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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

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments on the above-referenced Proposed Rule (the IPPS Rule), particularly as the Centers for Medicare & Medicaid Services (CMS) works to close the health equity gap in CMS hospital quality programs.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 140 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

Response to the Equity Request for Information

The NHC greatly appreciates CMS issuing the Request for Information (RFI) on equity and hospital

quality measures. We share CMS' goal to improve health equity and eliminate health disparities and are thus pleased to submit the following comments.

Improving Demographic Data Collection

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:

- Engage Patients in the Process – The best way to ensure 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.
- 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 – 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 disease.
- Data Interoperability – Data-collection methods must interface between providers and CMS or other Federal data-collection systems.
- 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.
- Security and Protecting Patient Privacy - Safeguards must be included to assure data security and privacy protection. This will be a critical part of building the trust for patients willingness to self-report.
- Build on Existing Resources – CMS should review existing data sets and collection methods and build upon successful approaches before creating new systems.

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 we 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.

To assure nationwide demographic data collection can be successfully implemented, we encourage CMS to improve the data collection infrastructure and ensure the least amount of burden for both patients and providers. One primary way to address implementation challenges is to update databases and increase the ability to cross check 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.

Future Potential Stratification of Quality-Measure Results by Race and Ethnicity

The NHC agrees with CMS, “self-reported race and ethnicity data are the gold standard for classifying an individual according to race or ethnicity.” A self-reporting system allows for the most authentic data about people’s identity because it does not force people into boxes defined by someone other than the individual, which can create stigma, poor response rates, and inaccurate information. We encourage CMS to work to achieve an effective self-reporting system as quickly as possible. While the algorithmic approach to estimate race and ethnicity may be functional and could allow us to get information more quickly, it is innately limited. It does not reflect the individual’s experience of their identity and can make flawed assumptions. If CMS does pursue this algorithm, we urge careful consideration of potential shortcomings and to work with data experts with a strong background in health disparities research to address this issue.

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

The NHC supports the creation of a health equity score for hospitals. This score could be a vital resource for hospitals and communities to address health equity. However, to achieve CMS’ goal of using this type of measure to achieve health equity, the score must:

- be built upon solid and consistent data, based on the principles outlined above;
- consider which elements are within the hospital’s control to impact, those a hospital can partner with others to address, and issues in the larger community that a hospital can play a role in addressing but not solely impact; and
- include appropriate safeguards to ensure that a score is a valid, useful tool before developing any payment incentives based on scores. This includes validating the score to assure that it takes into account the issues a hospital can and cannot address as well as the actual needs of patients, as reported by patients and their families.

We appreciate CMS' interest in using this equity score as an opportunity for hospitals to understand better how they are addressing equity and offering ideas to improve their equity score, rather than using this score to drive payment decisions at this point in time.

Once we have confidence in the scoring, it may eventually become appropriate for CMS to put incentives in place to drive hospitals to work with patients and communities to improve their score. However, even if this score is constructed correctly and providers gain experience reporting on it, it will be extremely important to put in place a system to evaluate and minimize unintended consequences of such a score so that hospitals aren't unintentionally perversely incentivized to serve certain patients and not others.

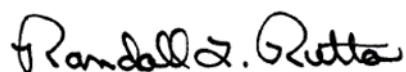
Additional IPPS Comment

In addition, the NHC has previously commented during the National Quality Forum's (NQF's) Measures Under Consideration (MUC) process on the inclusion of a Global Malnutrition Composite Score, which resulted in NQF endorsement. The NHC welcomes the use of cross-cutting quality measures that impact people with one or more chronic conditions and feel that considering the impact of malnutrition is important. Further, food insecurity is a significant social determinant of health for all people, especially for people with chronic conditions and disabilities, which impacts the agency's and broader health care community's shared goals to reduce health disparities. We urge CMS to include a composite malnutrition quality measure in the Inpatient Quality Reporting program.

Conclusion

We appreciate the opportunity to provide additional input on these critical issues. Please do not hesitate to contact Eric Gascho, Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,



Randall L. Rutta
Chief Executive Officer