June 9, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: FY 2024 Hospital Inpatient Prospective Payment System *(CMS-1785-P)*

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the FY 2024 Inpatient Prospective Payment System (IPPS) notice of proposed rulemaking (Proposed Rule).

The Task Force is a multistakeholder consortium that supports 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.

Our comments offer feedback on 1) two sets of proposals within the Hospital Value Based Payment (HVBP) program, including the proposed health equity adjustment, and proposed updates to HCAHPS data collection and submission requirements; 2) proposed changes to homelessness z-code designations; and 3) proposed removal of "Elective Delivery Prior to 39 Weeks" from the Inpatient Quality Reporting (IQR) program.

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I. Hospital Value-Based Purchasing Program

Health Equity Adjustment

The Task Force supports CMS' proposal to create a Health Equity Adjustment (HEA) that offers inpatient hospitals an opportunity to earn additional bonus points on their Total Performance Score (TPS). Our members also appreciate that CMS is proactively seeking to create similarities in their health equity adjustment policies across payment programs, including the

finalized adjustment for ACOs in the Medicare Shared Savings Program. Having similar measurement and methodology framing across programs provides a lane for reducing overall confusion and creating greater alignment across policies. The Task Force offers the following comments and recommendations regarding specific methodology design elements as described in the Proposed Rule:

- CMS proposes that in the future, the "underserved multiplier" component of the health equity adjustment calculation may be expanded beyond patients with Dual Eligibility Status (DES). The Task Force directionally supports CMS looking at ways to encompass a comprehensive measure of hospitals' underserved population but recommends the agency work with the private sector to develop the methodology that goes into this calculation. There are several challenges with using dual eligibility and the other proxies that CMS is considering for measuring a hospital's underserved populations. For example, dual eligible beneficiary percentages will vary across states depending on nonuniform criteria for Medicaid eligibility.

  In addition, as the Task Force has noted in last year's comments on the Medicare Physician Fee Schedule proposed rule regarding the use of the Area Deprivation Index (ADI) in the MSSP Health Equity Adjustment, applying the ADI national percentile rank of 85 percent to determine whether an IPPS hospital qualifies for the Health Equity Adjustment raises methodological concerns. In using the national percentile rank, some populations who may appear underserved relative to others in their surrounding area or state may in fact fall below the 85th percentile when compared to other communities nationwide. Finally, availability of ADI data can be limited for certain purposes (e.g., non-profit education, research, and public health) which may limit the ability of providers to partner with certain entities to ingest and validate data.

- As work continues in the inpatient hospital setting to identify inequalities in care that lead to disparities in outcomes by race, ethnicity, and other demographic variables, the Task Force recommends CMS continue to refine the formula for determining the percentage of a hospital's patients that are underserved. Toward that end, we recommend that CMS convene a multi-stakeholder Technical Expert Panel, including representatives from the hospital community, to develop an appropriate health equity adjustment methodology.

- Regarding the threshold methodology, Task Force members support the three levels of performance as described in the proposed rule, given that this methodology creates consistency with health equity adjustment calculations in other payment programs.

The Task Force offers the following recommendations (originally put forward in the FY 2023 IPPS NPRM comment letter) in response to CMS' request for other approaches the Agency could use to address health care disparities and advance health equity:

- *Stratify Quality Measures*: The Task Force continues to support the recommendation put forward by the Assistant Secretary for Planning and Evaluation to stratify Inpatient Quality Reporting Program (IQRP) measures by social risk factors. We also support reporting of 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 and develop more robust data sets both to better identify inequities and to allow for stratified public reporting of measures.**

- *Move Forward with Prioritizing Measures for Stratification*: In last year's IPPS NPRM, CMS proposed several principles to guide prioritization of measures for stratification. The Task Force agreed directionally with those principles but also suggested 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 continue to urge CMS to prioritize measures that relate to the conditions in which the inequities are starkest**.
- *Continue to Pursue Increased Rates of Self-Reported Demographic Data:* The ability to identify the opportunities and challenges present in any inpatient setting rely on accuracy of race, ethnicity, and other demographic data. The Task Force offers the following recommendations for addressing gaps in the current data pool:
    - 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 policies and infrastructure 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 interacts with the health care 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.

Overall, Task Force members support the concept of providing additional financial bonuses to hospitals that serve a greater percentage of underserved patients, and that demonstrate high quality performance.

Proposed Updates to the Data Collection and Submission Requirements for the HCAHPS Survey Measure Beginning with the FY 2027 Program Year

CMS proposes to add three new modes to create additional efficiencies in the HCAHPS survey administration. These include: (1) web-mail mode, (2) web-phone mode, and (3) web-mail-phone mode. These modes would not replace the current fielding strategies but would be used – starting in January 2025 – in addition to the current mail only, telephone only, and mail-phone modes. As included in the Proposed Rule, CMS ran the 2021 HCAHPS mode experiment that added an initial web component to the three current HCAHPS modes of survey administration. The findings from this experiment were successful as it resulted in increased response rates among patients. Therefore, **The Task Force fully supports the proposal to field HCAHPS via the most used forms of communication. This will enable patients to provide their information in a much more efficient way, and hopefully significantly increase response rates for this important survey tool.**

CMS also proposes to remove the requirement that only the patient may respond to the survey; the proposed change would allow patient proxies to respond on the patient's behalf, beginning with discharges in January 2025. The Task Force understands the importance of allowing a proxy to respond to the survey on the patient's behalf if the patient is incapacitated or otherwise unable to take the survey. **The Task Force supports this proposal and applauds proposals of this type that reflect practical and positive ways for family and caregivers to contribute to patient-centered care**.

Finally, CMS is proposing to collect information about the language the patient speaks while in the hospital, and requiring the official CMS Spanish translation of the HCAHPS survey to be administered to all patients who prefer Spanish, beginning with January 2025 discharges. Historically, the Task Force has supported collecting self-reported demographic data from patients. **The Task Force supports the proposal to collect information about the language the patient speaks while in the hospital during the survey, as well as administering the survey in Spanish to those who express that preference.**

II. Proposed Changes to Specific MS-DRG Classifications/Safety Net Hospitals RFI

Safety Net Hospitals Request for Information: Proposed Changes to Severity Level Designation for Z Codes Describing Homelessness

The Task Force supports CMS' proposal to change the severity level designation for the following three ICD-10-CM diagnosis codes describing homelessness – (Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness)) – from non-complication or comorbidity, to complication or comorbidity. Homelessness makes discharge planning more difficult and increases the length of stay for the patient, thereby increasing the amount of resources used per case. The new policy would improve reimbursement for the costs of treating these patients and prompt better collection of meaningful data on this population.

The Task Force also encourages CMS to consider the following ways to address persistent issues that may limit how accurately these codes are capturing the significant resources involved in providing care to this population:

- For homelessness to be considered and associated resources to be adequately captured, hospitals must report corresponding Z-codes. Only a small fraction of claims incorporate these Z-codes, mainly because these codes introduce complexity for coders, necessitating additional time and lacking incentivization.
- Coders will need additional guidance as they often see a listing of SDOH information in the patient's history, but nothing documented on how the SDOH are related to an associated problem or risk factor directly. Many times, this impact is inferred from the information in the record but not fully documented specifically by the provider, which complicates an already arduous process.
- Similarly, providers may not be accustomed to routinely capturing this information as part of their provision of care for a patient and may thus require training and education.
- Expressing certain social risk factors, such as homelessness, can be uncomfortable for patients, which could result in underreporting. As a result, the Z-code may not accurately represent the entire population.

III. Inpatient Quality Reporting Program

Elective Delivery Prior to 39 Weeks Gestation

The Task Force supports CMS' proposal to remove "Elective Delivery Prior to 39 Weeks" from the Inpatient Quality Reporting (IQR) program. The just-released State of Maternity Care report from The Leapfrog Group shows that this measure has essentially topped-out, and that the opportunity for improvement here is extremely small. Given the persistent high rates of maternal and infant mortality in the U.S., particularly for Black and Brown birthing people, and the breadth of areas in which maternity care can be improved, CMS should explore the implementation of other impactful maternity measures. This is an opportunity to demonstrate alignment of quality measures across payers and programs by selecting another measure or measures from the Core Quality Measure Collaborative's (CQMC) Obstetrics and Gynecology Core Measure Set.

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The Task Force appreciates the opportunity to respond to the FY 2024 IPPS NPRM. Please contact HCTTF Senior Director Tanya Alteras (tanya.alteras@hcttf.org) with any questions.

Sincerely,

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