Who/ What/ When

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period entitled, "*Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) and Proposed Policy Changes and Fiscal Year 2023 Rates*" (proposed rule).[1]

This memorandum summarizes the proposed policy changes relating to maternal health and health equity. Comments to the proposed rule are due no later than June 17, 2022.

Brief Summary

Summary of 2023 IPPS Rule

- Medicare Maternal Health Policies
    - Proposed cesarean Birth eCQM- hospitals can report on C-sections
        - Cesarean sections
    - Proposed severe obstetric complications eCQM
        - Maternal mortality and morbidity
            - Adopted in 2022 to assess if hospitals were participating in state or national Perinatal Quality Improvement Collaborative and implementing patient safety practices or bundles as a part of the QIs
        - Severe maternal morbidity (SMM)
        - Hemorrhage
        - Embolism
        - Severe hypertension
        - Stroke
        - Quality initiatives
        - Opioid use
    - Establish that hospitals must report four calendar quarters of data for each required eCQM:
        - (1) three self-selected eCQMs;
        - (2) the Safe Use of Opioids—Concurrent Prescribing eCQM;
        - (3) the proposed Cesarean Birth eCQM; and
        - (4) the proposed Severe Obstetric Complications eCQM
    - Advance Maternal Health Equity
        - Conditions of Participation (CoP)
        - Request for information
            - Racial and ethnic disparities in maternal health care

[1] Full text of the proposed rule can be found here: https://public-inspection.federalregister.gov/2022-08268.pdf

        - Geographical barriers to care
            - Rural health
- Health Equity
    - Social Determinants of Health (SDOH)
    - Mandate reporting of Hospital Commitment to Health Equity
    - Assess commitment to culture of equity and more equitable health care
        - Equity, Data collection, Analysis, quality improvement efforts, leadership engagement on fostering culture of equity
    - Health Related Social Needs (HRSNs)
        - Individual level adverse social conditions that impact health or healthcare
        - Screening for social drivers of health
        - Screen positive rate for social drivers of health
            - E.g. Food insecurity, housing instability, transportation, utility, interpersonal safety
        - Look at patients 18+ that agree and indicate prevalence to determine personalized patient action plans
- Indian Health Service, Tribal Hospitals, and Puerto Rico Hospitals
    - Uncompensated care
    - Discontinuing disproportionate share hospital Medicare payments
    - New permanent supplemental payment for hospitals
        - Based on difference between new payment amount using new DSH and old payment
- Healthcare quality disparities and healthcare equity in Long term care hospitals
    - Already looking at effect of SDOH on certain health disparities
    - Want to look at how this can be attributed to clinical and non clinical factors
    - How to narrow gaps in outcomes
    - Help LTCH address gaps in facilities
        - Equity for inclusion
            - Health equity summary score
            - Hospital Commitment to Health Equity
            - Reward providers that demonstrate good performance in care to those with social risk factors
        - Request for information
- Social Determinants of Health
    - Reporting of SDOH diagnosis codes to help understand utilization of Medicare Severity Diagnosis Related Groups (MS-DRGs)
    - Quality improvements
    - Screening, documenting, reporting
    - Homelessness on health
- Impact of climate change on healthcare
    - Climate related disasters
    - Climate related emergencies
    - Reducing emissions
    - Preparation for climate impacts
    - Emergency preparedness
    - Tracking progress

- Effect on Community

Detailed Summary

I. Key Proposed Medicare Maternal Health Policies

a. Background on Medicare Maternal Health Policies

Maternal mortality and morbidity in the U.S. are disproportionately high compared to other developed countries and continues to rise; further, data indicate significant racial and ethnic disparities in maternal health care and outcomes. In December 2020, the Department of Health and Human Services (HHS) released its Maternal Action Plan entitled, *Healthy Women, Healthy Pregnancies, Healthy Futures: Action Plan to Improve Maternal Health in America.*[2] As set forth in the Maternal Action Plan and summarized in the IPPS proposed rule, HHS aims to reduce maternal mortality and related disparities over the next five years; reduce severe maternal morbidity (SMM), or unexpected outcomes due to complications at labor and delivery that result in significant consequences to a woman's health, including hemorrhage, embolism, severe hypertension, stroke, and other serious complications; and increase hospital participation in HHS-sponsored maternal health quality improvement initiatives. Additionally, the Maternal Action Plan set a specific target of reducing low-risk C-sections by 25 percent over the next five years. CMS emphasized that a critical focus of its maternal health efforts is reducing existing disparities in maternal health outcomes across race, ethnicity, and geography. CMS intends to promote policies that ensure Americans living in rural areas have access to high quality health care, particularly maternal health care. Americans in rural areas have a nine percent greater probability of experiencing SMM and maternal mortality compared to Americans in urban areas.

Currently, CMS's Hospital Inpatient Quality Reporting (IQR) Program includes the Elective Delivery measure and the Maternal Morbidity Structural measure, which are intended to address maternal health. Pursuant to current Electronic Clinical Quality Measures (eCQM) reporting and submission requirements, hospitals must report on three self-selected eCQMs as well as the Safe Use of Opioids—Concurrent Prescribing eCQM. However, CMS states that neither measure directly addresses factors contributing to maternal mortality rates, such as the high rates of Cesarean sections (C-sections) in the U.S. or maternal morbidity and obstetric complications outcomes. As such, CMS proposes to establish additional measures that address these factors and mandate reporting on these measures.

[2] Full Maternal Action Plan can be found here: https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf

b. Proposed Adoption of Cesarean Birth and Severe Obstetric Complications eCQMs

i. Proposed Cesarean Birth eCQM

CMS proposes to adopt the Cesarean Birth eCQM as one of the eCQMs in the Hospital IQR Program measure set, to be available for hospitals to select for reporting beginning in the Calendar Year (CY) 2023 reporting period and the FY 2025 payment determination. CMS further proposes to mandate reporting of the Cesarean Birth eCQM beginning in the CY 2024 reporting period and the FY 2026 payment determination, except for hospitals without an obstetrics department that do not perform deliveries.

The Cesarean Birth eCQM is intended to facilitate safer patient care by ultimately reducing the number of non-medically indicated C-sections. It also aims to promote adherence to clinical guidelines and improve hospitals' practices for monitoring and care delivery for pregnant and postpartum patients. Overall, this eCQM is intended to further the goal of improving maternal health outcomes in the Hospital IQR program.

ii. Proposed Severe Obstetric Complications eCQM

CMS proposes to adopt the Severe Obstetric Complications eCQM as one of the eCQMs in the Hospital IQR Program measure set, to be available for hospitals to select for reporting beginning in the Calendar Year (CY) 2023 reporting period and the FY 2025 payment determination. CMS further proposes to mandate reporting of the Severe Obstetric Complications eCQM beginning in the CY 2024 reporting period and the FY 2026 payment determination, except for hospitals that do not perform deliveries or do not have an obstetrics department.

The Severe Obstetric Complications eCQM is intended to address high maternal morbidity and mortality rates in the U.S. In particular, this eCQM is intended to facilitate safer patient care by increasing awareness of the risks of obstetric complications; improving adherence to clinical guidelines; and encouraging hospitals' practices for appropriate monitoring and care delivery for pregnant and postpartum patients.

c. Proposed Modifications to eCQM Reporting and Submission Requirements to Include the Cesarean Birth and Severe Obstetric Complications eCQMs

CMS proposes to modify the Hospital IQR Program reporting and submission requirements for eCQMs, beginning in the CY 2024 reporting period and FY 2026 payment determination, to include mandatory reporting of the Cesarean Birth eCQM and the Severe Obstetric Complications eCQM, if finalized. This modification would establish that hospitals must report four calendar quarters of data for each required eCQM: (1) three self-selected eCQMs; (2) the Safe Use of Opioids—Concurrent Prescribing eCQM; (3) the proposed Cesarean Birth eCQM; and (4) the proposed Severe Obstetric Complications eCQM. Overall, this

modification would increase eCQM reporting requirements from four to six required eCQMs. This modification is intended to address maternal health and reduce health disparities related to maternal health.

d. Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

In the FY 2022 IPPS/LTCH PPS final rule, the Hospital IQR Program adopted the Maternal Morbidity Structural measure, designed to assess whether hospitals are: (1) participating in a state or national Perinatal Quality Improvement (QI) Collaborative; and (2) implementing patient safety practices or bundles as part of these QI initiatives.

CMS proposes to establish a maternity care quality hospital designation, which would be publicly reported on CMS's website beginning in Fall 2023. CMS proposes to initially give this designation to hospitals that meet both criteria under the Maternal Morbidity Structural Measure and are currently reporting on the Maternal Morbidity Structural measure in the Hospital IQR Program. Through future rulemaking, CMS intends to expand the designation eligibility components into a more robust scoring methodology that may include other maternal health-related measures as appropriate for the Hospital IQR Program Measure data set, such the Cesarean Birth and Severe Obstetric Complications eCQMs or future maternal health measures adopted in the Hospital IQR Program. CMS requests public comment on the designation name and additional data sources to consider for awarding this designation.

e. Request for Information to Advance Maternal Health Equity

CMS seeks to understand how to address the U.S. maternal health crisis through policies and programs to advance equity for all. Specifically, CMS seeks to explore how to leverage its Conditions of Participation (CoPs), or the health and safety standards that certified providers and suppliers must meet to receive payment from Medicare and Medicaid. CMS also seeks to explore how to improve measures in CMS quality reporting programs to address maternal health inequities. Specifically, CMS requests stakeholders respond to several questions as part of the Request for Information (see Appendix, Section I for more information).

II. Additional Proposed Medicare Policies to Broadly Advance Health Equity

a. Background of Medicare Policies on Advancing Health Equity

CMS states that it is re-envisioning health care quality and patient safety through a health equity lens. CMS intends to advance health equity by designing, implementing, and operationalizing policies and programs that improve health for all patients served by CMS. Specifically, CMS recognizes the significant impact of social determinants of health (SDOH) on health, functioning, and quality-of-life outcomes and risks. CMS states that SDOH can contribute to health disparities and inequities and are important potential predictors of risk for developing certain medical conditions.

b. Proposed Health Equity-Focused Measures in the Hospital IQR Program

i. Proposed Hospital Commitment to Health Equity Measure

CMS identifies hospital leadership as an important factor in promoting better quality care, improved patient outcomes, increased safety, and positive patient experience. CMS proposes to mandate reporting of the Hospital Commitment to Health Equity measure beginning in the CY 2023 reporting period and the FY 2025 payment determination. The measure would assess hospitals' commitment to establishing a culture of equity and delivering more equitable health care. To do so, the measure evaluates hospitals' activities across five key domains: strategic planning that prioritizes equity; improved data collection; effective data analysis; quality improvement efforts; and leadership engagement on fostering a culture of equity. Hospitals would need to attest to their activities in each of these domains.

ii. Proposed Measures to Improve Screening for Social Drivers of Health

CMS identifies health-related social needs (HRSNs), or individual-level, adverse social conditions that negatively impact an individual's health or health care, as significant risk factors associated with worse health. To screen for HSRNs, CMS proposes reporting on two measures: the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure. Both measures aim to identify specific risk factors for inadequate health care access and adverse health outcomes and encourage systematic collection of HRSN data. In particular, these measures would screen and identify HSRNs of food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

The proposed Screening for Social Drivers of Health measure aims to identify patients with HRSNs. To do so, this measure would evaluate the percent of patients, age 18 or older, who are admitted to the hospital and screened for HSRNs. This measure would assess the quality of care furnished by hospitals in inpatient settings, as well as allow health care providers to identify and potentially help address HRSNs during discharge planning to improve patient outcomes in the long term.

The proposed Screen Positive Rate for Social Drivers of Health structural measure would estimate the impact of individual-level HRSNs on an individual's health care utilization, including hospitalizations, to

evaluate quality of care. To do so, this measure would capture the percent of patients, age 18 or older, who screen positive for one or more HRSN. This measure is intended to track the prevalence of each HRSN among patients help hospitals close health equity gaps and develop personalized patient action plans for care, as well as improve data transparency.

CMS states that reporting data from both measures will quantify the levels of HRSNs in communities and provide greater insight into the relationship between HRSNs and health status, health care utilization, and quality of care. CMS proposes voluntary reporting of these measures in the CY 2023 reporting period and mandatory reporting beginning in the CY 2024 reporting period and FY 2026 payment determination.

c. Proposed Supplemental Payment for Indian Health Service, Tribal Hospitals, and Puerto Rico Hospitals

Currently, Medicare disproportionate share hospitals (DSHs) receive Medicare DSH payments for providing uncompensated care for uninsured individuals. These payments are calculated using data across several measures. In this proposed rule, CMS proposes to modify its methodology in calculating DSH and uncompensated care payments. Notably, CMS proposes to discontinue the use of low-income insured days as a proxy for uncompensated care costs in determining DSH payments for IHS, Tribal, and Puerto Rico hospitals. However, CMS recognizes that the Indian Health Services (IHS), Tribal, and Puerto Rico hospitals face unique challenges related to uncompensated care due to structural differences in health care delivery and financing and may be disproportionately impacted by these changes.

In response, CMS proposes to establish a new permanent supplemental payment for these hospitals beginning in FY 2023. This payment would be determined based on the difference between the new uncompensated care payment amount using CMS's new DSH calculation methodology and an estimate of the previous uncompensated care payment amount using proxy data. CMS also proposes to align the new supplemental payment's eligibility and payment processes with existing uncompensated care payment processes.

This supplemental payment would not affect CMS's existing DSH payment or uncompensated care payment methodologies. Additionally, if a hospital is not DSH eligible for a fiscal year, then that hospital is also not eligible for a supplemental payment. Hospitals that do not have FY 2022 proxy data or are new to the Medicare program would also not be eligible for the supplemental payment.

d. Proposed Approaches to Addressing Drivers of Health Care Quality Disparities and Developing Measures of Healthcare Equity in the LTCH QRP

i. *Proposed Approach to Identify Potential Drivers of Quality Disparities*

Currently, long-term care hospitals (LTCHs) must attempt to identify factors they believe are causing performance gaps and health care disparities, and LTCHs are responsible for developing strategies to address them with little guidance. CMS proposes to use already available enrollment, claims, and assessment data to help LTCHs better estimate the impact of various SDOH on health disparities. To do so, CMS proposes to use a regression decomposition method to estimate the extent to which disparities in measure performance between patient populations can be attributed to specific clinical or non-clinical factors. The regression decomposition could also identify and calculate the specific impact of SDOHs and other factors on disparities. CMS proposes to use the results to inform CMS's understanding of how to narrow gaps in health care outcomes. CMS also proposes to share the results with providers to help LTCHs better address the disparities within their facilities with targeted prioritization of certain performance areas.

ii. *Proposed Measures of Equity for Inclusion in LTCH QRP*

CMS is interested in developing measures of health equity that reflect an organization's performance in the LTCH Quality Reporting Program (QRP). CMS has developed measures to assess or promote health equity in other programs, and CMS proposes that some measures could be adapted for use in the LTCH QRP. In particular, CMS proposes to adapt the Health Equity Summary Score (HESS) measure and the proposed Hospital Commitment to Health Equity measure for the LTCH QRP. The HESS measure aims to identify and reward health care providers that demonstrate good performance in providing care to beneficiaries with social risk factors. The measure also aims to discourage providers from not treating potentially high-risk patients. The measure summarizes equity of care delivery by assessing performance and improvement across multiple measures and multiple at-risk patient populations. The proposed Hospital Commitment to Health Equity measure assesses hospitals' commitment to health equity across various measures.

iii. *Request for Information on LTCH QRP Quality Measure Concepts under Consideration for Future Years*

CMS issued a Request for Information regarding these principles and proposed approaches for the LTCH QRP, as well as additional conceptual and measurement priorities for the LTCH QRP to assess organizational commitment to health equity. Specifically, CMS seeks input on the importance, relevance, and applicability of the future quality measures under consideration for the LTCH QRP. In particular, CMS seeks input on measures of health equity, such as measures that assess leadership's investment in advancing equity goals or progress towards achieving equity priorities. (See Appendix, Section III for more information.)

e. Request for Information on Reporting Social Determinants of Health

CMS seeks to better understand how hospitals' reporting of SDOH-related diagnosis codes in Medicare claims may improve CMS's ability to evaluate the severity or complexity of illness or the utilization of resources under the Medicare Severity Diagnosis Related Groups (MS-DRGs). CMS specifically seeks feedback on how to improve the documentation and reporting of diagnosis codes detailing a patient's social and economic circumstances, as well as on how to increase the reliability and validity of the code data. CMS states that reporting SDOH codes in inpatient claims data could enhance quality improvement activities; monitor factors that impact health; and increase insight into existing health inequities. This data could also help CMS develop policies to address health equity.

In particular, CMS requests stakeholders respond to a series of specific questions (see Appendix, Section II for more information). CMS intends to use the feedback in designing future payment policies. Specifically, CMS asks whether it should consider requiring more robust documentation and claims data reporting of SDOH. CMS also requests comment on developing protocols to standardize SDOH screening for all patients and consistently documenting and reporting SDOH, as well as whether these protocols should vary by hospital size and type. CMS further seeks comment on which SDOH codes are most likely to increase hospital inpatient care resource utilization. In particular, CMS proposes understanding the impact of homelessness on health.

f. Additional Requests for Information Relating to Health Equity

In addition to the Requests for Information detailed in this memorandum, CMS issued several additional Requests for Information relating to health equity. See Appendix, Section IV-VII for more information.

* * *

We hope this summary was helpful to you. Please do not hesitate to reach out with any questions.

I. Request for Information to Advance Maternal Health Equity

CMS requests public comment on the following questions:

- CMS outlines best practices in the memorandum to state survey agencies entitled "Evidence-Based Best Practices for Hospitals in Managing Obstetric emergencies and Other Key Contributors to Maternal Health Disparities." What other additional effective best practices or quality improvement initiatives are currently being utilized by hospitals? How else can hospitals improve maternal health outcomes, enhance their quality of maternity care, and reduce maternal health disparities?
- For hospitals that offer inpatient maternity services, how could the CoPs be modified to improve maternity care and address disparities in maternal health outcomes? How would hospitals focus their governance, provider and staff training, and care-delivery activities to effectively demonstrate compliance with CoPs related to improving maternal health outcomes? What types of measurable activities targeting maternal health outcomes might demonstrate a reduction in maternal health care disparities or improvement in maternal health care delivery?
- Are there new requirements that could be established in the CoPs that would require hospitals to address and improve the quality of postpartum care and support provided to patients? How can the CoPs specifically address the need to improve behavioral health services and monitoring offered during prenatal and postpartum care?
- Might the potential additional maternal health-focused CoPs have unintended consequences on providers with certain characteristics (such as being located in a rural area or having low-volume)? Are there barriers or facilitators that would influence rural hospital achievement of a publicly-reported maternal health designation that may not relate directly to the quality of services provided? How might maternal health CoPs impact providers considering whether it is feasible or viable to offer labor and delivery services in their area?
- What services and staff training should hospitals without inpatient maternity services have in place in preparation for patients in labor?
- What are the best practices that hospitals are utilizing to educate and conduct outreach to patients in underserved communities to increase access to timely maternity care?
- What are best practices for hospitals to actively engage with patients and their families, community-based organizations, and others within their local community to obtain information on ways to improve maternity care? Are there barriers to such engagement (if so, what are the barriers)?
- Do hospitals provide prevention-related education and community outreach on the specific maternal health conditions that have the greatest impact on disadvantaged and underserved communities?
- How can hospitals review and monitor aggregate data on the maternal health risks of the patient population that they serve? What data should hospitals review related to the maternal health risks of the patient population they serve? What data sharing best practices are required for

hospitals to share data with external entities, including local and state health departments, community-based organizations, or other health care providers? How can hospitals connect data collected for mothers and their babies after delivery to support research and evaluation of maternal health care after delivery?

- What challenges are there to collecting data on patients with specific maternal health risks? Can these data be stratified by demographics (for example, race and ethnicity)? In addition, how can these data be used in a hospital's quality improvement efforts, and specifically, in their quality assurance and performance improvement (QAPI) program, to improve maternal health outcomes and advance health equity and reduce disparities within their facility? How can maternity care be incorporated into an ongoing QAPI program?
- How do hospitals conduct reviews of maternal deaths that have occurred within the facility?
- Are hospitals currently utilizing community health needs assessments to determine the specific maternity care needs and social determinants of health of the patient population that they serve? For those hospitals that are utilizing community health needs assessments, are there certain best practices or examples of ways that this assessment can be used to reduce disparities in maternal outcomes?
- Do hospitals have reporting relationships or mechanisms among primary care physicians, obstetrician-gynecologists, and other healthcare providers such as nurses and certified nurse midwives, and community-based perinatal workers, such as doulas, for optimal coordination of care?
- Do hospitals have readily available referral relationships and points of contact with community resources or community-based organizations to address additional services that a postpartum patient may need upon discharge? This could include the consideration of behavioral and mental health services or resources to address health-related social needs, such as food insecurity, housing instability, and transportation challenges. If hospitals do not have readily available referral relationships and points of contact within the community, what barriers and facilitators impact hospital relationships with community resources or community-based organizations?
- How do hospitals evaluate their perinatal customer experience? What are best practices that are currently being utilized for getting robust input from patients on their perinatal experience?
- What best practices exist for ensuring systemic racism and biases, including implicit bias, are not perpetuated in maternity care?

II. Request for Information on Reporting Codes for Social Determinants of Health

CMS requests comment on the 96 diagnosis codes that currently describe SDOH.[3] CMS also requests comment on the following questions:

[3] Full list of CMS IPPS diagnosis codes can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS

- How the reporting of certain Z codes – and if so, which Z codes24 - may improve our ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs?
- Whether CMS should require the reporting of certain Z codes – and if so, which ones – to be reported on hospital inpatient claims to strengthen data analysis?
- The additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries.
- Whether codes in category Z59 (Homelessness) have been underreported and if so, why? In particular, we are interested in hearing the perspectives of large urban hospitals, rural hospitals, and other hospital types in regard to their experience. We also seek comments on how factors such as hospital size and type might impact a hospital's ability to develop standardized consistent protocols to better screen, document and report homelessness.

III. Request for Information on LTCH QRP Quality Measure Concepts under Consideration for Future Years

CMS requests comments on the following topics:

- *Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs* –
  - The use of the within- and between-hospital disparity methods in LTCHs to present stratified measure results;
  - The use of decomposition approaches to explain possible causes of measure performance disparities; and
  - Alternative methods to identify disparities and the drivers of disparities.
- *Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting* –
  - Principles to consider for prioritization of health equity measures and measures for disparity reporting, including prioritizing stratification for validated clinical quality measures, those measures with established disparities in care, measures that have adequate sample size and representation among healthcare providers and outcomes, and measures of appropriate access and care.
- *Principles for Social Risk Factor and Demographic Data Selection and Use* –
  - Principles to be considered for the selection of SRFs and demographic data for use in collecting disparity data including the importance of expanding variables used in measure stratification to consider a wide range of SRFs, demographic variables, and other markers of historic disadvantage. In the absence of patient-reported data, CMS will consider use of administrative data, area-based indicators, and imputed variables as appropriate.
- *Identification of Meaningful Performance Differences* –
  - Ways that meaningful difference in disparity results should be considered.
- *Guiding Principles for Reporting Disparity Measures* –
  - Guiding principles for the use and application of the results of disparity measurement.
- *Measures Related to Health Equity* –

- The usefulness of a HESS score for LTCHs, both in terms of provider actionability to improve health equity, and in terms of whether this information would support Care Compare website users in making informed healthcare decisions.
- The potential for a structural measure assessing an LTCH's commitment to health equity, the specific domains that should be captured, and options for reporting these data in a manner that would minimize burden.
- Options to collect facility-level information that could be used to support the calculation of a structural measure of health equity.
- Other options for measures that address health equity.
-

Notably, CMS will not respond to specific comments submitted in response to this Request for Information in the FY 2023 IPPS/LTCH PPS final rule. However, CMS states that it will consider all stakeholder input when developing future regulatory proposals or policy guidance.

IV. Request for Information on Inclusion of Health Equity Performance in the Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program currently groups hospitals into peer groups based on their proportion of dually eligible beneficiaries for Medicare and Medicaid, which is a widely used and accepted proxy for a beneficiary's financial risk.

CMS seeks comment on approaches to update the Hospital Readmissions Reduction Program by including measures of hospitals' performance for socially at-risk populations across readmissions, treatment, or other measures. CMS intends to encourage providers to improve health equity and reduce health care disparities without disincentivizing or disproportionately penalizing hospitals that treat socially at-risk beneficiaries.

In particular, CMS is seeking comment on data variables associated with, or measures of, social risk and beneficiary demographics. CMS is also seeking comment on potentially broadening the definition of dual eligibility to include beneficiaries enrolled in a Medicare Savings Program or the Medicare Part D Low Income Subsidy. CMS requests that comments include information about publicly available data sources and methodologies used to calculate social risk.

V. Request for Information: Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity

CMS seeks comment on the following:

- How hospitals, nursing homes, hospices, home health agencies, and other providers can better prepare for the harmful impacts of climate change on their patients, and how CMS can support them in doing so.
- What the U.S. Department of Health and Human Services (HHS) and CMS can do to support hospitals, nursing homes, hospices, home health agencies, and other providers in more effectively:
    - (a) determining likely climate impacts (that is, both immediate impacts associated with climate-related disasters and long-term chronic disease implications of climate change) on their patients, residents and consumers so that they can develop plans to mitigate those impacts;
    - (b) understanding exceptional threats that climate-related emergencies (for example, storms, floods, extreme heat, wildfires) present to continuous facility operations (including potential disruptions in patient services associated with catastrophic events as a result of power loss, limited transportation, evacuation challenges, etc.) so they can better address those; and
    - (c) understanding how to take action on reducing their emissions and tracking their progress in this regard.

CMS also requests public comments on the following topics:

- The availability of information, such as analyses of climate change impacts (whether developed internally or collected from outside sources), that hospitals, nursing homes, hospices, home health agencies, and other providers can access to better understand climate threats to their patients, community, and staff.
- The degree to which different provider types currently complete comprehensive climate change risk assessments to better understand risks to their patient populations and the costs incurred due to catastrophic climate events and climate-related chronic disease.
- The degree to which facility efforts to prepare for climate impacts overlap with the work they already complete to meet CMS's Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, and the degree to which related CMS requirements sufficiently (or insufficiently) prepare them for the threats created by climate change and help or hinder these efforts.
- The degree to which hospitals, nursing homes, hospices, home health agencies, and other providers measure and share performance associated with their response to climate-related catastrophes (for example, measuring harm to vulnerable populations as a result of such events, or extent of disruption in service).
- The nature of facility plans for assisting the community and patients to prepare for and recover from climate-related events, as well as the nature of plans for evacuating patients with differing needs, including those with disabilities.
- The degree to which climate change, and climate change linked to health equity, is publicly addressed in strategic plans and objectives in your facility or system, and the degree to which hospital leadership regularly reviews progress on goals related to climate preparedness and mitigation and invests in health professional training on this topic.
- Whether health systems and facilities have time-bound, public aims for GHG emissions reduction, and, if yes, whether those aims relate to direct facility emissions, emissions associated with purchased energy, emissions associated with supply chain or some combination of these.

- The measures that health systems and facilities use to track their progress on GHG emissions reduction and use of renewable energy, as well as the data collection tools that they may use support this tracking.
- The tools and supports that health systems and facilities most heavily rely on to support their efforts to reduce GHG emissions.
- How HHS and CMS can support hospitals, nursing homes, hospices, home health agencies, and other providers in their efforts to more fully prepare for climate change's catastrophic and chronic impacts on their operations and the people they serve, as well as what incentives (for example, recognition, payment, reporting) might assist them in taking more action on climate readiness and emissions reduction.
- Whether accrediting organizations assess facilities' readiness for climate-related threats and their efforts to reduce GHG emissions.

VI. Request for Information: Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs

CMS requests comments on key considerations in five specific areas:

- Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Programs – identifying potential
- approaches for measuring healthcare disparities through measure stratification in CMS quality reporting programs;
- Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting Across CMS Quality Reporting Programs – describing considerations that could inform the selection of healthcare quality measures to prioritize for stratification;
- Principles for Social Risk Factor and Demographic Data Selection and Use – describing several types of social risk factor and demographic data that could be used in stratifying measures for healthcare disparity measurement;
- Identification of Meaningful Performance Differences – describing several strategies for identifying meaningful differences in performance when measure results are stratified; and
- Guiding Principles for Reporting Disparity Results – describing considerations CMS could take into account in determining how quality programs will report measure results stratified by social risk factors and demographic variables to healthcare providers, as well as the ways different reporting strategies could hold healthcare providers accountable for identified disparities.

CMS also invites stakeholders to submit additional comments about disparity measurement or stratification guidelines suitable for overarching consideration across CMS quality programs.

CMS further requests comments on the following topics:

- Overarching goals for measuring disparity that should be considered across CMS quality programs, including the importance of pairing stratified results with overall measure quality programs, including the importance of pairing stratified results with overall measurer and comparison of care for a subgroup of patients across healthcare providers.

- Principles to consider for prioritization of measures for disparity reporting, including prioritizing stratification for: valid clinical quality measures; measures with established disparities in care; measures that have adequate sample size and representation among healthcare providers; and, measures that consider access and appropriateness of care.
- Principles to be considered for the selection of social risk factors and demographic data for use measuring disparities, include the importance of identifying new social risk factor and demographic variables to use to stratify measures.
- The use of imputed and area-based social risk and demographic indicators for measure stratification when patient reported data are unavailable.
- Preferred ways that meaningful differences in disparity results can be identified or should be considered.
- Guiding principles for the use and application of the results of disparity measurement such as providing confidential reporting initially.

VII. Request for Information: Overarching Principles for Measuring Equity and Healthcare Quality Disparities across CMS Quality Programs

a. Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification across CMS Quality Programs

CMS requests feedback on several systematic principles under consideration to better prioritize measures for disparity reporting across programs:

- Programs may consider stratification, among existing *clinical quality measures for further disparity reporting*, prioritizing recognized measures which have met industry standards for measure reliability and validity.
- Programs may consider measures for prioritization that show *evidence that a treatment or outcome being measured is affected by underlying healthcare disparities* for a specific social or demographic factor. Literature related to the measure or outcome should be reviewed to identify disparities related to the treatment or outcome, and should carefully consider both SRFs and patient demographics. In addition, analysis of Medicare-specific data should be done in order to demonstrate evidence of disparity in care for some or most healthcare providers that treat Medicare patients.
- Programs may consider establishing *statistical reliability and representation standards* (for example, the percent of patients with a SRF included in reporting facilities) prior to reporting results. They may also consider prioritizing measures that reflect performance on greater numbers of patients to ensure that the reported results of the disparity calculation are reliable and representative.

- After completing stratification, programs may consider prioritizing the *reporting of measures that show differences in measure performance* between subgroups across healthcare providers.

b. Identifying Meaningful Performance Differences

CMS also requests feedback on the benefits and limitations of the possible reporting approaches described below:

- *Statistical approaches* could be used to reliably group results, such as using confidence intervals, creating cut points based on standard deviations, or using a clustering algorithm.
- Programs could use a *ranked ordering and percentile approach*, ordering providers in a ranked system based on their performance on disparity measures to quickly allow them to compare their performance to other similar providers.
- LTCHs could be categorized into groups based on their performance using *defined thresholds*, such as fixed intervals of results of disparity measures, indicating different levels of performance.
- *Benchmarking*, or comparing individual results to a state or national average, is another potential reporting strategy.
- Finally, a ranking system is not appropriate for all programs and health care settings, and some programs may *only report disparity results*.