquired Condition (HAC) Reduction Program for the FY 2023 program year. We agree with CMS' justification that these measure suppression policies should be enacted "to ensure that these programs do not reward or penalize hospitals based

on circumstances caused by the Public Health Emergency for COVID-19 that the measures were not designed to accommodate."

Similarly, we also commend CMS' proposal to suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the five Hospital Acquired Infection (HAI) measures for the FY 2023 program year. We agree with CMS that the TPS score should not be calculated and that all participating hospitals should not experience any payment adjustments under the Hospital Value-Based Purchasing program in FY 2023.

However, the proposal notes CMS will "publicly and confidentially (through Hospital Specific Report) report CDC NHSN HAI measure results but not calculate or report measure results for the CMS PSI 90 measure for the HAC Reduction Program FY 2023 program year due to misaligned data periods." It is our understanding that CMS will publicly and confidentially report CDC NSHN HAI measures even though there is no penalty or gain in VBP. We recommend that CMS take the same approach with regard to the CMS PSI-90 measure; the PSI-90 data should be calculated and shared but not reported on CareCompare. There is valuable information for health systems to learn from this data, and this change would ensure any distorted measure results for health systems severely impacted by the COVID-19 pandemic would not be used by outside organizations for the purposes of calculating various scores, grades, and ratings.

Hospital Inpatient Quality-Reporting (IQR) Program

We commend CMS for the proposal to include the Hospital Commitment to Health Equity as a new measure in the IQR program. Our organizations agree with CMS that "strong and committed leadership from hospital and board members is essential and can play a role in shifting organizational culture and advancing health equity goals." However, we are concerned about the lack of detail and clear timeline provided for each of the five domains included in the proposal. We've included additional comment about the Hospital Commitment to Health Equity and other new equity-related measures in the section below titled Proposed Initiatives to Advance Health Equity.

Furthermore, as noted above, CMS proposes to apply a measure of suppression policy to the Value-based Purchasing (VBP), Hospital Readmissions Reduction (HRRP) and Hospital-acquired Conditions (HAC) programs to account for the public health emergency caused by the COVID-19 pandemic. Under this policy, CMS will suppress certain measure scores when calculating performance so that hospitals are not penalized. We encourage CMS to adopt this policy in the Inpatient Quality Reporting (IQR) program as well, as it would help assess any deviation in national performance during the COVID-19 PHE compared to historical performance. While hospitals are not penalized for their performance in the IQR program, this policy would help determine if there should be any adjustment to the timeframes reported publicly for all IQR measures. Publicly reporting measures that have been impacted by the pandemic can result in patients erroneously concluding that the hospital offers low-quality care. Even if there is a disclaimer acknowledging the impact from COVID-19, consumers do not have the clinical context necessary to understand how the pandemic impacted measure performance. This information should be shared with health systems as part of their Medicare feedback reports instead or CMS should give health systems the option to opt-in for public reporting.

The Future of the Medicare Hospital Quality Incentive Programs

Of utmost importance to The Academy Advisors and our member organizations, we encourage the Administration to think about the long-term impacts of the COVID-19 pandemic on the Medicare hospital quality programs, and urge CMS to develop a sustainable framework for quality measurement that reflects the ongoing challenges brought by new COVID variants and continues to drive meaningful improvement in care quality for every patient across the country.

Researchers and epidemiologists, including experts at the Centers for Disease Control and Prevention (CDC), have concluded that the COVID-19 virus will continue to evolve, and new variants will impact communities in different areas across the country for years to come. From a health system clinical quality perspective, this creates numerous concerns as health system leaders cannot predict exactly when surges will happen, where they will happen, or the extent to which any variant will prove to be more virulent or cause more severe illness in their communities.

To that end, we expect that health systems will continue to be impacted by rolling waves of COVID surges for the better part of the next decade, creating challenges not unsimilar to those faced throughout the last 2 years. That said, the likelihood that operations simply 'return to normal' is near zero, and we believe the quality incentive

programs should be updated to reflect both the spatial and temporal differences in caseload surges our country will experience over the next several years.

Again, the Academy Advisors and our member organizations are unequivocally committed to quality improvement. As CMS thinks about the continuation of these programs, and particularly the re-instatement of associated fiscal incentives or penalties, we urge the Administration to engage with our organizations to develop an appropriate framework for baseline performance periods and data benchmarks.

We are confident CMS would agree that it is inappropriate to use data from the acute phase of the pandemic as an appropriate benchmark or baseline performance period by which to compare quality improvement. Likewise, given all the challenges health systems have faced over the last few years, we also do not believe it would be appropriate to use data from 2019 as a baseline performance period. As organizations have been variably impacted over the course of the pandemic – some areas of the country were plagued by heavy caseloads of each variant, while other communities were more fortunate – we believe the establishment of a new baseline is warranted.

In thinking through the establishment of a new baseline, CMS must consider the rolling nature of COVID waves both in terms of geography and temporally when the surges occur in each community. Deciding on a single year (i.e 2023) as a benchmark, or even a shorter timeframe of several months (i.e. Jan-June 2023), could have unintended consequences. At the very least, we believe CMS should use community viral load data as a correction factor for reported data. Moreover, we would be curious to discuss with CMS whether a "self-benchmark" – where each participating hospital is benchmarked against itself year over year– would be an appropriate solution until COVID reaches endemic levels. A self-benchmark, adjusted by community viral load would rectify concerns about rolling waves, as organizations would not be benchmarked against other organizations in other areas of the country that experienced different surges. We would ***enthusiastically welcome*** the opportunity to meet with CMS to discuss the pros and cons of different approaches to benchmarking and baseline performance periods as it relates to quality improvement programs.

Proposed Health Equity-Related Initiatives and Programs

The Academy Advisor's members share the Administration's deep commitment to reducing health disparities and improving health equity in the communities we serve across the country. We commend the Administration for their ongoing efforts to evaluate appropriate initiatives and incentives within existing programs, and their dedication to the creation of new programs to create equity in the U.S. healthcare system.

In one example, as part of its Healthy State initiative designed to raise Louisiana's overall health ranking among states from 50th to 40th by 2030, Ochsner Health (Ochsner) made an initial investment of $100 million over five years to support projects that eliminate barriers to healthcare; bring resources into underserved, urban and rural communities; collaborate with partners to research and better understand health disparities; utilize technology to improve outcomes and invest in Louisiana's next generation of healthcare providers and frontline staff. More specifically, Ochsner will open 16 community health centers in underserved areas across the state, expanding access to primary and preventive care, and behavioral health; and, offer opportunities and provide scholarships to develop a diverse pipeline of physicians and other health care providers. In addition, Ochsner has established the Ochsner Xavier Institute for Health Equity and Research in partnership with Xavier University, combining each organization's research and expertise in population health, health careers, engagement, and advocacy to improve health inequities in the state of Louisiana, and prepare more physicians and clinicians who reflect the demographics of the state

In another example, Virtua Health in New Jersey is committed to devoting resources to the upstream factors that lead to food insecurity; Virtua is a leading participant and funding partner in Roots to Prevention – a cross-sectoral coalition aimed at the promotion of nutrition education and food access in our region. Through Roots to Prevention, Virtua purchases produce that is cultivated by local growers in the Camden area to create a closed loop supply chain, which systematically addresses the intersecting social determinants of health related to workforce development, healthy eating, nutrition education, and access to healthcare services. In practice, along with deliberately purchasing locally grown produce, Virtua collaborated with The Food Trust, Rowan University, and the Gretchen Swanson Center for Nutrition in designing a nutrition incentive distribution program for Virtua patients, with the goal of measuring the self-reported and clinical impact that iterative nutrition education sessions as well as subsidies for healthy, locally grown food have on health outcomes. Virtua's long-term goal is in to continue deepening upstream programming that is intersectional by nature, so that disparities in health outcomes between

communities are eliminated, overall healthcare spend decreases, and healthcare is seen by all as equitable, transformative, and truly healing.

Overall, our organizations were pleased to review the proposed Hospital Commitment to Health Equity and Social Determinants of Health measures in the Hospital Inpatient Quality-Reporting program. We also commend CMS for their ongoing commitment to improving maternal health outcomes. As with most work related to health equity, the key to these initiatives' success will be in the appropriate and successful implementation within healthcare systems and clinical settings. We look forward to working with CMS to ensure these proposals are meaningful and scalable and would be happy to meet with CMS to further discuss our comments.

New Health Equity-Related Measures in the IQR Program

As stated above, The Academy Advisors commends CMS for the proposal to include the Hospital Commitment to Health Equity as a new measure in the IQR program. Our organizations agree with CMS that "strong and committed leadership from hospital and board members is essential and can play a role in shifting organizational culture and advancing health equity goals." We support the goal of measuring, collecting, and analyzing demographic and social needs data; however, we are concerned about the lack of clear timeline, standards, and definitions included in the proposed rule.

For the Hospital Commitment to Health Equity measure to truly be successful in driving improvements for health disparities, organizations across the country will need time to implement operational changes, train personnel, and develop a campaign to build awareness and support amongst patients. The Academy Advisors recommends CMS consider a phased approach with regard to the proposed Hospital Commitment to Health Equity. We *strongly* urge you to work with our Health Equity Alliance to determine what activities, definitions, and standards are realistically achievable year-over-year.

As an example, successful data collection (Attestation Domain 2) must happen before meaningful data analysis (Attestation Domain 3) can be performed. Within the data collection domain, CMS should first identify a standard set of definitions and categories for demographic information and social determinants of health information, so that health systems can work with EHR vendors to ensure the systems can properly capture the data. Right now, in terms of REAL data, our health systems report that most of the demographic data categories in major EHR systems are based on 2010 census categories for race and ethnicity; the platforms are relatively limited in their current ability to capture information on patients who self-report as bi-racial or for patients who report a demographic category not listed (captured as "other"). These platforms are further limited in capturing SDOH data with wide variation across EHR vendors and health systems.

Separately, CMS should encourage the prioritization of staff training for culturally sensitive data collection and social needs screening and should define expectations for patient-reported data collection. The definition of Attestation Domain 2: Data Collection currently states, "Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients," but is unclear about the expectations for patient-reported data versus data derived through other means (such as algorithm-derived data). To that end, The Academy Advisors strongly discourages the use of an algorithm to indirectly estimate race and ethnicity, especially for purposes of analysis, as the existing limitations in algorithms (i.e. limitations in surname analysis) outweigh the potential benefit and could misrepresent health disparity data. When possible, the preference would be to use the gold standard of self-reported patient demographic information.

In one example of health system innovation in this space, ChristianaCare, based in Wilmington, Delaware, developed a course, in-house, to standardize the data collection process and align their registrars across the system. The course, "Get REL," coaches registrars on micro-messaging and how to ask questions related to race, ethnicity and language, as well as how to answer patients' questions related to data collection. The course utilizes videos with patients modeling behaviors and includes multiple exercises to walk registrars through the process. Course trainees learn about implicit biases and compare their guesses about a patient's REL data to the patient's self-reported information. While there is still more work to be done, the goal of the course is to help registrars understand why data collection is important, why self-reported information is preferred, and ultimately, to create alignment and standardization throughout the system.

Recognizing that accurately collecting self-reported demographic and social needs data requires a greater time, resource, and personnel investment, we encourage CMS to consider ways to support efforts to collect self-reported data. Fortunately, because self-reported race, ethnicity, ancestry, and language is the gold standard, many health

systems have already made significant investments and implemented efforts to collect this information and are willing and eager to share best practices. Many of our organizations have already been working to streamline their data intake process by educating their provider and administrative teams about the registration and data collection processes. Many are also partnering with community groups to share why a hospital would want to gather race and ethnicity information from patients, and how the demographic data will and will not be used.

In 2010, Sacramento, California-based Sutter Health underwent a system-wide effort to update their patient-facing portal and to collect self-identified information. The interface update included changing the demographic variables for race, ethnicity, and ancestry to match the US Census categories and to disaggregate Asian and Hispanic subgroups. The effort also included the addition of a robust "drop down" menu for ancestry. Sutter Health created a toolkit reflecting their process (available upon request) and published a paper based on an internal audit of the data they collected once their updated interface was created.

When healthcare organizations across the country are able to successfully collect patient-reported demographic and social determinants of health data in a meaningful and standardized way, CMS should then work with stakeholders to define best practices, standards, and expectations for data sharing and analysis. In addition to working closely with the Health Equity Alliance and our member organizations, we also encourage CMS to engage with the GRAVITY Project and the U.S. Core Data for Interoperability Taskforce. Both groups are working across industry stakeholder organizations to understand and develop standards and best practices. As these organizations include EHR vendors, engaging with these outside groups will help ensure the relevant domains are included in EHR platform and will help mitigate challenges associated with implementing different questionnaires into the EHR. We also ask that CMS work with states to standardize the data submission processes for ease of reporting and analysis.

Separately, we commend CMS for the two social determinants of health (SDOH) measures proposed in the IPPS rule: Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. We believe collecting this information is not only helpful in understanding a patients' medical history, but is also necessary in creating appropriate care plans. We encourage CMS to align these IPPS measures with quality reporting measures for other care sites including out-patient, ambulatory, and others.

Additionally, when it comes to screening for social drivers of health and social risk factors, health systems must be resourced to respond to patients that screen positive. Implementing a system of care to respond to unmet social needs like housing and food insecurity requires significant multi-stakeholder engagement both within health systems but also with community-based organizations. This requires implementing new, complex operational workflows that often require IT, analytics and informatics supports and realignment—which comes with additional cost. To help address cost barriers, we recommend CMS consider a grant program to support organizations that demonstrate commitment to developing an advanced workflow and technology support system to appropriately screen for social needs and connect patients with necessary resources.

Furthermore, we urge the Administration to recognize that many times, organizations other than a health system may be best suited to address those patient needs. Health systems should not be collecting SDOH data in a vacuum; instead, it should be collected in a way that is standardized and can be shared with state public health departments, community organizations, and even other federal agencies. The Administration should work across these funding siloes to help health systems match patients with the appropriate community, state, and federal resources.

Ochsner Health currently screens Medicare attributed ACO beneficiaries and Medicare Advantage enrollees for unmet food, housing, transportation, and other needs and uses a coordinated social services platform, Unite Us, to refer individuals for various social service and community support programs that may be available. Ochsner has also been part of a demonstration program for several years sponsored by a local health plan where its clinicians have been authorized to use a Lyft ride service that can be used to transport patients to their physician appointments for those individuals that live in "transportation deserts" where there is no bus service or other types of public transportation available.

Advocate Aurora Health, headquartered in Milwaukee, Wisconsin, is also contracted with Unite Us (formerly NowPow) which provides a multi-site referral platform including a local community resource directory, SDOH screenings, resource matching algorithms and the ability to track referrals. Advocate Aurora uses the program to provide important SDOH resource referrals to our patients. A pilot program in South Chicagoland showed 25% of patients screened through Unite US demonstrated a need for SDOH support. Food security and affordable housing

were the top two needs identified. Advocate Aurora's data indicates that screenings lead to an 11.6% reduction in ED visits.

Advocate Aurora Health also has a Primary Care Connection Program, offered at Advocate Christ Medical Center, Advocate Condell Medical Center, Advocate Sherman Hospital, and Advocate Trinity Hospital, that deploys community health workers as local resource navigators to serve patients in the emergency department (ED). From January to September 2020, the program served more than 4,400 patients at an estimated cost avoidance of nearly $465,000, with a less than three percent 90-day re-admission rate among all patients.

Proposed Maternal Health Initiatives

The Academy Advisors commends the Administration for their focus on addressing maternal mortality, and the inclusion of new maternal health measures and a new *Birthing Friendly Hospital* designation in the IPPS proposed rule. Our members share CMS' dedication to improving maternal health; we have been working to improve outcomes within our communities, and have been advocating to Congress for policies that will improve maternal healthcare for patients across the country.

In one example of how health systems are committed to improving maternal health outcomes and decreasing disparities, Cedars-Sinai in Los Angeles, California identified low utilization of the United States Preventive Services Task Force (USPSTF) recommendation for low dose aspirin as preventive medication in women who are at high risk of preeclampsia, and noted considerable disparities when demographic data was analyzed. Upon identification of this disparity, Cedars-Sinai developed a best practice alert within their hospital EHR system. This small change had a major impact and resulted in a significant increase in prescribing recommendations and decreased disparities across the entire health system.

In New Jersey, Virtua Health delivered a record number of babies - 9,109 - in 2021. With the responsibility of managing such a large annual volume of deliveries, Virtua recognizes the utmost importance of working to improve maternal health outcomes within the communities they serve.
Upon review of detailed data obtained from the Southern New Jersey Perinatal Cooperative comparing outcomes of women within the City of Camden to those within Camden County, Virtua pursued the opportunity to implement a full-time Maternal Fetal Medicine/Antenatal Testing program within the city of Camden in support of women delivering at Virtua Our Lady of Lourdes. Virtua will continue to monitor the impact this has on early term deliveries and low birth weight, both of which showed disparity among outcomes impacting both maternal and newborn health. Virtua Health is also preparing to participate as a site for NJ Healthcare Quality Institute TeamBirth Shared Decision-Making Pilot Program in fall 2022, designed to empower each team member to contribute information, reliably structure communication, and help the team arrive at shared plans together.

Ochsner Health created a Connected Maternity Online Monitoring (MOM) program that provides remote blood pressure monitoring during pregnancy by allowing the mother to send weight and blood pressure readings from her home to her medical team via a digital blood pressure cuff and scale that interfaces directly with her electronic medical record. A recent study demonstrated the positive impact of the Connected MOM program, which showed a 20 percent increased likelihood of pregnancy associated hypertension diagnosis; frequent at-home monitoring significantly raising the likelihood of hypertension diagnosis compared to less frequent in-clinic visits; and 20 percent lower risk of preterm delivery.

AdventHealth developed a Perinatal Collaborative, which aims to improve hospitals' performance on the quality measures PC-01, PC-02 and PC-06, aiming to reduce episiotomies, c-section rates and maternal complications rates. The collaborative has developed a quality dashboard and convened a team of clinical experts and external stakeholders to accomplish the goal of improving maternity care. AdventHealth is also part of the HHS Perinatal Improvement Collaborative, working to improve maternal health outcomes nationwide.

In Illinois, Advocate Aurora Health's obstetric safety and comprehensive efforts to eliminate serious morbidity and mortality are built around an established Perinatal Nursing Council, Obstetric Safety Forum and Maternal Neonatal Quality Forum. The Obstetric Safety Forum has been in place for close to a decade and consists of our Obstetric Department Chairs, Nursing Directors and data analysts. An illustrative example of their work is the near elimination of early elective deliveries which has been a priority for the Illinois Perinatal Quality Collaborative (ILPQC) as well as many national organizations including the March of Dimes. Through sharing of best practices, checklists and the empowerment of any labor and delivery staff person to question an elective induction, the rate for 2021 was 0.34% (four out of 1,165) for early elective deliveries. Additionally, through the ILPQC Severe Hypertension Initiative

endorsed by the Alliance for Innovation on Maternal health (AIM), Advocate Aurora Health has greatly decreased the time to treatment for patients with severe hypertension and continue to exceed the ILPQC goal of treatment within 60 minutes for 80% of patients with severe hypertension.

Recognizing the nomenclature is similar, we urge CMS to clearly identify the differences between CMS' new *Birthing Friendly Hospital* designation and the existing World Health Organization Baby-Friendly Hospital Initiative, perhaps on CMS' consumer-friendly website. We believe both designations will be meaningful for patients and should not be conflated. We also urge CMS to add detail and clarity to the criteria for the *Birthing Friendly Hospital* designation.

As with the data collection efforts, we urge CMS to engage with the Health Equity Alliance and other multi-stakeholder organizations that have been working diligently in this space to develop maternal health programs and measures. That said, to ensure all efforts undertaken are meaningful, we also feel strongly that CMS should only adopt NQF-validated or specialty society-developed measures.

Importantly, to avoid deepening existing systemic inequities in the healthcare system, we urge the agency to avoid pursuing punitive actions or establishing perverse incentive structures for hospitals and health systems who do not qualify for the Birthing Friendly Hospital designation, or otherwise have lower scores on health equity-related measures. Instead, we recommend that CMS create a grant program that would support patients by encouraging health systems to pursue innovative care models designed to improve equity. We envision these grants being awarded to innovative organizations looking to address a specific issue related to health equity within their market or community. As part of the grant process, the recipient would work closely with CMS to identify the appropriate patients, interventions, short- and long-term outcomes, and metrics to evaluate success. This would allow necessary flexibility for health systems to pursue different solutions designed for unique patient populations throughout the country and would allow health systems the opportunity to partner with community, state, and local agencies to achieve common goals. Ideally, CMS would evaluate the success of these grant-supported programs to determine if the program is scalable on a national level, and/or what additional patient populations would benefit from said intervention, and/or if additional policy interventions (both new policy and the reduction of existing barriers) are needed to achieve the desired outcomes.

Again, we appreciate your commitment to addressing healthcare quality and proposing necessary changes within the Medicare hospital quality programs, as well as your dedication to the identification and reduction of health disparities. Thank you again for the opportunity to provide feedback to the FY 2023 Inpatient Prospective Payment System Proposed Rule. We would welcome the opportunity for our coalition, or individual integrated delivery network members, to serve as a resource for you and your staff. Please do not hesitate to reach out to Stephanie Bernardes, Managing Director, Health Policy & Strategy (sbernardes@hmacademy.com) with any questions. We look forward to working with you.

Sincerely,

The Academy Advisors
AdventHealth
Advocate Aurora Health
Carilion Clinic
ChristianaCare
Banner Health
The Health Equity Alliance
Intermountain Healthcare
Novant Health
Ochsner Health
Sharp Healthcare
Sutter Health
UnityPoint Health