AMERICA'S ESSENTIAL HOSPITALS

March 29, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Re: CMS Equity Measurement

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the leadership of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) in prioritizing health equity through cross-agency initiatives to identify disparities and close gaps in care quality. Essential hospitals are committed to addressing health equity and support the creation of policies that drive accountability and transparency. We encourage CMS to be thoughtful in its approach to structuring, collecting, and reporting equity data for the purposes of improving health outcomes.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including underrepresented people and underserved communities. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.[1]

Members of America's Essential Hospitals not only shoulder a disproportionate share of the nation's uncompensated care, but they also are at the forefront of cutting-edge medical research and innovation that continues to improve the quality of care received by all patients. And through their work with underserved populations, essential hospitals have uniquely focused on the needs and challenges of patient populations that face the greatest disparities and barriers to receiving quality care, including low-income populations and racial, ethnic, sexual orientation, and gender identity minority groups. The barriers these patients face often are compounded by other social issues, such as food and housing insecurity and transportation barriers. This commitment to promote equity of care and eliminate disparities puts our members in a unique position within the health care delivery system.

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed March 8, 2022.

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We applaud the administration's emphasis on health equity and efforts across agencies to evaluate appropriate initiatives to reduce health disparities. America's Essential Hospitals and its members are committed to tackling these important topics. We provide the following comments for consideration as CMS continues its work to develop policies that promote equity and support the health of all beneficiaries. This includes the development of equity measures for the Medicare or Medicaid programs.

1. CMS should promote standardized, culturally appropriate collection of patient race and ethnicity data and information on social risk factors to identify disparities and target activities to achieve equity, as well as addressing electronic health record (EHR) challenges.

The unconscionable rates of COVID-19 infections and deaths among Black, Latino, and other people of color have emphasized the need for collection and analysis of data by patients' race, ethnicity, and preferred spoken and written language. Data are critical to understanding the unique challenges and disparities patients face. When equipped with proper data, essential hospitals can innovate and collaborate with community partners to mitigate health disparities, improve outcomes, and reduce health care costs. Standardized and updated definitions are needed to ensure completeness, accuracy, and uniformity of data and to help identify disparities and target activities to achieve equity.

a. CMS should work to ensure the uniform collection of race and ethnicity data that are accurate, reliable, and valid.

America's Essential Hospitals appreciates CMS' work to ensure transparency on disparities in health care and improve care for patients with social risk factors. In 2019, people of color constituted more than half of essential hospitals' discharges.[2] However, the lack of consistently available and reliable race and ethnicity data in health care continues to be a barrier to measurement. Several components have been noted to improve the collection of race and ethnicity data at an organization. These include having leadership buy-in and support, streamlining data collection process and structure, standardizing staff education, engaging patients in direct communication, and measuring and monitoring.[3]

CMS currently does not consistently collect self-reported race and ethnicity information for the Medicare program; the agency largely relies on Social Security Administration data for these data.[4] The lack of consistent standards related to data collection, in particular on marginalized population subgroups, is a challenge for adequately collecting, reporting, and tracking information on health disparities. The Office of Management and Budget's (OMB's) governmentwide standards, revised in 1997, include five categories for race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and white. The OMB minimum categories for ethnicity include Hispanic or Latino and Not

[2] Ibid.
[3] Shapiro A, Meyer D, Riley L, et al. Building the Foundations for Equitable Care. *NEJM Catalyst*. September 1, 2021. https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0256. Accessed March 8, 2022.
[4] Filice C, Joynt K. Examining Race and Ethnicity Information in Medicare Administrative Data. *Medical Care*. 2017; e170–e176. https://journals.lww.com/lww-medicalcare/Abstract/2017/12000/Examining_Race_and_Ethnicity_Information_in.26.aspx. Accessed March 10, 2022.

Hispanic or Latino.[5,6] Finalized in 2011, HHS data standards for race and ethnicity include additional granularity under the OMB standard categories. For example, the HHS race data standard includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian which roll-up to the broader Asian category of the OMB standard. Likewise, the HHS ethnicity data category provides more granularity for respondents who are Hispanic, Latino, or Spanish origin.[7] In addition to OMB and HHS standards, the U.S. Census Bureau also collects information on race and ethnicity. Improvements to the 2020 Census Hispanic origin questions include revision of the example groups to represent the largest Hispanic origin population groups.[8] There is a need for standardization and alignment of federal guidance on racial and ethnic categories to ensure the consistent collection of self-reported data across providers. Further, the U.S. population has continued to become more racially and ethnically diverse. **Revisions to the OMB standard, aligned with HHS' additional granularity, might improve the quality of race and ethnicity information collected and presented by federal agencies.**

Additionally, there is potential benefit in standardizing when data is collected (e.g., upon admission or patient registration), as well as providing consistency in how hospitals respond to patient concerns about the ways in which that data will be used.[9] For example, hospitals could provide standardized scripting to assist hospital registration staff in explaining the reasons for collecting these data or develop tools and processes that allow patients to accurately self-report their identity. Collecting this sensitive information should build trust—not fear—between patient and provider. **We encourage CMS to raise awareness and develop resources to support data collection and sharing, with clear information about how the agency or others will use the data.**

b. CMS should ensure equity measurement addresses challenges related to incorporation of social determinants of health (SDOH) data into EHRs; resources needed to support data collection; and complexities of connecting screening and referral to social services.

America's Essential Hospitals supports efforts to improve the collection of SDOH information to better understand how these factors impact outcomes. It is critical essential hospitals have the resources and infrastructure to support robust data collection. Essential hospitals employ a variety of tools and approaches for the resource-intensive endeavor of screening for social needs and the process of referral. Hospital staff must undergo training and dedicate time to performing screenings, and information technology systems might require updates to

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[5] Office of Management and Budget. Directive No.15 – Race and Ethnic Standards for Federal Statistics and Administrative Reporting. 1977. https://wonder.cdc.gov/wonder/help/populations/bridged-race/directive15.html. Accessed March 8, 2022.
[6] Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. 1997. https://obamawhitehouse.archives.gov/omb/fedreg_1997standards. Accessed March 8, 2022.
[7] HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. U.S. Department of Health and Human Services Office of Minority Health. October 30, 2011. https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0. Accessed March 9, 2022.
[8] Improvements to the 2020 Census Race and Hispanic Origin Question Designs, Data Processing, and Coding Procedures. United States Census Bureau. August 3, 2021. https://www.census.gov/newsroom/blogs/random-samplings/2021/08/improvements-to-2020-census-race-hispanic-origin-question-designs.html. Accessed March 10, 2022.
[9] Pittman MA, Pierce D, and Hasnain-Wynia R. Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals. The Commonwealth Fund. May 1, 2004. https://www.commonwealthfund.org/publications/fund-reports/2004/may/who-when-and-how-current-state-race-ethnicity-and-primary. Accessed March 8, 2022.

incorporate new screening tools and referral systems. Further, hospitals must build and maintain referral relationships with an array of local organizations.

Regardless of the method of collection—screening or self-reporting—patient medical records must incorporate SDOH data for providers to use in clinical decision-making or referral to community-based services. However, interoperability and a lack of standard codes for SDOH data make this difficult. Providers can use Z codes—a subset of ICD-10 codes—to capture SDOH information for Medicare fee-for-service (FFS) beneficiaries. However, an analysis from CMS found less than 2 percent of Medicare FFS beneficiaries in 2017 had a Z code associated with a claim.[10] We support the collection of SDOH data in a standardized manner to improve the underlying data used in equity measurement.

While EHR vendors offer various optimization services to boost care coordination by allowing providers to outline SDOH in patient records (similar to vital signs or laboratory results), there is still variation in how providers document these data in their EHR systems. Further, vendors' competing care coordination solutions further fragmented our nation's health care industry. For example, health care organizations that serve the same community but operate on different EHR systems or use different care coordination software might not be able to exchange data as easily on their shared patient populations. **CMS should support standardized collection and reporting of SDOH data across platforms to ensure interoperable electronic exchange and aggregation.**

Further, the connection between screening and referral to social services is key in addressing SDOH and advancing equity measurement. Hospitals use referral platforms to assist in connecting patients to community partners and tracking referral outcomes. This requires investment not only in sharing technology with community partners but also in training their staff and developing effective workflows for monitoring and responding to incoming referrals.[11] Before being held accountable through equity measures, hospitals need a consistent way to refer a person to an organization that can intervene and to know whether and when that intervention is provided.[12] **We urge CMS to examine the connections between screening, resource identification, referral between health and social services, and outcomes.**

Challenges also exist in collecting social needs data, including the sensitive nature of these conversations, a lack of alignment across screening tools, and a need to link data from medical and nonmedical sources (i.e., community services). Further, users of referral technology often span the health care spectrum and include navigators, social workers, community health workers, volunteers, care coordinators, and nurses, based largely on the needs and organizational workflows of each institution. **We urge CMS to promote best practices that improve the transfer of information across a referral network that links medical and nonmedical sources, including platform integration with EHRs.**

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[10] Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017. CMS Office of Minority Health. January 2020. https://www.cms.gov/files/document/cms-omh-january2020-zcode-datahighlightpdf.pdf. Accessed March 24, 2022.

[11] Cartier Y, Fichtenberg C, Gottlieb LM. Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters. *Health Affairs*. April 2020. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01588. Accessed March 24, 2022.

[12] Wortman Z, Cuervo Tilson E, Krauthamer Cohen M. Buying Health For North Carolinians: Addressing Nonmedical Drivers Of Health At Scale. *Health Affairs*. April 2020. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01583. Accessed March 24, 2022.

As use of the technology spreads, rigorous process and outcome evaluations will be needed to ensure that platform design and implementation are tailored to generate health gains and system efficiencies, including platform integration with EHRs.

2. CMS should allow providers to focus their equity strategies on unique areas of need in their communities, which might evolve over time.

The Centers for Disease Control and Prevention (CDC) defines health equity as "when all members of society enjoy a fair and just opportunity to be as healthy as possible." Further, the agency states "[p]ublic health policies and programs centered around the specific needs of communities can promote health equity."[13] Essential hospitals understand factors driving heath equity go well beyond the delivery of hospital care and are highly dependent on the characteristics and needs of a hospital's patient population and the community it serves.

Our members recognize the effect of upstream social factors and are working to mitigate social determinants of poor health by screening patients for food insecurity, housing instability, and other social needs and referring these patients to community resources. By identifying the needs of their patient population, essential hospitals work tirelessly—and with limited resources—to eliminate disparities and provide cutting-edge care to all, regardless of income or insurance status.

In many cases, an approach to equity must be tailored to a community's needs. For example, in South Carolina, leaders at an essential hospital committed to investing in community health care in the form of rebuilding housing around its main campus; this partnership seeks to improve health outcomes in an area plagued with high rates of obesity, cancer, and heart disease, along with high crime. Similarly, recognizing the need for a comprehensive solution to address the increased gun violence that plagues the communities in the Chicago area, an essential hospital in 2019 joined with another medical system and community partners to form a collaborative that provides grants for summer youth programs.

There is risk in prescribing standards or metrics of equity without knowing the unique and evolving needs of the community in which the metrics would be applied. A one-size-fits-all approach to equity measurement, with scores across hospitals indicating commitment to equity, will fail to capture a hospital's efforts, informed by the community, to address their specific needs, such as transportation, food, or housing. In many ways, the community must dictate the unique standards that will lead to better outcomes. Further, just as hospitals continue to adapt and respond to an evolving health care payment and delivery landscape, we expect an evolution of community-level needs. Being responsive to the needs of those you seek to serve can itself represent a strong commitment to equity. And, a hospital's best practices ultimately will be tailored to the needs of their community and based on regional data, when applicable. **We urge CMS to be flexible in its approach to equity measurement to account for a variety of activities that not only demonstrate a commitment to equity but also address the varying needs of each community.**

Additionally, equity measures should account for circumstances outside a hospital's control, such as a lack of community-based social services in a particular geographic area that might limit a hospital's ability to meet the needs of a patient. We encourage CMS to work with stakeholders to identify barriers that might make it more difficult to connect patients to needed services and mitigate any unintended consequences that these challenges could have on

[13] *Health Equity Considerations and Racial and Ethnic Minority Groups*. Centers for Disease Control and Prevention. April 19, 2021. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html. Accessed March 9, 2022.

measures of equity.

3. CMS should ensure equity measurement is evidence-based and gradually implemented with testing and monitoring, along with feedback from essential hospitals and the communities they serve.

As a country, we must remain committed to eliminating disparities in health and health care. The broader community, including governmental entities, health care providers, social service and community organizations, academic institutions, employer groups, and all individuals, must be involved in developing and implementing solutions to effectively eliminate disparities. We also must recognize systemic factors that create and reinforce disparities while examining which factors can and should be addressed by providers through evidence-based interventions.

a. CMS should further examine evidence-based practices that can be replicated and shared, as appropriate, among providers to improve outcomes and equity.

Hospitals should be armed with as much meaningful information as possible to inform their decision-making and quality improvement efforts. Over the years, hospitals nationwide have had success in addressing rates of health care–associated infections through development of multifaceted infection prevention programs. While these programs vary between organizations, their critical functions often fall into specific categories, including:

- managing data and information (e.g. surveillance, reporting of infections);
- developing and implementing policies to prevent or minimize infection (e.g., isolation precaution policies);
- intervening to prevent disease transmission (e.g., outbreak investigation and control); and
- collaborating with other programs to achieve common goals (e.g. environmental health and safety, microbiology laboratory).[14]

Providers are expected to adhere to evidence-based care guidelines and demonstrate that their patients have experienced optimal outcomes as a result. As a field, there is a lack of evidence linking health equity activities and improved outcomes. Without this evidence base, the foundation of equity measurement is weak and providers are left to build on a patchwork of solutions or interventions to demonstrate improved outcomes.

A report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) on developing health equity measures lists criteria for evaluating measurement approaches. Among the criteria is that the approach be based on available evidence of the relationship between the social risk factor and outcome. Further, the measurement approach should be reliable in that it is able to distinguish performance between providers or programs and guard against disincentivizing resources for any beneficiaries.[15] **We urge CMS to incorporate evidence-based equity interventions or standards of care that are tied to improved outcomes as an initial step in developing meaningful equity measures for its programs.**

At a minimum, providers and policymakers would benefit from guidance on the appropriate terminology and distinctions between SDOH, social risk factors, and social needs. Agreement on common language to guide activities aimed at addressing these often, interconnected

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[14] Torriani F, Taplitz R. History of infection prevention and control. *Infectious Diseases*. 2010;76–85. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7151947/. Accessed March 9, 2022.
[15] Developing Health Equity Measures. ASPE Report. May 2021. https://aspe.hhs.gov/sites/default/files/private/pdf/265566/developing-health-equity-measures.pdf. Accessed March 9, 2022.

concepts would likely enable partnerships across sectors.[16] Further, this shared understanding and use of terminology provides the standardization that is needed to support equity measurement. As noted in the ASPE report, "[a]ddressing health equity issues requires implementing interventions to address the drivers of outcome differences and monitoring outcomes to determine whether equity improved."[17] Additional research is needed to assess the effect of social services on health outcomes and to identify which policies or programs addressing SDOH have been effective in improving health or health behaviors.[18] **Innovative and novel approaches, as well as evidence-based best practices for addressing disparities, should be embraced, practiced, supported, and shared.** Further, investments should be made in conducting and translating research into successful practices, replicating such practices, and disseminating findings.

b. CMS should allow providers and patients time to fully learn and understand new measures of equity and to implement processes for data collection, reporting, and analyses. The agency should provide confidential reports of equity data to hospitals before publicly reporting.

Essential hospitals are committed to transparency and accuracy in quality measurement. Our members understand the importance of quality improvement reporting, especially with increasing demands for accountability, movement toward value-based purchasing, and growing consumer engagement. Our members also know the importance of sound data to reduce disparities in care, and they lead efforts to close gaps in quality for racial and ethnic minorities.

Building the infrastructure to leverage equity data (e.g., stratification to identify inequities) can be substantial. Further, all health care professionals and others working in the delivery system must be trained on collecting accurate socioeconomic and sociodemographic data and educating patients on why such data are being collected. **Providers need time to become familiar with the data and the data collection processes, as well as how equity data might help set priorities and drive outcomes.** The magnitude of the issue—health equity—demands a thoughtful, phased approach that accommodates providers at various stages along the path to health equity.

For essential hospitals, already operating on margins well below that of other hospitals, it is critical the introduction of equity measures does not penalize the very hospitals that are striving to deliver equitable care and needed resources to marginalized and underserved populations. Penalizing essential hospitals that treat populations with significant social barriers to care by not factoring in these barriers when assessing performance creates a vicious cycle that reduces the already scarce resources these hospitals have to treat vulnerable populations. In developing equity measures, we urge CMS to provide special recognition and consideration to providers who disproportionately deliver care to disadvantaged populations in areas of high social vulnerability suffering the impacts of long-standing inequities.

Additionally, essential hospital leaders deeply understand the characteristics of the populations their hospitals treat and the challenges they face and are the best audience to view and interpret

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[16] Green K and Zook M, When Talking About Social Determinants, Precision Matters. *Health Affairs*. October 29, 2019. https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/. Accessed March 9, 2022.
[17] Developing Health Equity Measures. ASPE. May 2021. https://aspe.hhs.gov/sites/default/files/private/pdf/265566/developing-health-equity-measures.pdf. Accessed March 9, 2022.
[18] Building the Evidence Base for Social Determinants of Health Interventions. ASPE. May 2021. https://aspe.hhs.gov/sites/default/files/documents/e400d2ae6a6790287c5176e36fe47040/PR-A1010-1_final.pdf. Accessed March 9, 2022.

equity data. Publicly posting equity measures with methods that introduce potential variability and inaccuracy could lead to consumer confusion and would be a misrepresentation of care quality. Further, it is unknown at this point what the data will show; CMS and providers need time to ensure the validity, accuracy and meaningfulness of this data before it is publicly reported or used in CMS payment programs. **We strongly urge CMS to refrain from publicly posting equity measure results until hospitals become familiar with the collection and reporting of these types of measures and can review the data.**

As CMS looks to close the equity gap by leveraging quality measures, the above outlined challenges and opportunities ensure underrepresented people and underserved communities are prioritized in efforts to measure equity. America's Essential Hospitals and its members look forward to continued engagement and partnership on this topic.

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If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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