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June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1771–P
P.O. Box 8013
Baltimore, MD 21244–1850
Submitted electronically to http://www.regulations.gov

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

Dear Administrator Brooks-LaSure,

The Children's Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment System (IPPS) and other policies, CMS–1771–P. We urge you to consider the unique implications for children's health and children's hospitals related to proposed hospital reporting requirements, the maternity care quality hospital designation and changes to graduate medical education (GME) policy. In addition, we offer our perspective in response to the request for information (RFI) on patient access to health information.

Specifically, we ask you to:

- Work with hospital stakeholders to evaluate the data necessary to address a future pandemic response before requiring additional reporting, including any pediatric specific elements needed.
- Clarify how self-governing children's hospitals that do not participate in IPPS and provide maternity care are eligible to receive birthing friendly designation since they do not report under the Inpatient Quality Reporting System.
- Clarify any implications of the proposed Medicare GME policies on the Children's Hospitals Graduate Medical Education Program.
- Address the privacy and safety concerns of children and adolescents in policies to increase patients' access to their electronic health information (EHI).

Our more detailed comments are below.

Hospital Reporting Requirements

We appreciate the importance of data reporting and patient safety but remain concerned about the burdens imposed by the revised CMS Conditions of Participation (CoPs) and their implications for children's hospitals. We encourage CMS to ensure continued reporting provides value for the time and resources it takes to collect the information. In addition, we ask CMS to work with stakeholders on improving data collection and share how the data will be used in a pandemic response before automatically extending the requirements.

As you know, CoPs are the health and safety standards that certified providers and suppliers must meet to receive payment from Medicare and Medicaid. Currently, the CMS CoPs require that hospitals have active facility-wide programs for the surveillance, prevention and control of Hospital Acquired Infections (HAIs) and other infectious diseases. This rule revises hospital CoPs by proposing to extend the current COVID-19 reporting requirements, beginning after the conclusion of the current COVID-19 public health emergency (PHE) declaration until April 30, 2024. In addition, hospitals would be required to report information on Acute Respiratory Illness, SARS-CoV-2 or COVID-19, and other viral and bacterial pathogens or infectious diseases with pandemic and epidemic potential.

Since the beginning of the pandemic, children's hospitals have been devoted to providing the best care for our patients, but our hospital resources have been stretched thin. We believe that a focus on improving disease data collection and dissemination is a much more effective way to meet our shared objective of enhancing patient safety, not the imposition of new requirements and penalties on providers. In particular, the pandemic has demonstrated the need for standardization of the collection of pediatric data and their public displays from state to state. In addition, a real-time surveillance data network that includes pediatric data (from hospital inpatient, outpatient and emergency departments, as well as school settings) is needed with the capability to connect data with other already existing data resources for better insight into pediatric cases. We believe that these types of data enhancements will enhance patient safety and improve care now and during future pandemic and other health care crises.

Maternity Care Quality Hospital Designation

We appreciate CMS's efforts to address maternal health by establishing a publicly reported, public-facing hospital designation on the quality and safety of maternity care. We seek clarification on whether IPPS-exempt, self-governing children's hospitals are eligible for maternity care designation since they do not report under the Inpatient Quality Reporting Program, and approximately a dozen self-governing acute children's hospitals offer obstetrics or high-risk obstetrics services.

Children's hospitals are an important access point to address maternal health by providing intensive neonatal care services and fetal medicine programs that provide specialized, family-centered care to mothers carrying fetuses that require fetal surgery and treatment before or after birth. We are committed to quality care for mothers and recommend an ongoing dialogue to ensure these efforts are recognized moving forward.

Graduate Medical Education

We seek clarification on the implications for hospitals that participate in the Children's Hospitals Graduate Medical Education (CHGME) program of the proposed new calculation for hospitals that receive payments through Medicare GME and have a weighted full-time equivalent (FTE) count higher than their Medicare cap. As you know, children's hospitals treat virtually no Medicare patients, so they receive very few or no Medicare GME payments.

Instead, eligible hospitals (those that have a Medicare Provider Agreement but do not participate in Medicare IPPS) receive Direct Graduate Medical Education and Indirect Graduate Medical Education payments through the CHGME program. Those payments are structured similarly to Medicare GME and are based on FTE counts, which are capped as they are under Medicare GME. The caps were established in 1996 based on data from hospitals' Medicare cost reports.

We would like more information on whether CHGME payments for those CHGME hospitals that have weighted FTE counts over their caps would be readjusted as proposed in the rule. If so, we also seek clarification on whether the rule's retroactive application of the new calculation to hospitals with open or reopenable cost reports would also apply to CHGME hospitals. Finally, we seek clarification on how payments would be distributed—or redistributed—amongst hospitals, if the revised formula does apply to CHGME hospitals given that CHGME spending is limited by the size of its annual appropriation. Unlike Medicare GME, total available CHGME funding is capped annually as CHGME is funded through the annual congressional discretionary appropriation process.

Patient Access to Health Information Measure—Request for Information (RFI)

We appreciate the department's commitment to the promotion of equitable patient access and use of their health information that does not add unnecessary burden on the provider. We also agree with the goal of ensuring patients' immediate access to their EHI throughout the health care system. We encourage you to address the privacy and safety concerns of children and adolescents as you develop and advance those systems.

Proxy access to a minor child's record must be incorporated into the portal for both parents and guardians. Children's hospitals work with, and obtain proxy consent from, parents, legal guardians or other authorized representatives when providing care to minor children and before extending an invitation for portal access. It is not unusual for a hospital to receive a request from a parent, non-guardian, foster parents or temporary court-ordered care providers (i.e., extended family, friends, etc.) who do not have authority to receive the child's information or face other complicated proxy situations. Providing EHI access to the person with parental rights for an at-risk child who may have been subjected to abuse or neglect could cause further harm to the child and would be inappropriate.

There should also be a default mechanism that prevents parental access to an adolescent's information without proper authorization, as allowed under applicable state or federal law. Privacy and confidentiality functions are critically important in relation to the care of adolescents, particularly related to issues such as behavioral health, reproductive health, gender identity, drug use and genetic issues. At the same time, there should also be a mechanism that allows providers to grant proxy information access to parents/guardians under certain circumstances, such as parents/guardians of an adolescent with a developmental delay or cognitive or health condition for whom lack of parental access could jeopardize health outcomes. State-based differences in a minor's right to consent and assent to services, particularly mental health services, will need to be considered, as well as guardianship for patients 21 years of age or over being cared for in a pediatric setting.

We are also pleased that CMS is seeking information on common barriers to patients' access to their portals and is interested in easing access to EHI on multiple patient portals. A common barrier to the coordination of EHI in pediatrics is the lack of standardization of pediatric systems amongst providers, vendors and states. The new voluntary pediatric electronic health records certification guidelines adopted in 2019 by the Office of the National Coordinator (ONC) were a vitally important and promising first step towards that barrier reduction and we hope that CMS will collaborate with the ONC to achieve optimal operationalization across the health care system.

We thank you for the opportunity to provide comments and look forward to continuing to work with you to improve the delivery of children's health care. Please contact Natalie Torentinos at natalie.torentinos@childrenshospitals.org should you need more information.

Sincerely,

Aimee C. Ossman
Vice President, Policy Analysis
Children's Hospital Association