



NATIONAL HEALTH COUNCIL

June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

RE: CMS-1771-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide input to the Centers for Medicare and Medicaid Services' (CMS') "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates (IPPS)."

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 145 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

Of particular importance to the NHC are questions CMS raised regarding increasing health equity. The NHC is fully committed to mobilizing our members to advance health equity from the patient perspective. The NHC has historically engaged in health equity advocacy through much of the work that we do with our members. The COVID-19 pandemic and the national dialogue on equity that emerged in 2020 strengthened our resolve to focus on a more coordinated, mission-focused approach to our health equity work. We undertook an 18-month-long effort to identify where equity gaps exist in the health ecosystem. Through engagement with leaders in the health and other sectors, we found consensus on defining the problem and areas of prioritization, reflected in the

recommendations of our report, [Access, Affordability and Quality: A Patient-Focused Blueprint for Real Health Equity](#). The four core areas of focus are:

- [Equitable Access to Affordable and Comprehensive Health Insurance Coverage](#);
- [Access to Care](#);
- [Social Determinants of Health](#); and
- [Medical Innovation](#).

We commend CMS for the continued focus on health equity that is included in the 2023 IPPS.

We offer comments on the following questions raised in the IPPS.

Improving Demographic Data Collection

We support CMS' efforts to develop future policies around the use of measure stratification as one quality measurement tool to address health care disparities and advance health equity across quality programs. Many of the questions raised by CMS in the request for comments hinge upon the creation of an effective data collection system that captures sufficient data as free from bias as possible and limits the burden on beneficiaries who are asked to report demographic information. In general, the NHC recommends that CMS consider the following principles when considering data stratification and prioritization:

- **Engage Patients** – The best way to ensure quality data is to include the full array of patient characteristics that might drive equity. Engaging patients in the process of determining which data is collected and how it is collected will result in better outcomes. This engagement needs to directly and actively involve representatives from marginalized communities. This is especially important to ensure data collection does not further stigmatize patients or put them at risk. By taking the following two steps, CMS will collect more accurate information:
 - Work with patients/partners to identify which data are associated with health equity; and
 - Design the data collection strategy with patients/partners.
- **Data Comprehensiveness and Consistency** – The demographic data collected and tracked must capture the full range of data needed in the most comprehensive way possible and be consistent regardless of provider, site, patient type, or disease.
- **Data Interoperability** – Data-collection methods must interface between providers and CMS or other Federal data-collection systems.
- **Educate Patients and Providers on Data Usage** – CMS should undertake education to help patients and providers understand why and how these data are being collected and how data will be used.

Social Determinants of Health Diagnosis Codes

As previously stated, the NHC has led an effort to solicit policy recommendations from the patient perspective to address health equity. Included in our recommendations on access to coverage and social determinants of health¹ is an alignment with CMS on the need to focus on social determinants of health. Our findings support that the focus on partnerships and flexibility to address social determinants of health needs is the right approach, as is the need to better collect and share data on social needs.

We agree that proposed reporting of “z codes” in claims data could offer increased granularity and improve CMS’ ability to direct equity initiatives to areas of greatest need. However, we are concerned that the use of these codes is often underutilized and misunderstood by providers. We urge CMS to undertake an education and outreach campaign to increase provider awareness of the codes and their appropriate use, as well as to identify any barriers to using the codes. Part of this effort is clear communication about why these codes are critical to resources decisions and how usage of them will improve outcomes and equity.

Finally, we know that there are efforts underway to create social determinants of health quality measures. We encourage CMS to consider utilizing measures such as the Physicians Foundation’s social determinants of health measure recommendations² and National Committee for Quality Assurance’s (NCQA) social determinants of health measures³ into your federal quality efforts.

Inclusion of the Global Malnutrition Composite Score in the Hospital Inpatient Quality Reporting (IQR) Program

The NHC, along with many of our member organizations, have been advocating for inclusion of the Global Malnutrition Composite Score in the IQR program. We are pleased that CMS has proposed to include the score in the 2023 IPPS. Malnutrition affects more than 30% of hospitalized patients,⁴ but only 9% of discharged patients had a coded malnutrition diagnosis in 2018⁵. As CMS makes clear through the IPPS, it is critical that we capture this information to better direct resources, improve outcomes, and increase equity.

¹ <https://nationalhealthcouncil.org/wp-content/uploads/2021/10/Designed-Roundtable-on-Coverage-Recommendations-Final.pdf>

² <https://physiciansfoundation.org/wp-content/uploads/2022/04/The-Physicians-Foundation-Letter-to-CMS-and-HHS.pdf>

³ https://www.ncqa.org/wp-content/uploads/2021/06/20210622_NCQA_Health_Equity_Social_Determinants_of_Health_in_HEDIS.pdf

⁴ Corkins, Mark R., et al. “Malnutrition diagnoses in hospitalized patients: United States, 2010.” *Journal of Parenteral and Enteral Nutrition* 38, no.2 (2014): 186-95. <https://doi.org/10.1177/0148607113512154>. 1

⁵ Guenter, Peggi, et al. “Malnutrition diagnoses and associated outcomes in hospitalized patients: United States, 2018.” *Nutrition in Clinical Practice* 36, no. 5 (2021): 957-69. <https://doi.org/10.1002/ncp.10771>

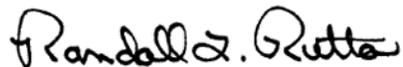
Addressing Rare Diseases and Conditions Represented by Low Volumes

The NHC appreciates the attention CMS pays to access to treatments for rare diseases in the IPPS. We urge CMS to take concrete actions to improve and protect beneficiary access to care by sufficiently reimburses providers for the items and services needed to appropriately treat rare disease patients. CMS has focused on minimizing the number of MS-DRGs and a 500-inpatient-stay volume threshold when deciding whether an MS-DRG change request should be considered. This makes sense for many areas but does not work in the rare disease space. CMS should develop more flexible approaches to supporting Medicare beneficiary access to available treatments for patients with serious, rare conditions.

Conclusion

Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs if you or your staff would like to discuss these issues in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,

A handwritten signature in black ink that reads "Randall L. Rutta". The signature is written in a cursive, slightly slanted style.

Randall L. Rutta
Chief Executive Officer