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June 2, 2023

Submitted via Regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; CMS-1785-P; RIN 0938-AV08

Dear Administrator LaSure,

The National Health Law Program (NHeLP), founded in 1969, protects and advances the health rights of low-income and underserved individuals and families by advocating, educating, and litigating at the federal and state levels. NHeLP has long advocated for increased commitment to health equity and culturally and linguistically appropriate, accessible care as a key part of health care quality initiatives. We thank you for the opportunity to comment on the proposed Inpatient Prospective Payment System (IPPS) rule, which builds on the prior year's commitment to health equity measures.

We support the proposal to add a health equity adjustment that accounts for hospitals serving a higher proportion of patients from underserved communities. We also support the proposed Facility Commitment to Health Equity requirement for Prospective Payment System-Exempt Cancer Hospitals (PCHs) that would require public reporting of PCHs' commitments to –

and progress toward – health equity at their facilities. However, we implore CMS to put equal focus on demographic data collection and stratified quality reporting to advance health equity across all hospital programs.

Proposal to Revise the Hospital VBP Program Scoring Methodology

CMS requested comment on a proposal to add a health equity adjustment to a hospital's Total Performance Score (TPS), which would support hospitals that both perform well on quality performance measures and serve a higher proportion of people from underserved communities. CMS notes that patients who live in a low-income area, who are Black or Hispanic, and who are dually enrolled in Medicare and Medicaid experience greater health inequities, including significant disparities in quality of and access to care.¹ CMS proposes to use the total number of dually enrolled patients served by the hospital as a proxy for determining the proportion of patients who are underserved.

We support a health equity adjustment that would reward hospitals for serving a higher proportion of underserved populations. However, we strongly encourage CMS to incorporate in this score a way to directly measure outcomes, access, and quality for underserved populations. Measuring the number of dual eligible patients served by the hospital only indirectly measures whether the hospital provides quality care to people who are disproportionately likely to face disparities in quality and access to care. Because the proposal does not require hospitals to show that the care that they provide to dual eligibles is of the same quality that is provided to non-dual eligibles or the overall patient population, it does not require a hospital to actually prove that care is equitable. The focus only on dual eligibles also cannot speak to quality of care provided to other underserved populations that have historically faced discrimination and disproportionate access to and quality of care, such as communities of color, people with disabilities, LGBTQI+ people, and people with limited English proficiency.

¹ Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership, 88 Fed. Reg. 26658, 27039 (May 1, 2023).

We hope that CMS will adopt a component as part of this health equity adjustment that would require hospitals to directly measure and account for how the hospital promotes access to care and good quality care for underserved populations, including dual eligibles and historically underserved groups. Hospitals should not only be required to improve overall patient outcomes, but to track how those performance improvements actually impact specific underserved populations. As discussed in the following sections, CMS must commit to requirements for health care entities to collect and analyze demographic information on patient populations. Only then can hospitals actually track performance metrics and stratify performance data by demographic and socioeconomic traits to show that they are advancing health equity.

Facility Commitment to Health Equity Measure

CMS proposes to require PCHs to report on a new measure, the Facility Commitment to Health Equity, beginning in FY 2026. This measure is identical to the Hospital IQR Program measure adopted in the 2023 IPPS/LTCH Rule, which was known as the Hospital Commitment to Health Equity.² As part of this new requirement, CMS aims to encourage PCHs to actively promote health equity for “racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges.”³ Rather than setting parameters or expectations for specific actions, CMS intends for hospitals to make use of existing data to identify gaps, implement plans to address disparities, and dedicate resources to equity initiatives.⁴

We support the Facility Commitment to Health Equity Attestation, and we believe it will encourage PCHs to be more accountable for health disparities and inequities. We appreciate that CMS will require the Health Equity Attestations reported by each facility to be publicly available, enabling better accountability toward health equity goals. We hope that CMS will develop this measure to include more concrete steps that PCHs must take to

² 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, 87 Fed. Reg. 28108, 28495 (May 10, 2022).

³ 88 Fed. Reg. 27199.

⁴ 88 Fed. Reg. 27199-21.



improve equity initiatives for specific historically underserved communities, such as LGBTQI+ people, people with disabilities, communities of color, limited English proficient individuals and immigrants—particularly if CMS continues to expand use of this model.

Our recommendations concern Domains 2 and 3 of the Health Equity Attestations, which involve data collection and analysis. Domain 2 requires PCHs to attest that the hospital collects demographic information, “such as self-reported race, national origin, primary language, and ethnicity data and/or social determinant of health information” on the majority of patients.⁵ We believe this attestation requirement is not specific or stringent enough to effectively identify underserved communities in the PCH’s patient population.

First, the language of this attestation is not specific enough because it fails to identify other demographic information that PCHs should collect from patients. If CMS expects entities to improve health equity for “racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges,” then such entities must collect all relevant information from the patient population.⁶ Particularly of note, the language of the attestation itself leaves out mention of LGBTQI+ patients and patients with disabilities, stating: “Our hospital collects demographic information, such as self-reported race, national origin, primary language, and ethnicity data.”⁷ CMS should be more specific about the ways it expects hospitals to engage with underserved patients to achieve greater health equity.

CMS should take care not to conflate sociodemographic characteristics with social determinants of health (SDOH) information. Collecting information on demographic characteristics of patients helps PCHs understand whether they meet civil rights requirements for serving different populations equitably. It also helps PCHs plan for culturally and linguistically appropriate, accessible care both on a broad scale and for each individual patient. SDOH information cannot be substituted with comprehensive demographic information on the patient population because it informs the PCH about patients’ basic social needs, not whether the patient may be facing discrimination or access issues. We strongly encourage CMS to focus its efforts on implementing demographic data

⁵ 88 Fed. Reg. 27120.

⁶ 88 Fed. Reg. 27119.

⁷ 88 Fed. Reg. 27120.

collection requirements before addressing SDOH or, at a minimum, require demographic data if it also is going to require SDOH data.

Second, the language of the attestation is not stringent enough because it fails to place concrete requirements on PCHs to improve demographic data collection. Without setting parameters for what demographic information must be collected, the information collected becomes much less comparable from facility to facility, and thus much less useful. CMS should specify what demographic information PCHs should collect in the language of the attestation. We also believe that the requirement to collect information from “a majority of patients” is too lax to meet the goal of health equity.⁸ Demographic information should be voluntarily self-reported from patients, but mandatory for providers and administrative staff to ask at enrollment and at each visit. With provider and staff education, training on interview and communication strategies, and appropriate means to address patient concerns, it is reasonable and demonstrably possible to expect PCHs to collect demographic information at rates much higher than 51%.⁹ Instead, we recommend that CMS require attestation to above 75% of patient demographic information reported, plus a plan to improve demographic data collection in PCHs by an incremental amount each year to ultimately achieve 100%.

Domain 3 concerns the analysis of demographic and social determinants data to support equity initiatives. We support the requirement for PCHs to stratify performance data and use this information to inform strategic plans to reduce disparities. We strongly support the requirement for PCHs to share this stratified information publicly on performance dashboards.

However, we encourage CMS to require demographic stratification of measures separately from stratification by SDOH information. Demographic information serves a different purpose than social determinants—to allow PCHs to measure the quality of care provided to historically underserved communities, to plan for accessibility and culturally and linguistically competent care, and to close long-standing equity gaps. SDOH information

⁸ 88 Fed. Reg. 27120.

⁹ One study from 2022 found patient-reported race/ethnicity data improved to over 90% completion within one hospital system over 5 years with structural reform, provider training, and patient education. Ruben D. Vega Perez et al., *Improving Patient Race and Ethnicity Data Capture to Address Health Disparities: A Case Study from a Large Urban Health System*, 14 *Cureus* 1 (2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8815799/>.

cannot be a proxy for whether a patient requires an interpreter to be present, for example, or whether people with disabilities receive timely breast cancer screenings, or whether the hospital complies with federal civil rights laws. Therefore, we recommend CMS change the language of this attestation domain to require PCHs to stratify performance indicators by demographic variables and state which demographic variables PCHs must use when stratifying quality data.

Recommendations for Demographic Data Collection to Advance Health Equity Measure Proposals

The success of these new health equity measures depends on the quality of demographic data collected by CMS-supported hospital programs. Priority 1 of CMS’s Framework for Health Equity 2022-2032 is to “Expand the Collection, Reporting, and Analysis of Standardized Data.”¹⁰ Priority 1 and this Proposed Rule both acknowledge that CMS programs must collect patient-reported demographic information to understand gaps in care.¹¹ As such, improving collection of patient-reported demographic data should be CMS’s first step in implementing new quality measures that address health equity.

CMS should require its programs to collect demographic data on “race, ethnicity, language, gender identity, sex, sexual orientation, and disability status.”¹² Without this information, it will be difficult if not impossible for the programs or for CMS to demonstrate change or improvement in health care quality among any of the historically underserved populations named and therefore progress toward the health equity commitments made.

CMS should support health equity improvements in its programs by requiring standard practices for demographic data collection. Standardized data collection, including use of common language and demographic categories, supports Priority 2 of the Framework for Equity by enabling “within provider” and “across provider” comparisons on health care disparities, as well as “within program” and “across program” comparisons.¹³ The ability to

¹⁰ Ctrs. for Medicare & Medicaid Servs., *CMS Framework for Health Equity 2023-2033* (2022), <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf> [hereinafter “Framework for Health Equity”], at 10.

¹¹ 88 Fed. Reg. 27118.

¹² Framework for Health Equity at 12; *and see* 88 Fed. Reg. at 27119.

¹³ “CMS plays a pivotal role in ensuring health care professionals and health insurance issuers who receive funding through any CMS programs uphold civil rights laws and protections which prohibit discrimination based on race, color, national origin, sex, age, or disability. CMS has a responsibility

conduct these data comparisons increase programs' capability to stratify core quality measures and develop initiatives for quality improvement. Quality data analysis stratified by demographic traits also allow appropriate allocation of resources for targeted quality improvement activities at both the agency- and program-level.

HHS's 2011 Data Standards provide a baseline for common language to collect demographic information on race, ethnicity, primary language, and disability or functional status.¹⁴ HHS should apply these existing standards while conducting additional testing on how to further disaggregate to account for unrepresented populations. For example, consensus recommendations from the National Academies of Sciences, Engineering, and Medicine provide momentum to adopt, for the first time, practices on demographic data collection of sexual orientation, gender identity, and sex characteristics (SOGISC) in administrative, clinical, and survey settings.¹⁵ We endorse the adoption of NASEM recommendations for collection of SOGISC demographic information as well as NASEM's recommendations to continue testing SOGISC data collection practices.

The proposed rule names the need for programs to use their own data to study health outcomes among the patient population.¹⁶ However, quality of data varies widely from program to program. Further, programs may not invest in resources to gather new data absent a requirement to ensure equity across populations. Therefore, in addition to setting standards for demographic data collection in its programs, CMS must also support programs by providing resources, technical assistance, and infrastructure capacity to collect and analyze demographic data. Many resources already exist within CMS and from health care quality organizations that provide evidence-based recommendations on how to collect demographic information in both the administrative and clinical settings, how to protect individual privacy, how to conduct training of health care workers, and more. CMS

to monitor and oversee health care organizations' adherence to these laws." Framework for Health Equity at 18; *and see* 88 Fed. Reg. at 27153.

¹⁴ See U.S. Department of Health and Human Services, *Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status* (Oct. 2011), <https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0>.

¹⁵ Nancy Bates et al., National Academies of Sciences, Engineering, and Medicine, *Measuring Sex, Gender Identity, and Sexual Orientation* (2022), <https://nap.nationalacademies.org/read/26424/chapter/1#x>.

¹⁶ 88 Fed. Reg. 27199.



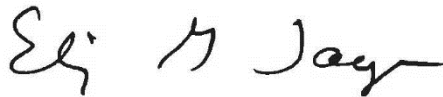
should compile best practices into recommendations and invest in developing further resources to improve data quality.

NHeLP has previously provided detailed recommendations on how CMS should engage in demographic data collection across its programs. We request that our recommendations in comments to the 2023 IPPS/LTCH Proposed Rule are incorporated here by reference.¹⁷

Conclusion

Thank you for the opportunity to comment on this important issue. Our comments include citations to supporting research and documents for the benefit of CMS in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks, and we request that CMS consider these, along with the full text of our comments, part of the formal administrative record on this proposed rule. For more information on our comments, please contact Staff Attorney Charly Gilfoil at gilfoil@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director

¹⁷ Charly Gilfoil, Nat'l Health L. Prog., NHeLP Comment on the 2023 Medicare Inpatient Prospective Payment Systems (IPPS) Rule and Request for Information on Health Care Quality Disparities (Jun. 17, 2022), <https://healthlaw.org/resource/nhelp-comment-on-the-2023-medicare-hospital-inpatient-prospective-payment-systems-ipps-rule-and-request-for-information-on-health-care-quality-disparities/>.

