June 28, 2021

VIA ELECTRONIC MAIL

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1752-P: Medicare Hospital Inpatient Prospective Payment Systems Proposed Policy Changes and FY 2022 Rates

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Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS), Medicare Hospital Inpatient Prospective Payment Systems (IPPS) Proposed Policy Changes and FY 2022 rates (CMS-1752-P) ("Proposed Rule").

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

We appreciate the opportunity to provide input on the following topics and questions:

- *IX.B. Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers; Potential Expansion of the CMS Disparity Methods: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information*
- *IX.C.5.a. Hospital Inpatient Quality Reporting (IQR) Program: Proposed Maternal Morbidity Structural Measure*
- *X.C. Proposed Changes for Hospitals and Other Providers and Suppliers: Medicare Shared Savings Program Proposed Policy Changes*

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IX.B. Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers; Potential Expansion of the CMS Disparity Methods: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information

a. *Future Potential Stratification of Quality Measure Results by Race and Ethnicity.*

CMS proposes using algorithms to indirectly estimate the race and ethnicity (R/E) of Medicare beneficiaries to overcome the current challenges with demographic information collection and enable timelier reporting of equity results until other ways to improve demographic data accuracy materialize. The agency notes that indirect estimation techniques do not impose additional data collection burden on hospitals, since these are derived using administrative and census-linked data.

The Task Force appreciates the importance of increasing the use of race and ethnicity data to allow for more accurate data stratification and agrees with CMS that understanding the impact of race and ethnicity on achieving health equity is critical. That being said, we are concerned that indirect estimation methods as described in the NPRM will not yield accurate data. We provide recommendations on other methods to achieve the stated goal. Underlying our comments below is the sentiment that CMS design and implement approaches to data collection that are consistent and aligned with existing efforts, to ensure that the process of increasing the volume of accurate demographic data for purposes of addressing gaps in health equity does not inadvertently create additional data collection burden. We urge CMS to focus on the following strategies:

1. Leverage the data collection efforts already in place via other federal vehicles and commercial EHRs by investing in interoperability infrastructure that supports CMS' ability to access self-reported race and ethnicity data.

The Task Force does not support the use of indirect estimation techniques, due to concerns that this imprecise approach may result in data inaccuracy, and because of the potential for it to divert resources from seeking improved methods of direct reporting. Instead, we urge CMS to rapidly and meaningfully pursue efforts to improve access to directly collected race and ethnicity data from more reliable sources (including potentially the US Core Data for Interoperability (USCDI)) and exchanged via HL7. We note that eCQM reporting already requires the inclusion of race and ethnicity data of the affected populations when this information is available at the time of measure calculation. This and other requirements should be catalogued and leveraged before devoting resources to indirect estimation algorithms that are not proven to provide accurate information.

Relatedly, the Task Force recommends CMS seek opportunities to leverage the rich R/E data being collected via the National Health Interview Survey (NHIS), the Medical Expenditure Panel Survey (MEPS) and the 2020 Census. These efforts have gone

beyond the minimum data collection of R/E data to include categories such as Mexican, Cuban, Puerto Rican, Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese categories, among others. Disaggregating by subgroup is critical because the common demographic groups used in the United States aggregate many distinct communities with widely different experiences with health and health care, structural inequities, and the social influencers of health. For example, data that combines all Hispanic or Asian American and Pacific Islanders often mask deep inequities between subgroups.

In addition to seeking federal data collection vehicles, we urge CMS to continue working with ONC to establish health information exchange that supports CMS' access to electronic health record (EHR) data. Private sector EHRs are successfully collecting demographic data – in many cases going beyond R/E to include data on other social determinants of health – with high volume and high levels of accuracy.

Finally, we suggest CMS look at the processes used by Medicaid Managed Care Organizations (MCOs) to collect demographic data and consider ways to apply these methods to Medicare.

2. Expand the notion of demographic data beyond R/E to include data representative of other social determinants of health that have an impact on equitable access to health care.

To achieve the goal of increasing CMS' ability to identify areas of health disparities and address the challenges to achieving health equity, we suggest the agency require collection of data beyond race and ethnicity. One model to build off of is the Epic Social Determinants of Health (SDOH) Wheel, a graphic that represents ten domains: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress and food insecurity. Patients' responses to demographics and medical history questions turn the panels in the wheel graphic green (low risk), yellow (moderate risk), or red (high risk), allowing providers to better identify and address the social needs of patients. The SDOH Wheel is available to participating providers in ambulatory settings, as well as in inpatient and emergency departments, in organizations that use the Epic EHR model.

Other examples of valuable demographic data include data on gender orientation (Fenway Health's efforts to capture these data is a useful example), data on written and spoken primary language, and veteran status, all of which can be used to even further develop interventions that address how inequities are affecting certain patient demographics.

b. Improving Demographic Data Collection

In response to CMS' request for comments on current data collection practices by hospitals to capture demographic data elements, the Task Force supports efforts that result in more robust self-reporting of R/E data at point of service. Such efforts, as reflected by health systems that have implemented such systems successfully, are marked by several characteristics, including:

- Training all patient-facing staff – including registration staff and those doing care delivery – on how to respectfully ask patients about their background. This training includes a focus on building trust with patients by communicating how the data will or will not be used, with whom it will be shared, and what how it will be protected. As noted in the NPRM, self-reported data is considered the gold-standard.
- Requiring registration staff to request demographics information each time a patient enters the system, which has been shown to improve overall accuracy.

c. Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risk Factors

CMS proposes developing a Hospital Equity Score to quantify how hospitals are performing at reducing disparities of care for patients who traditionally have experienced inequitable access to care and subsequent poor outcomes in contrast to their peers. The Task Force supports this endeavor; however, we urge CMS to look beyond the Health Equity Summary Score (HESS) referenced as a model in the RFI, to consider the following components when designing the methodology for a Hospital Equity Score.

Conceptually, a Hospital Equity Score should include both measures of clinical quality (to identify disparities in care) as well as measures that reflect the implementation of equity practices such as: anti-racism, implicit bias, and cultural competency training. Are these trainings designed to be part of a larger strategy to address inequitable care (*i.e.,* the training is one means to an end, and not the end in and of itself)? Is patient feedback integrated into care delivery norms? Is the institution making investments in the community with a strategic lens toward addressing inequities?

The Hospital Equity Score should also include a comprehensive set of clinical outcome measures, such as readmission, mortality, adverse events, and denial of services, and seek to stratify by R/E and other relevant demographics data that comprise social risk factors.

One example for CMS' consideration is the Johns Hopkins University Hospital Measuring Hospital Contributions to Community Health with a Focus on Equity.

IX.C.5.a. Hospital Inpatient Quality Reporting (IQR) Program: Proposed Maternal Morbidity Structural Measure

CMS proposes to implement a maternal mortality structural measure that captures whether a hospital participates in a State or National Perinatal Quality Improvement (QI) Collaborative initiative, and whether the hospital implements the patient safety practices or bundles related to maternal mortality and complications.

The Task Force supports the implementation of this measure in the Inpatient Quality Reporting (IQR) program as a preliminary step toward meaningful improvements in reducing the systemic inequities that exist for pregnant and birthing Black, Indigenous and People of Color (BIPOC) people. The Proposed Rule notes that consideration will be made to public reporting of this measure; the Task Force strongly supports public reporting of this measure, and to the extent possible, including information on what processes are included in a given hospital's patient safety practices as they relate to maternity care.

Finally, in addition to the two components of this structural measure as described in the NPRM, the Task Force recommends that CMS requires hospitals to attest to a third component: that within their quality improvement data collection process they are collecting and reporting data by race and ethnicity, thereby allowing them to identify and address disparities in care.

X.C. Proposed Changes for Hospitals and Other Providers and Suppliers: Medicare Shared Savings Program Proposed Policy Changes

The Task Force supports CMS' proposal to continue the policy, established in the FY 2021 IPPS Final Rule, to allow ACOs in the Medicare Shared Savings Program (MSSP) to continue operating within the same track level during PY 2022 as they did PY 2021, or choose to move to the subsequent level. The Task Force commends CMS' efforts to provide flexibility to practices that are participating in the MSSP, in recognition of the impact that the Public Health Emergency has had on provider readiness to move from shared savings to downside risk.

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The Task Force appreciates the opportunity to respond to the IPPS Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to this statement.

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