NATIONAL
HEALTH
LAW PROGRAM

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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: Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements, CMS-1771-P

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 IPPS rule and accompanying Request for Information, which aim to advance health equity through enhanced attention to quality of care.

CMS requested comments on the 2023 Medicare Inpatient Prospective Payment Systems (IPPS) Rule as well as on overarching principles for measuring health care quality disparities in CMS programs. We offer these suggestions for improvement of quality measurement in CMS programs and comments on the proposed Health Equity Attestation for hospitals. We ground our comments in and the five Priorities CMS identifies in its 2022 Framework for Health Equity.[1]

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Request for Information on Overarching Principles for Measuring Health Care Quality Disparities Across CMS Programs

Priority 1 of CMS's Framework for Health Equity 2022-2032 is to "Expand the Collection, Reporting, and Analysis of Standardized Data."[2] Priority 1 and this Request for Information (RFI) both acknowledge that CMS programs must collect patient-reported demographic information to understand gaps in care.[3] As such, initiating collection of patient-reported demographic data should be CMS's first step in implementing new quality measures that address health equity.

CMS's Framework for Health Equity also prioritizes assessing the causes of disparities and addressing inequitable policies to close gaps in care (Priority 2), building capacity of health care organizations to address disparities (Priority 3), advancing culturally and linguistically appropriate care (Priority 4) and improving accessibility (Priority 5).

We offer the following recommendations for applying the Framework for Equity priorities to measure quality disparities across CMS programs:

- **Collect Demographic Data**. In Priority 1 and in this RFI, CMS names the need to collect demographic data on patients' "race, ethnicity, language, gender identity, sex, sexual orientation, and disability status."[4] CMS should immediately ensure this data is collected in all CMS-funded and -supported programs. Without this information, it will be difficult if not impossible for CMS to demonstrate change or improvement in health care quality among any of the historically underserved populations named. As CMS acknowledges, "stratification of quality measures by additional social risk factors and demographics (such as race, ethnicity, language, religion, sexual orientation, and gender identity) or disability, is important to provide more granular

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[1] Centers for Medicare and Medicaid Services, *CMS Framework for Health Equity 2022-2032* 12 (2022), https://www.cms.gov/files/document/cms-framework-health-equity.pdf. [Framework for Health Equity]

[2] Framework for Health Equity at 10.

[3] 87 Fed. Reg. 28108, 28483 (May 10, 2022) ("stratification of quality measures by additional social risk factors and demographics [such as race, ethnicity, language, religion, sexual orientation, and gender identity] or disability, is important to provide more granular information for healthcare providers to act upon").

[4] Framework for Health Equity at 12; *and see* 87 Fed. Reg. at 28482.

information for healthcare providers to act upon."[5] CMS has also acknowledged that stratified quality data can demonstrate whether its programs comply with civil rights requirements or where there are gaps.

- **Standardize Data Practices**. As part of adopting demographic data collection measures, CMS should publish standardized practices for data collection that can be applied across its programs. Standardized data collection 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.[6] The ability to conduct these data comparisons increase organizations' capability to stratify core quality measures and develop initiatives for quality improvement as well as allow appropriate allocation of resources for targeted quality improvement activities at both the agency- and program-level.

- **Use Uniform Language to Collect Data.** Long standing recommendations exist with regard to the language used to collect information on race, ethnicity, primary language, and disability status.[7] HHS's 2011 Data Standards provide a baseline for collection of demographic information on race, ethnicity, primary language, and disability or functional status.[8] HHS should apply these existing standards while conducting additional testing on how to further disaggregate to account for unrepresented populations. New 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

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[5] 87 Fed. Reg. at 28481.

[6] "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 to monitor and oversee health care organizations' adherence to these laws." Framework for Health Equity at 18; 87 Fed. Reg. at 28481.

[7] *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.

[8] *Id.*

settings.[9] 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.

- **Adopt Data Collection Practices While Continuing to Develop Standards.** We are encouraged to see adoption of new demographic data collection practices across the agency, including on the MA/PDP Model Enrollment Form, Medicare Current Beneficiary Survey, and ACO Reach programs.[10] CMS should not delay adopting demographic data collection requirements in its programs until further testing can be completed. As with the MA/PDP Model Enrollment Form, CMS should simultaneously adopt data collection practices and continue to develop new recommendations to improve those practices. CMS should apply existing data collection recommendations, as discussed above, while using the feedback and results to improve data quality. Infrastructure already exists to support demographic data reporting in CMS programs: Many providers and organizations already collect demographic information on patients and program participants,[11] demographic data

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[9] 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.

[10] Information Collection Request, Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request, 87 Fed. Reg. 26759 (May 5, 2022); Information Collection Request, Medicare Current Beneficiary Survey (MCBS), 87 Fed. Reg. 19517 (Apr. 4, 2022); Ctrs. for Medicare and Medicaid Svcs., *ACO REACH*, CMS.gov (May 18, 2022), https://innovation.cms.gov/innovation-models/aco-reach.

[11] *See, e.g.*, Health Resources & Svcs. Admin., *Health Center Program UDS Data, Table 3B: Demographic Characteristics*, data.HRSA.gov (2019), https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=3B&year=2019; Pittman et al., The Commonwealth Fund, *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals* (2004) https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2004_may_who__when__and_how__the_current_state_of_race__ethnicity__and_primary_language_data_collection_in_ho_hasnain_wynia_whowhenhow_726_pdf.pdf (noting that most hospitals collect race and ethnicity data from patients).

collection is broadly supported by professional organizations[12] and stakeholders,[13] and the U.S. Core Data for Interoperability (USCDI) system facilitates collection of race, ethnicity, primary language, SOGISC, and disability demographic data collection in clinical settings.[14]

- **Provide Technical Assistance and infrastructure.** Priority 3 of CMS's Framework calls for increased organizational capacity to evaluate and address health disparities. CMS should invest in its own infrastructure as well as make resources available to support health care organizations in building their capacity. For example, CMS must ensure that its systems enable providers, organizations, and programs to report information on the demographic characteristics of program participants so that CMS can serve as a repository and analyze that data. CMS must also provide resources for the many programs or organizations that have not yet developed capacity to engage in broader demographic data collection. Many resources already exist within CMS and from healthcare quality organizations that provide scientifically-tested recommendations on how to collect demographic information in both the administrative and clinical settings. CMS should compile best practices into recommendations and invest in developing further resources to improve data quality.

- **Prioritize Self-Reported Demographic Information.** CMS should invest first in methods to increase the prevalence of patient-reported demographic information. Strategies and resources to improve self-reported data include training for front-line staff, options to solicit demographic self-reporting on program applications, at

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[12] *See* The Fenway Institute and the University of Chicago, *Helping Your Organization Collect Sexual Orientation and Gender Identity Data* 5 (2019) (noting that the American Medical Association, Institute of Medicine, and the Joint Commission have endorsed SOGI data collection); Geniene Wilson et al., *Implementing Institute of Medicine Recommendations on Collection of Patient Race, Ethnicity, and Language Data in a Community Health Center*, 24 J. Health Care for the Poor and Underserved 875 (2013).

[13] *See* David Baker et al, *Patients' attitudes toward health care providers collecting information about their race and ethnicity*, J. Gen. Intern. Med. (2005), https://pubmed.ncbi.nlm.nih.gov/16191134/; Sean Cahill et al., *Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers*, PLOS One (Sept. 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4157837/pdf/pone.0107104.pdf.

[14] Office of the National Coordinator for Health Information Technology (ONC), *United States Core Data for Interoperability (USCDI)*, HealthIT.gov, https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.

enrollment, and during encounters, and the ability to crosswalk data between programs.[15] Encounter data that is not self-reported, as well as other imputed data, should be used only as a validation measure or back up to self-reported data.

- **Emphasize Privacy Protections.** CMS must ensure that providers, organizations, individuals, and patients are aware of how their data will be used and shared. To address privacy concerns, it must be clear that demographic questions are optional to answer, though they should be mandatory for the program to ask. Patients must be informed about the purpose of demographic information collection – to measure health care quality – as well as the privacy protections in place.[16] We recommend that CMS issue guidance alongside any data collection requirement that clarifies how patient data may be used and what constitutes misuse.

- **Limit Phase-in of Required Reporting**. CMS should balance the need for organizations to make structural adjustments and investments with the need for the public to be aware of health care quality disparities and the timeliness of reporting stratified health care quality measures. A phased-in requirement is only appropriate where health systems and providers will be collecting or analyzing new data, such as SOGISC. CMS should ensure that demographic data collection becomes mandatory for organizations to report as soon as is practicable if a phase-in period is given.

- **Ensure Public Reporting of Data and Analysis**. CMS should require organizations to make data publicly available, and/or publish its data analysis on a public-facing website. Public data enables transparency and allows stakeholder groups to

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[15] See David Blumenthal and Cara James, *A Data Infrastructure for Clinical Trial Diversity*, New England Journal of Medicine 2 (2022), https://www.nejm.org/doi/pdf/10.1056/NEJMp2201433?articleTools=true; 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/; Brittany Brown-Pordgorski et al., *Improving Medicaid Data to Advance Racial and Ethnic Health Equity in the United States*, Health Affairs Forefront (May 24, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220517.465853?utm_medium=social&utm_source=twitter&utm_campaign=forefront&utm_content=brown-podgorski.

[16] David Baker et al, *Patients' attitudes toward health care providers collecting information about their race and ethnicity*, J. Gen. Intern. Med. (2005), https://pubmed.ncbi.nlm.nih.gov/16191134/

understand how CMS and health care organizations use their data.[17] Public reporting also ensures stakeholder access to data and promotes engagement in actions to reduce healthcare disparities.[18] Priority 2 of the Framework for Health Equity reflects CMS's commitment to partner with stakeholders to achieve health equity and close disparities.[19] Without access to this information, all stakeholders, and especially those who are members of underserved communities, cannot meaningfully participate.

- **Promote Accountability**. As discussed further in the below comments, CMS should explore ways to encourage organizations to use the demographic information they collect to address the disparities they identify. Priorities 4 and 5 of the Framework for Health Equity address the use of health care quality information to improve culturally and linguistically appropriate and accessible care. CMS must ensure that any new initiatives or requirements to measure disparities link to efforts within the agency or its programs to address the causes of those disparities.

Hospital Commitment to Health Equity Measure

CMS requested comment on a new attestation-based structural measure, the Hospital Commitment to Health Equity. As part of this new requirement, CMS aims to encourage hospitals to adopt measures to 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."[20] CMS intends for hospitals to make use of existing data by identifying equity gaps, implementing plans to address disparities, and dedicate resources to equity initiatives.[21]

We support the Hospital Commitment to Health Equity Attestation, and we believe it will encourage hospitals to be more accountable for health disparities. We hope that CMS will

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[17] See Farah Kader et al., *Disaggregating Race/Ethnicity Data Categories: Criticisms, Dangers, and Opposing Viewpoints*, Health Affairs, (Mar. 25, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220323.555023.

[18] *Id.*

[19] Framework for Health Equity at 19.

[20] 87 Fed. Reg. at 28493.

[21] *Id*.

continue to develop this measure to include more concrete steps that hospitals must take to improve equity initiatives for specific historically underserved communities, such as the LGBTQI communities, people with disabilities, and immigrant communities.
Our recommendations concern Domains 2 and 3 of the Health Equity Attestation, which involve data collection and analysis. Domain 2 requires hospitals to attest that the hospital collects demographic information, "including race and ethnicity and/or social determinant of health information" on the majority of patients. We believe this attestation requirement is not specific or stringent enough to effectively identify underserved communities in the hospital's patient population.

First, the language of this attestation is not specific enough because it fails to identify other demographic information that hospitals should collect from patients. If CMS expects hospitals 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 hospitals must collect all relevant information from the patient population. CMS should also take care not to conflate sociodemographic characteristics with social determinants of health (SDOH) information. Collecting information on demographic characteristics of patients helps hospitals understand whether they meet civil rights requirements for serving different populations equitably. It also helps hospitals 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 hospital 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 collection requirements before addressing SDOH.

Second, the language of the attestation is not stringent enough because it fails to place concrete requirements on hospitals to improve demographic data collection. Without setting parameters for what demographic information must be collected, the information collected becomes much less comparable from hospital to hospital, and thus much less useful. CMS should specify what demographic information hospitals should collect in the language of the attestation.[22] We also believe that the requirement to collect information from "a majority of

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[22] As stated above, a phase-in requirement may be appropriate for hospitals who do not already collect demographic information on their patients beyond race and ethnicity.

patients" is too lax to meet the goal of health equity. 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 hospitals to collect demographic information at rates much higher than 51%.[23] Instead, we recommend that CMS require attestation to above 75% of patient demographic information reported, plus a plan to improve demographic data collection in hospitals 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 hospitals to stratify performance data and use this information to inform strategic plans to reduce disparities. We strongly support the requirement for hospitals to share this stratified information 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 hospitals 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 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, CMS should change the language of this attestation domain to require hospitals to stratify performance indicators by demographic variables and state which demographic variables hospitals must use when stratifying quality data.

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

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[23] 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/.

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