OCHIN

A driving force for health equity

Submitted via regulations.gov

June 9, 2023

Honorable Chiquita Brooks-LaSure
Administrator
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program: FY 2024 Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, I appreciate the opportunity to provide comments on the *Medicare Program: FY 2024 Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements (Proposed IPPS Rule)*. OCHIN is a national nonprofit health information technology and research network that serves nearly 2,000 community health care sites (including rural hospitals) with 25,000 providers in 40 states, reaching more than 8 million patients in underserved and rural communities. For over two decades, OCHIN has advanced health care solutions by leveraging the strength of our network's unique data set and the practical experience of our members to drive technology innovation for patients and providers in rural and other underserved communities. We applaud the Agency's proposals to advance access and equity in rural and underserved communities by addressing the increased cost, complexity and structural challenges such providers face as well as the social drivers of health (SDOH) that create barriers to care and drive worse health outcomes for patients if not addressed. We urge CMS to ensure sufficient time is made to undertake testing, training, workflow redesign, and implementation of these proposed changes.

The following OCHIN recommendations are focused on key components of the Proposed IPPS Rule that impact sustainability for hospitals in rural areas and broader initiatives to remedy persistent health disparities in rural and underserved communities. Broadly speaking, OCHIN strongly supports the provisions of the proposed rule that advance interoperability and national uniform digital data and quality measures as the foregoing can reduce administrative burden, complexity, and costly duplication that hospitals would otherwise shoulder. Further, OCHIN applauds the focus on advancing equity throughout the proposed rule and offers recommendations and evidence in support thereof as these impact access to care for patients and sustainability for hospitals, particularly in rural communities.

RECOMMENDATIONS

- Strongly support the adoption of the Screening and Screen Positive Rate for SDOH Measures Beginning with Voluntary Reporting in the FY 2026 Program Year and Mandatory Reporting in the FY 2027 Program Year for PPS-exempt Cancer Hospitals to Align with the Hospital Inpatient Quality Reporting (IQR) Program and the Merit-based Incentive Payment System. OCHIN applauds CMS' efforts to align and standardize quality measures across the many CMS payment programs. The complexity, confusion, and cost of non-uniform measures undermines effort to advance quality and improved outcomes across sites of care and provider types. The proposed adoption of the screening

and screen positive rate SDOH measures as part of the PPS-Exempt Cancer Hospital Quality Reporting is an important continuation of the effort to create consistent quality measures among Medicare payment programs that have been rigorously tested. Further, advancing measures that address structural inequities faced by patients in rural and underserved communities is an essential priority to overcome health disparities and improve provider sustainability. As of April 2023, OCHIN members have electronically documented over 1.8 million screenings involving 975,000 unique patients nationwide. Nearly 30% have reported social need (in the domains of transportation, housing status, food insecurity, financial strain, utilities, stress and isolation, education, employment, and interpersonal violence). Screening and reporting screen positive rate for social drivers of health are essential foundational steps to ensuring equity in the current payment and delivery models and to transition to new payment models. OCHIN appreciates the proposed phased-in approach that will allow time to implement new processes and workflow changes.

- Support CMS Framework for Health Equity 2022-2032 Priority to Expand the Collection, Reporting, and Analysis of Uniform, Nationally Standardized Health Equity Data. In order to address health disparities, data to identify where it exists and how to address it are necessary. However, OCHIN strongly urges CMS to work with other federal agencies, including, for example the Health Resources Services Administration (HRSA), and state Medicaid agencies to ensure that varied data collection requirements for the same types and categories of information are standardized and uniform nationally. OCHIN has invested time and resources to advance digital data and technical standards in the area of SDOH and public health to address the growing proliferation of data collection and reporting requirements our members are shouldering. While such data is needed to support new payment and delivery models while dismantling structural inequity, scaling capacity to do this work is resource intensive. We applaud efforts to advance equity, while underscoring the significant cost that providers in underserved communities must absorb to meet varied and growing reporting requirements at the federal and state level where there is a lack of national standardization and uniformity.

- Support Proposed Changes to the Medicare Promoting Interoperability Program for Eligible Hospitals (EH) and Critical Access Hospitals (CAH) *Except Urge Retention of Existing Attestation requirements related to Guidelines for Safety Assurance Factors (SAFER).* The current SAFER guideline requirement allows eligible hospitals EH/CAH to attest either yes or no in order to satisfy the definition of a meaningful EHR user under 42 CFR 495.4 to avoid penalties. EH/CAHs would have a significant level of effort in meeting the proposed new requirement mandating that eligible hospitals and CAHs would have to attest "yes" to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs, beginning with the EHR reporting period in CY 2024. There is not sufficient time by CY 2024 to operationalize these requirements and OCHIN urges continuation of the existing requirement with, at a minimum, a delayed implementation until CY 2025.

- Strongly Support Proposed Changes to the Severity Level Designation for Diagnosis codes (Z Codes) related to Homelessness and Urge Use of Additional SDOH Z Codes for Severity Level Designation. The relationship between Z-codes, including those for homelessness, and poor health outcomes in the inpatient setting have been well-documented.[1,2] Specifically, this work has highlighted how patients with Z-codes have substantially greater odds of readmission, higher inpatient and emergency department utilization, greater costs, and a higher prevalence of a wide variety of high priority

conditions.[1] Given this evidence, there is strong support for the proposed severity designation change of the Z-codes for homelessness. However, Z-codes, despite increasing in use since their implementation in 2015, are not increasing consistently in each care setting with meaningful differences across states and hospital size and teaching status, with teaching hospitals increasing their use of Z-codes more rapidly.[2] This evidence calls attention to the need to ensure that all providers, including safety net hospitals that may be less resourced, can equitably benefit from the proposed severity designation changes and its implications for payment. For example, CAH would not be paid differentially based on this policy.

- Support Policies and Target Resources that Ensure that *Rural* Safety-Net Hospitals Are Able to Modernize Their Health IT Systems to Meet Their Unique Needs and Challenges**.** In response to CMS' Request for Information on Safety-Net Hospitals, as a threshold manner OCHIN urges CMS to ensure that defining "Safety Net Hospitals" does not inadvertently minimize the resource and structural challenges faced by rural hospitals that may have a more diverse patient mix than safety net providers in urban/suburban areas. Second, ensuring that rural safety-net hospitals are able to implement their own modernized health IT system designed to meet the specific needs of their patients and community, while helping them to reduce clinician burden, streamline care delivery, and enhance their operational efficiency is urgently needed. Rural safety net hospitals must be at the center of sustainable health care transformation and payment and not dependent on larger health systems for health IT systems that do not meet their needs and may undermine their capacity to build financial sustainability while ensuring access to local, community providers.

Please contact me at stollj@ochin.org if we can provide any additional information to support your efforts/if you have any questions/if we can be of further assistance.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs

[1] Bensken WP, Alberti PM, Stange KC, Sajatovic M, Koroukian SM. ICD-10 Z-Code Health-Related Social Needs and Increased Healthcare Utilization. Am J Prev Med. 2022;62(4):e232-e241; and Bensken WP, Alberti PM, Koroukian SM. Health-Related Social Needs and Increased Readmission Rates: Findings from the Nationwide Readmissions Database. J Gen Intern Med. 2021;36(5):1173-1180.

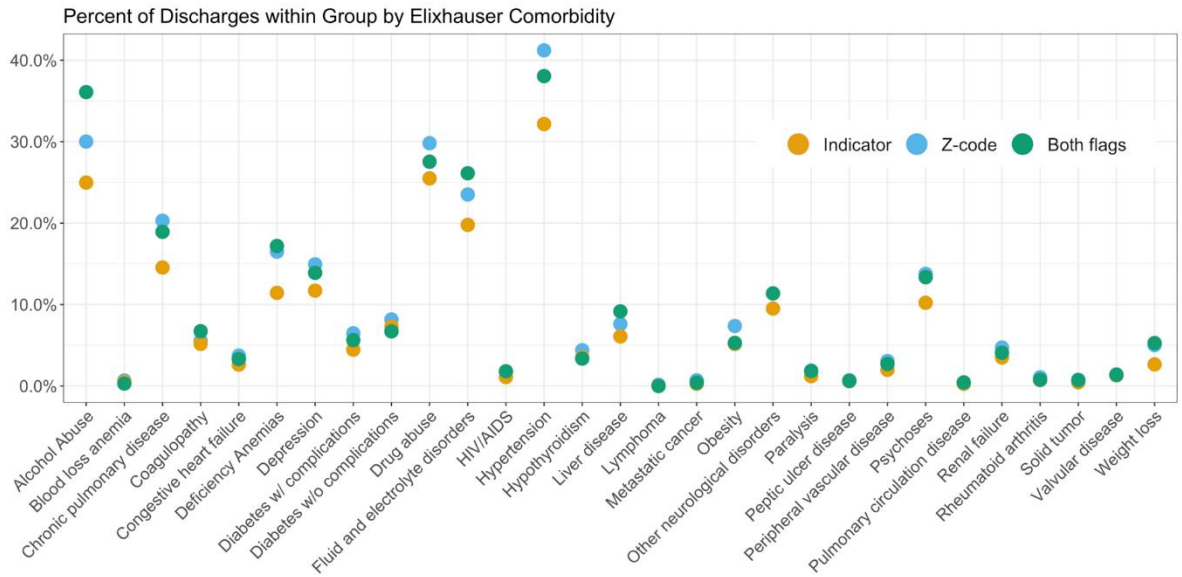
[2] Bensken WP, Alberti PM, Baker MC, Koroukian SM. An Increase in the Use of ICD-10 Z-Codes for Social Risks and Social Needs: 2015 to 2019. Popul Health Manag. 2023;26(2):113-120.

APPENDIX

Relevant Papers related to SDOH and Z Codes

Bensken WP. How do we define homelessness in large health care data? Identifying variation in composition and comorbidities. *Health Services and Outcomes Research Methodology*. 2020;21(1):145-166.

- Compared an address-based indicator to a Z-code for homelessness (Z59.0) using the Florida State Inpatient Database from AHRQ for 2016.
- 1.1% of all hospitalizations had a Z-code, 0.6% had an address-based indicator.
- Only 26.2% of those with Z-codes also had an address-based indicator.
- 50.0% of those with an address-based indicator had a Z-code.
- Those with Z-codes tended to have greater comorbidities than those with the address-based indicator.
- Overall, there appears to be bias in who has a Z-code recorded in the inpatient setting.



Bensken WP, Alberti PM, Koroukian SM. Health-Related Social Needs and Increased Readmission Rates: Findings from the Nationwide Readmissions Database. *J Gen Intern Med.* 2021;36(5):1173-1180

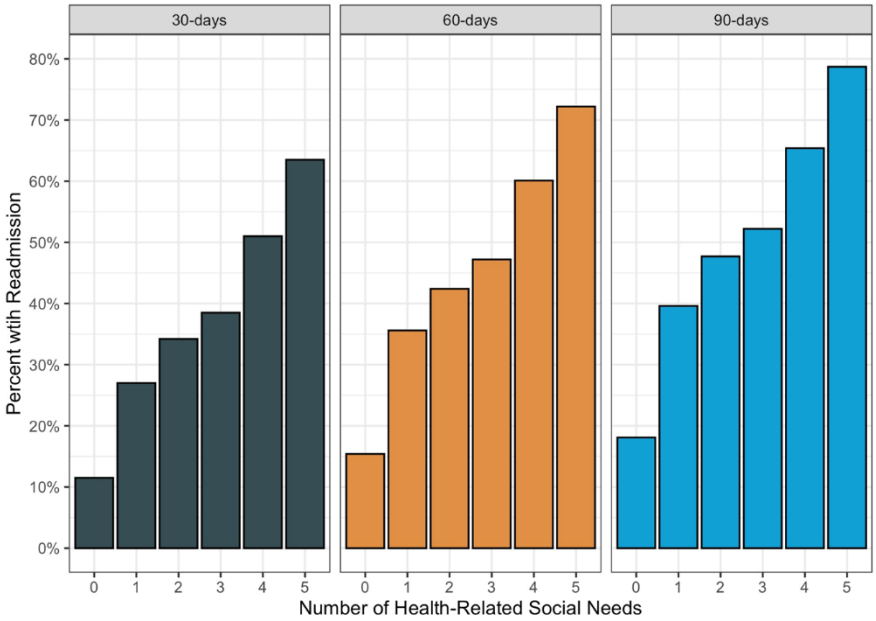
- Using the 2017 Nationwide Readmission Database from AHRQ, we found that 2.4% of patients had at least one Z-code.

- There was a clear dose-response relationship with readmission among those with Z-codes.
    - Those with just 1 domain had 2.16 times the odds of 30-day readmission.
        - 2 domains (versus 0): 4.14
        - 3 domains (versus 0): 5.34
        - 4 domains (versus 0): 8.03
        - 5 domains (versus 0): 12.55

- Those patients with housing-related Z-codes had 2.29 times the odds of a 30-day readmission.

- Among those with patients with *multiple* Z-code domains, if housing was one of them those patients had 3.04 times the odds of 30-day readmission.

- There is a clear relationship between Z-codes and 30-day readmission.



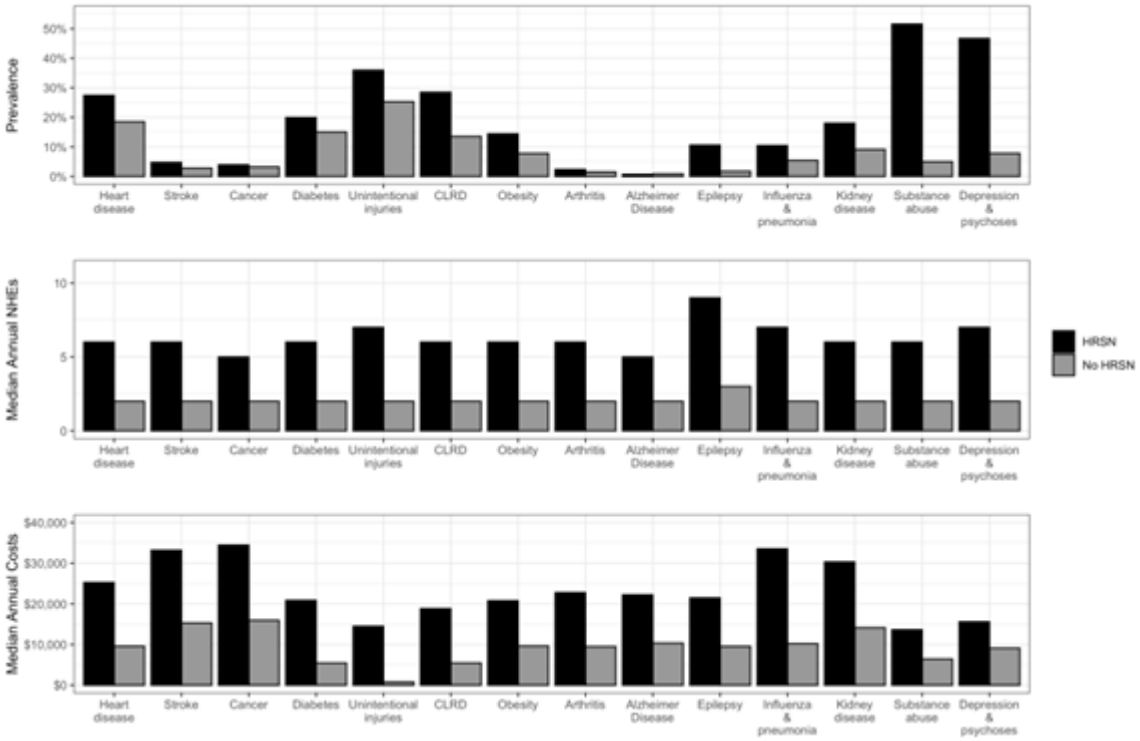
Bensken WP, Alberti PM, Stange KC, Sajatovic M, Koroukian SM. ICD-10 Z-Code Health-Related Social Needs and Increased Healthcare Utilization. *Am J Prev Med.* 2022;62(4):e232-e241

- Using the 2017 Florida State Inpatient Database and State Emergency Department Database from AHRQ, we found that 1.0% of patients had a Z-code.

- Those with a Z-code had 4 times the number of hospitalizations and emergency department visits, and 9.3 times the total annual costs.
    - These trends were consistent across all conditions that were the top 10 leading causes of death in the U.S. in 2017 and drivers of the economic costs of chronic disease by the Centers for Disease Control and Prevention.

- Those with housing or economic Z-codes had 5 times the number of emergency department visits and hospitalizations and a median of $11,193 greater costs.

- Those with Z-codes have a higher prevalence of high-priority conditions and increased utilization.



Bensken WP, Alberti PM, Baker MC, Koroukian SM. An Increase in the Use of ICD-10 Z-Codes for Social Risks and Social Needs: 2015 to 2019. *Popul Health Manag.* 2023;26(2):113-120.

- Using the 2015 (Q4) – 2019 State Inpatient Databases for Florida and Maryland from AHRQ, we compared the use of Z-codes over time between these two states.

- In total, 495,212 (0.84%) of 58,993,625 encounters had a Z-code
    - Z-codes were less common in Florida than Maryland, with Maryland having 2.1 times the use
    - Z-codes were more commonly used at major teaching facilities and for patients who were uninsured or on Medicaid

- Z-codes were increasing in use for each quarter and were increasing more quickly in Maryland

- Overall, Z-codes likely remain underutilized and vary substantially across states and care settings.