



American Association on Health & Disability

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AAHD - Dedicated to better health for people with disabilities through health promotion and wellness



LAKESHORE

June 28, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1752-P: Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2022 Rates....Section IX – Proposed Quality Data Reporting Requirements...Subsection B. Closing the Hospital Equity Gap in CMS Hospital Quality Programs-RFI

Submitted through www.regulations.gov comment portal

Dear Administrator Brooks-LaSure:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health

promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

We write to support comments submitted by the **National Health Council (NHC)**, particularly as the Centers for Medicare & Medicaid Services (CMS) works to close the health equity gap in CMS hospital quality programs. AAHD is a NHC member. We value the expertise, leadership, and inclusiveness of the NHC.

Further, we are actively involved in the work of the **National Quality Forum (NQF)**. We assume, encourage, and reinforce CMS utilization of NQF products, reports, and deliberations around equity implications, special population impacts, and methodological considerations. Information and experiences from the NQF work on risk adjustment and Medicare STAR Hospital ratings can be very helpful to CMS in its equity RFI. The NQF current draft risk adjustment report available for public comment has several important observations about disparities and the search for equity.

Improving Demographic Data Collection

For the past two years, three coalitions that we belong to – Consortium for Citizens with Disabilities (CCD); Disability and Rehabilitation Research Coalition (DRRC); and Trust for America's Health (TFAH) led social determinants of health (SDOH) and equity efforts have advocated demographic data collection, analysis, and public sharing: **Language consistently advocated by the three coalitions: "Include in every measure by emphasizing the importance of stratification and cross-tabulation of data by race, ethnicity, disability status, age, sex, sexual orientation, gender identity, race, ethnicity, primary language, rural/urban environment, and service setting for all core measures."**

National Health Council (NHC): "Many of the questions raised by CMS hinge upon the creation of an effective data collection system that captures sufficient data as free from bias as possible and limits the burden on beneficiaries who are asked to report demographic information. In general, the NHC recommends that CMS move as quickly as possible to create a data system that meets the following criteria:"

- NHC: "Engage Patients in the Process – The best way to assure self-reported data is to include the full array of patient characteristics that might drive equity. This engagement needs to directly and actively involve representatives from marginalized communities. This is especially important to ensure self-reporting does not further stigmatize patients or put them at risk. By taking the following

two steps, CMS will improve self-reporting rates and collect more accurate information:”

- “Work with patients/partners to identify which data are associated with health equity; and
- Design the data collection strategy with patients/partners.”
- NHC – “Remove Bias When Possible – As we create a self-reporting system, we must be vigilant to reduce bias in data-collection methods. For example, providing training for intake specialists on asking demographic questions in ways that support accurate answers without stigma.”
- Data Comprehensiveness and Consistency – Modified NHC: The demographic data collected and tracked must capture the full range of data needed in the most comprehensive way possible and be consistent regardless of provider, site, patient type, or health condition.
- Data Interoperability – Modified NHC: Data-collection methods must interface between providers and CMS or other Federal data-collection systems. This will require a targeted federal investment as many specialty providers lag behind other hospital providers.
- NHC: “Educate Patients on Data Usage – CMS should undertake education to help patients understand why and how these data are being collected and how data will be used.”
- NHC: “Build on Existing Resources – CMS should review existing data sets and collection methods and build upon successful approaches before creating new systems.”

NHC: “The NHC supports the CMS proposal to begin collecting a minimum set of demographic data elements by hospitals at the time of admission. Having this consistent approach in place will meet one of the core data requirements outlined above, data comprehensiveness and consistency. However, we recommend three additional data points to consider as part of the minimum set – education level, income level, and location of residence.”

NHC: “To assure nationwide demographic data collection can be successfully implemented, we encourage CMS to improve the data collection infrastructure. Databases should have the ability to crosswalk data with enrollment data. CMS should also assess the ability of the full spectrum of providers to collect, aggregate, and share demographic data responsibly and safely. Where gaps are identified, we need to develop educational tools and support for infrastructure improvements for providers.”

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkross10@comcast.net.

Sincerely,



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National Quality Forum (NQF) Involvement includes: Medicare Hospital Star Ratings Technical Expert Panel (June-November 2019 and September-October 2020); workgroup on Medicaid adult measures (appointed December 2017); Medicaid-CHIP Scorecard Committee (appointed October 2018); Measure Sets and Measurement Systems TEP (June 2019-August 2020); workgroup on persons dually eligible for Medicare and Medicaid (July 2012-July 2017); and NQF population health task force. Clarke was the NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports (2012-2017). Dr. Ross was the 2016-2017 NQF duals workgroup liaison to the NQF clinician workgroup; 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. Clarke is the AAHD Representative to the CMS-AHIP-NQF Core Quality Measures Collaborative (2019-present).

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