June 17, 2022

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

Re: CMS-1771-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates

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 System (IPPS) Proposed Rule for FY 2023.

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 a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

The Task Force offers comment on the following sections.

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II.D.13.d. Request for Information on Social Determinants of Health Diagnosis Codes

The Task Force supports CMS prioritizing data collection for the purpose of identifying – and ultimately addressing – the ways in which patients' social determinants of health (SDOH) are affecting their overall health status. We offer the following input in response to the request for information on SDOH diagnosis coding issues.

Our members favor standardizing the use of tools to collect SDOH data, and are eager to access and utilize broader data sets in which this effort will likely result. However, several

members express concern with a potential requirement to use z-codes as this tool for the following reasons. Available ICD-10 z-codes that are relevant to SDOH coding do not always align with EHR-based SDOH screening tools. There is also a lack of alignment between z-codes and ONC/HIT certification requirements. Given that the submission of z-codes for use in documenting patient characteristics does not affect reimbursement, the use of these codes by providers in the in-patient setting has been inconsistent at best. One Task Force member notes that for optimal uptake, SDOH should be aligned with health and social needs gaps identified in local communities, however the current range of z-codes do not allow for this localized approach. Finally, some members expressed confusion over how to apply z-codes to SDOH screening and requested there be more training and education provided if this coding is to become a requirement.

The ability to recognize severity of illness and utilization of resources is critical to addressing health inequities and establishing interventions to best support patients' needs once they leave an inpatient hospital setting. Thus, we strongly recommend that instead of establishing requirements based on a z-code platform, CMS consider developing a broader strategy for collecting SDOH data that leverages technology available across multiple settings, and doesn't impose an additional data collection burden on providers. One option is to pull these data from EHRs using the US Core Data for Interoperability (US CDI). [USCDI Version 3](#) will be released by the Office of the National Coordinator (ONC) in July 2022 and includes categories of data elements that capture health status (including health concerns, functional status, disability status, and mental function), demographics (including race, ethnicity, tribal affiliation, sexual orientation, gender identity and preferred language), and problems (including SDOH problems and concerns).

Another option – if the SDOH screening measures are implemented in the Inpatient Quality Reporting (IQR) program – is to leverage data collected via Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health discussed in NPRM Section IX.E.5. This would allow hospitals to leverage their SDOH data in multiple ways, to both account for IQR public reporting efforts and to contribute to overall systemwide understanding of the social determinants and social risk factors experienced by patients. Ideally these measures would be implemented in settings beyond the inpatient hospital environment to ensure that CMS achieves the goal of identifying SDOH across the system.

A related option that also leverages existing data collection efforts is for CMS to explore coordinating the use of already-collected SDOH data via electronic health records (EHRs).

While directionally the Task Force fully supports efforts to improve and increase the collection of SDOH data, we believe that these options can and should be designed in a way that would make it feasible for hospitals of all sizes and types to consistently collect data in a standardized manner without creating undue burden when better data sources may already be available. If CMS does mandate the use of-z-codes for this purpose, we support a delayed implementation of compliance penalties as needed.

In addition, we recommend CMS support the creation of educational resources that help providers make the case to patients for why these data are being requested, and for what purposes they will be used. While stakeholders understand that these data are critical to the ability to develop meaningful interventions and policies that help patients, several Task Force members note that personal information is being asked of patients, without the requisite time spent providing patients with a clear rationale. When a provider codes a patient's social drivers of health codes via an EMR or other form of collection, that screening and result will show up on the patient's after-visit summary, which many patients may find concerning. The process of improving patient-reported data requires a foundation of trust; we encourage CMS to consider its role in addressing this need.

Finally, we urge that any SDOH screening instruments go through rigorous cross-cultural validation. Without such validation, there is the potential to under- or over-report unmet need in certain communities, and inadvertently develop or exacerbate existing disparities within communities.

IX.B. Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs - Request for Information

The Task Force appreciates CMS' commitment to achieving equity in healthcare outcomes by supporting quality improvement activities to reduce health inequities, enabling beneficiaries to make more informed decisions, and promoting health care provider accountability for inequities. We support the following strategies as outlined in the RFI:

- *Stratifying Measures*: The RFI describes current implementation of measure stratification based on dual eligibility status, which the Task Force supports. We also fully support the recommendation put forward by the Assistant Secretary for Planning and Evaluation to stratify measures by social risk factors, and report results in a way that reflects both "within-provider" and "across-provider" assessments of the level of disparities in clinical processes and outcomes. For decades, there have been concerns raised about the potential bias conveyed when stratifying measures that do not include adequate sample sizes across the stratification cohorts. CMS and many other stakeholders recognize the need for increased patient-level data on race, ethnicity, language, and social risk factors; **We strongly support efforts to close the data gaps both to better identify inequities and to allow for stratified public reporting of measures.**

- *Prioritizing Measures for Stratification*: Toward that end, we agree directionally with the principles outlined in the RFI for how to prioritize measures for disparity reporting. We do, however, suggest aligning two principles: (1) prioritizing existing clinical quality measures and (2) prioritizing measures with identified disparity in treatment or outcomes for the selected social or demographic factor. The CDC reports that people from racial and ethnic minority groups experience higher rates of illness and death across a range of conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when

compared to white patients. **We urge CMS to prioritize measures that relate to the conditions in which the inequalities are starkest**.

- *Principles for Social Risk Factor and Demographic Data Selection and Use*: The NPRM notes that CMS is considering three sources of social risk and demographic data to allow for reporting of stratified measure results. One of these sources is imputing race, ethnicity, and language data using indirect estimation based on a person's surname and address. In past comments the Task Force has raised concerns about the accuracy of indirect estimation methodology for imputing demographic data, and urged CMS to invest in collection of "gold standard" self-reported data, noting that the costs associated with less accurate imputation methods in already underserved communities may be greater than the benefits this method seeks to provide. Members have also raised that imputation methodologies are even less accurate for populations for which there are smaller sample sizes (e.g., Asian Americans or Pacific Islanders and Native Americans). However, when self-reported data are not available or collection efforts are unsuccessful, then imputing data is acceptable provided that is it done on more than just surname and there are reasonable verification attempts undertaken.

  The Task Force recognizes the value of a defined, time-limited period of using imputed data, coupled with contemporaneous efforts to gather patient self-reported data. These data should be used in developing interventions aimed at improving care equity when the only alternative is to substantially delay deployment of these interventions, and not for purposes of accountability or payment.

  In the long term, if self-reported race and ethnicity data are persistently missing for a proportion of patients, the Task Force offers the following recommendations:

  - 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, 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.

  - Continue working with ONC to establish data exchange supports that allow CMS to access 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.

- Invest in strategies to improve 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 how it will be protected. As noted in the NPRM, self-reported data is considered the gold-standard.
  - Requiring registration staff to request demographic information each time a patient enters the system, which has been shown to improve overall accuracy.
- Look to the processes used by Medicaid Managed Care Organizations (MCOs) to collect demographic data and consider ways to apply these methods to Medicare in the interest of driving consistent data collection across payers.

If the only alternative is to exclude patients' data from accountability programs altogether or assign them as "unknown race" or similar missing data values, the Task Force views imputation as preferable. However, we recommend that CMS include a flag for any race, ethnicity, and language data derived from imputation so that users (providers, researchers, etc.) know what proportion of data are self-reported versus imputed.

- *Public Reporting of Disparity Results*: The Task Force believes in using quality measurement for public reporting to support consumer engagement and education. We also recognize that some measures are important for internal quality improvement but may not be appropriate for public reporting. In the case of reporting disparity results, the proposed principles and goals outlined in this RFI would indicate that CMS will prioritize stratification of measures that are equally important to consumers' decision-making as they are to health care providers' ability to identify and address inequalities. The RFI also notes that any measure stratification strategy will include a process for validating the data to guard against sample size biases.

  Thus, **we do not support the proposal to confidentially report the stratified data during the initial reporting period; rather we recommend publicly reporting results from the start of the implementation period.** We do note, however, that public reporting should be predicated on self-reported data, using methodology that is evidence-based, valid, and reliable through a multi-stakeholder consensus-based review.

IX.E.5. New Measures Being Proposed for the Hospital IQR Program Measure Set

CMS seeks feedback on four new measures, proposed for implementation in the Inpatient Quality Reporting (IQR) Program:

- *Hospital Commitment to Health Equity Measure (CY 2023 reporting period/FY 2025 payment determination):* To better assess inpatient hospital settings' commitment to health equity, CMS proposes implementing Hospital Commitment to Health Equity, which is designed to assess a hospital's commitment to establishing a culture of equity and delivering equitable health care. Hospitals will attest to their efforts along five domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement. We appreciate the thought with which CMS developed this structural measure, leveraging comments that were submitted in response to the FY 2022 IPPS NPRM RFI on the topic, as well as research on the main drivers of health equity conducted by the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, and the Institute of Healthcare Improvement (IHI). We agree with the NPRM's statement that the domains and elements that comprise this measure are actionable, and that this measure will incentivize providers to establish systems for collecting and utilizing data, identifying equity gaps, and implementing plans to address those gaps. We also are heartened that this measure is designed to look not only at addressing inequities related to race and ethnicity, but also to disability status, sexual orientation and gender identity, language, geography, religion, and socio-economic status. **The Task Force supports finalizing this measure to begin collection in CY 2023 and supports CMS' proposal to publicly report the measure results.**

- *Social Drivers of Health Measures Beginning with Voluntary Reporting in the CY 2023 Reporting Period and Mandatory Reporting Beginning with CY 2024/FY 2026 Payment Determination*

  CMS proposes two measures relating to the social drivers of health:

  - *Screening for Social Drivers of Health* would assess the percent of patients (18 or older) admitted to the hospital and are screened for: (1) food insecurity, (2) housing instability, (3) transportation problems, (4) utility difficulties, and (5) interpersonal safety.
  - *Screen Positive Rate for Social Drivers of Health* would identify the proportion of patients who screened positive on the date of admission for one of five domains previously mentioned.

  The Task Force supports the implementation of both measures into the IQR (with a few concerns noted below), and strongly suggests that CMS look to these measures as a way to collect SDOH data, as per the RFI in section II.D.13.d., "Request for Information on Social Determinants of Health Diagnosis Codes."

  The Task Force also appreciates CMS offering hospitals the ability to use their existing screening tools to collect and submit data on these measures. This flexibility

helps reduce provider burden and cost, particularly when it comes to having to implement new screening tools.

In addition to serving multiple purposes across this NPRM, these measures also align with the proposal in the CY 2023 Medicare Advantage NPRM to require that all Special Needs Plans (SNPs) complete health risk assessments of enrollees including questions on housing stability, food insecurity and access to transportation.

We do want to note that screening positive for interpersonal safety does require providers to connect the patient to law enforcement within a certain amount of time. One Task Force provider member suggests that this domain be considered for a separate measure, to allow providers to understand the impact of positive screens on resources. In addition, we recommend CMS provide inpatient settings with lessons learned from the Accountable Health Communities model on best practices related to this domain (e.g., are there times when it is appropriate to not ask or revisit this question; ethical dilemmas around mandated reporting; licensing considerations for screeners ascertaining this information; and times when self-reporting may differ from observations).

The Task Force supports the direction of the *Positive Rate for Social Drivers of Health* measure as it is important for hospitals to not only screen patients for social needs, but to track the rate of positive screens, as these indicate where unaddressed social needs lie. There are myriad benefits to hospitals collecting data on the rate of positive screenings and using those data to inform their programs and policies addressing health equity. For purposes of publicly reporting of this measure, the Task Force urges CMS to consider making the data available via a downloadable file, rather than on Hospital Compare, and to concurrently conduct timely research on how consumers internalize these data points. For example, it is unknown currently how seeing a high rate of positive screenings attributed to a hospital will affect patients' decision-making, with some expressing concern that these data may lead patients to avoid going to a certain hospital for care resulting in a negative impact on access. Publicly reporting the rate of positive screening may make hospitals that serve a larger population of marginalized and underserved communities appear as though they are lower performing, without adjusting for the impact of serving patients who are affected by multiple social drivers of health.

One issue for the measure developers and CMS to address in future efforts is to quantify the rate at which hospitals are closing the screening loop by addressing the needs identified in the screening. While screening for social drivers of health is a great step in the right direction, the patient is not served until steps are taken to support follow-up and referral to the needed services. The Measure Applications Partnership Health Equity and Rural Health work groups expressed similar concerns during their December 2021 meeting.

We suggest CMS work with the measure developer to develop and test a composite measure that provides data on the rate at which providers refer positive-screened patients to other organizations and whether follow up services are being

provided. The design of this measure should account for the fact that providers do not have full control as to which follow-up services are sought and provided. The measure should also incorporate in its design a way to account for the availability of services in a community to address social needs. Finally, on the "closing the loop" issue, given that efforts to connect patients to services outside of the clinical environment are often not reimbursable, we recommend CMS provide resources so that hospitals can achieve positive outcomes in this area.

Regardless of the screening tool or measure, **we strongly urge CMS to develop recommendations on how to best educate patients and providers on the importance of collecting social needs data, and that screening tools demonstrate a minimum level of cross-cultural validation and/or demonstration of how community members and/or patients participated in identifying and prioritizing the domains.**

- *Cesarean Birth eCQM With the CY 2023 Reporting Period/FY 2025 Payment Determination and Mandatory Reporting Beginning with CY 2024 Reporting Period/FY 2026 Payment Determination.*

    CMS proposes a measure to assess the rate of NTSV (nulliparous, term, or singleton vertex) pregnancies delivered via C-section. This would be publicly reported to allow hospitals to compare outcomes. **The Task Force supports this measure, as well as having a one-year period of voluntary reporting** to prepare hospitals for mandatory reporting beginning in 2024.

- *Severe Obstetric Complications eCQM Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination with Mandatory Reporting Beginning with CY 2024/FY 2026 Payment Determination*

    CMS proposes to measure the proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization. The measure would be risk-adjusted for patient age; a number of specified pre-existing conditions present on admission; pregnancy characteristics, lab tests and vital signs upon arrival; long term anticoagulant medication use; and social risk measured by housing instability.

    The Task Force supports the implementation of PC-07 to the IQR program and supports mandating it as one of the six measures that hospitals will report; it will be a powerful tool in addressing the urgent need for action in response to the ongoing maternal health crisis.

IX.E.8. Proposed Establishment of a Publicly Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

- *Proposed Establishment of Publicly Reported Hospital Designation to Capture the Quality and Safety of Maternity Care*

    CMS proposes a publicly reported hospital designation to capture the quality and safety of maternity care in the United States. The Task Force directionally supports the

concept of a designation that will help birthing people identify higher-quality facilities. However, such a designation should be based on a set of measures that together provide meaningful distinctions among facilities and indicate where one might confidently expect to have a better experience and attain better outcomes compared with non-designated facilities. Such designations require careful thought about measures to be included, thresholds or benchmarks indicative of higher quality, weighting of the various components, data displays, and effective communication of the meaning of the designation to the general public and health care community.

The Task Force is also concerned that the concept of conferring a "birthing-friendly" designation on any hospital that attests "yes" to participating in a perinatal quality collaborative and "yes" to implementing a quality improvement project will be misleading. In our comments on the FY 2022 IPPS proposed rule, the Task Force did support the Maternal Morbidity Structural Measure on which this designation relies; however, we recognize that a "yes/yes" attestation on this measure merely indicates some level of participation in a PQC and in at least one QI initiative. It does not indicate whether quality actually improved in the facility in at least that one area (e.g., hemorrhage, pre-eclampsia), and whether this had any impact on care in the many other areas that could be important to birthing people and more directly relevant to their care. Given the nation's inequitable, underperforming maternity care system, we should expect PQC and QI participation to be routine and to be a floor rather than treating these as exceptional.

Further, in states in which the vast majority of birthing facilities participate in PQC QI projects, such a designation would not help distinguish among possible birth setting options in many communities. Because this designation will only be awarded to hospitals, this designation could harm the reputation and standing of birth centers, and other non-hospital birth settings, despite meeting the same criteria of participating in PQC QI projects. Finally, we ask that CMS work with consumer advocacy organizations to determine the factors or measures that are most valuable to community members and patients to determine the "birthing friendly" designation.

We urge CMS to take these concerns into consideration and create a designation status that more effectively captures the quality of maternity care being delivered in a hospital.

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The Task Force appreciates the opportunity to respond to the FY 2023 IPPS NPRM. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with any questions.

Sincerely,

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