OCHIN

A driving force for health equity

Submitted via electronic mail

June 10, 2024

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

Re: *Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes*

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, I appreciate the opportunity to provide comments on the *Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes (Proposed Rule)*. OCHIN is a **national nonprofit health information technology and research network** that serves over 2,000 community health care sites with 25,000 providers in 43 states, reaching more than 6.1 million patients including Critical Access Hospitals (CAHs), rural and frontier health clinics as well as federally qualified health centers and local public health agencies. 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 our providers face as well as the social drivers of health (SDOH) creating barriers that drive worse health outcomes for patients if not addressed.

OCHIN: 21ST CENTURY EQUITABLE ACCESS TO HEALTH IT

Since its inception over 24 years ago, the OCHIN collaborative of community providers has focused on expanding access in underserved and rural communities to quality health care services through technology solutions, technical assistance, operational support, informatics, evidence-based research, workforce development and training, and policy. Today, the OCHIN network includes critical access hospitals (CAHs), federally qualified health centers (FQHC) (the largest network in the nation), FQHC look-alikes, rural health clinics, tribal health organizations, and other community health providers and local public health agencies. 55 percent of our members' patients live at or below the poverty level and more than 34 percent prefer a language other than English.

Health equity is at the core of our mission. OCHIN is committed to improving the integration and delivery of healthcare services across a wide variety of practices, emphasizing clinics and small practices in historically underserved and marginalized communities, public health agencies, as well as critical access and small rural hospitals. With over 510 million clinical summaries securely exchanged since 2010, we believe our "one patient, one record" model will bring us one step closer to health equity by

ensuring patients and providers in underinvested communities gain access to advanced health IT tools and services.

RECOMMENDATIONS

The following OCHIN recommendations focus on key components of the Proposed Rule that impact sustainability for hospitals in rural areas and broader initiatives to mitigate persistent health disparities in rural and underserved communities. OCHIN broadly supports the provisions of the proposed rule that advance interoperability and national uniform digital data and quality measures – a crucial step for reducing administrative burden, complexity, and costly duplication that hospitals would otherwise shoulder. Further, we applaud the focus on advancing health equity throughout the proposed rule and offer recommendations and evidence to support, especially as these impact access to care for patients and sustainability for hospitals, particularly in rural communities.

OCHIN urges the following changes to the proposed rule:

- **We call for a more appropriate increase in payments for rural hospitals.** CMS proposes a 2.6% increase in payments to IPPS hospitals but only a 1.9% increase for rural hospitals. Given external pressures related to inflation, deepening workforce shortages, and labor and supply costs rural hospitals must face, the 1.9% increase rural hospitals will receive is not sufficient. From 2005-2022, 186 rural hospitals either closed completely or converted to facilities that no longer provide inpatient services.[1] Rural hospitals and facilities that make up rural health care systems are cornerstones of their local community and often serve as the first point of contact in the health care system for rural Americans – losing a hospital would be devastating to rural beneficiaries who lose both a key access point to care in their communities as well as a vital economic anchor. Bolstering rural hospital sustainability requires not only legislative action but regulatory action. **To protect rural hospitals, OCHIN recommends CMS use the broad authority granted by Congress to update the final payment rate to reflect the difference between prior years' actual and forecasted market basket increase through its exceptions and adjustments authority to improve reimbursement for rural hospitals.**
- **Remove the proposed Optional Services Conditions of Participation (CoP) for obstetric services.** Due to the fragile state of rural hospitals, as well as CAHs and REHs, and their obstetrical services (OB) units, OCHIN does not support adding an Optional Services COP for rural hospitals providing OB services as this will contribute administrative and regulatory burden that they cannot shoulder. Serious financial and workforce challenges already make operating OB units difficult and unsubsidized losses in maternity care can contribute to hospital closure.[2] Imposing one-size-fits-all obstetric services CoPs could have a chilling effect on existing OB units in rural areas and could contribute to further closures for hospitals.

***OCHIN supports the following proposals*:**

- **Continuing the low wage index policy for rural hospitals for at least three more years, which increases the wage index for hospitals with a value below the 25th percentile.** OCHIN supports the continuation of this policy, concurring with CMS' position that it is necessary to wait for the policy to be in place for enough time after the end of the COVID-19 public health emergency

[1] Ostmo, P. Rural Hospital Closures: 2023 Update. Rural Health Research Recap. 2023.
[2] Center for Healthcare Quality and Payment Reform. Addressing the Crisis in Rural Maternity Care. 2024.

(PHE) to evaluate its effect before making any decisions regard the policy. To align with CMS' goal to keep the policy in place for four fiscal years to determine its effectiveness, **we recommend CMS should extend the low wage index policy through FY 2030, at minimum,** given that the policy began in FY 2019 and CMS itself noted the first full FY of wage data following the COVID-19 PHE would be FY 2028.

- **Changes to the Medicare Promoting interoperability (PI) Program for Eligible Hospitals and Critical Access Hospitals Related to the Separation of the Antimicrobial Use and Resistance Surveillance Measure.** OCHIN has previously supported the inclusion of the Antimicrobial Use and Resistance (AUR) Surveillance measure into the Medicare PI Program due to its importance in tracking antimicrobial use and stewardship implementation across health care settings. Given that hospitals have the option to use the National Healthcare Safety Network (NHSN) as an option to meet the Public Health Registry reporting requirements within the Program, we understand the logic of separating the AUR measure into the two measures – Antimicrobial Use (AU) Surveillance and Antimicrobial Resistance (AR) Surveillance as it allows clearer reporting requirements and for hospitals and CAHs to have the opportunity to submit data for either AU or AR if they can only submit data for one of the two, versus an all-or-nothing approach. We also support the adoption of a new exclusion for eligible hospitals and CAHs that lack discrete electronic access to data elements that are required for reporting as it would reduce administrative burden, removing the need for the eligible hospital or CAH to manually extract the data elements needed to successfully report on the new separated measures. OCHIN also supports CMS' proposal to allow eligible hospitals and CAHs to spend only one electronic health record (EHR) reporting period at Option 1: Pre-production and Validation of active engagement before being required to progress to Option 2: Validated Data Production level for the next EHR reporting period for which they report the two measures if finalized. However, separating the current AUR Surveillance measure into the AU Surveillance and AR Surveillance measures will require changes in workflow as eligible hospital and CAHs will need to assess any adaptation in data collection and reporting for these measures. While CMS's proposal would offer eligible hospitals and CAHs an additional year to gain familiarity with reporting in the NHSN AUR Module before they are required to participate in Option 2: Validation Data Production, and, if finalize, the AU Surveillance and AR Surveillance measures, we ask CMS to reconsider pushing back the required start to, at minimum, begin with the EHR reporting period in CY 2026 rather than CY 2025.
- **Strongly support CMS's proposed change in the severity designation of the seven ICD-10-CM diagnosis codes describing inadequate housing and housing instability from non-complication or comorbidity (NonCC) to complication or comorbidity (CC).** As OCHIN has previously highlighted, the relationship between Z-codes, including housing instability, and poor health outcomes in the inpatient setting have been well-documented.[3,4] This work has specifically focused on how patients with Z-codes have increased odds of readmission, higher inpatient and emergency department utilization, greater costs, and a higher prevalence of a wide variety of high priority conditions. Additionally, despite increased use since their implementation in 2015, documentation of Z-codes is not increasing consistently across care settings, with meaningful

[3] 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.

[4] 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.

differences across states, hospital sizes, and teaching status. This evidence underlies the need to ensure all providers, including those less resourced such as safety net and critical access hospitals, can equitably benefit from proposed severity designation changes and their implications for payment. Given this evidence, **we strongly support the proposed severity designation change of the Z-codes for inadequate housing and housing instability.** The current methodology used to assess the impact of inadequate housing and housing instability may not accurately reflect the intensity of resources used by hospitals in caring for these circumstances with clinical evaluation, extended hospital stays, increased care or monitoring, and comprehensive discharge planning. Updating the severity level designation for these Z-codes would provide hospitals with higher inpatient payment rates to recoup added expenses when caring for patients with inadequate or unstable housing.

- **Support the Agency's proposal to update hospital and CAHs infection prevention and control and antibiotic stewardship programs' Conditions of Participation (CoPs) and replace the COVID-19 and Seasonal Influenza reporting standards for hospitals and CAHs with a new standard that will address acute respiratory illness (COVID-19, influenza, and respiratory syncytial virus (RSV)) *except for the proposed timeline to start reporting by October 1, 2024*.** OCHIN's supports the agency's proposal for a streamlined data reporting structure for respiratory illness as these are crucial for public health surveillance and resource allocation. Furthermore, collecting limited demographic information, including age, will contribute to understanding of how these illnesses impact different groups, enabling more targeted interventions. While OCHIN recognizes the importance of up-to-date information, we raise concern regarding the proposed weekly reporting cadence and the potential administrative burden associated with it. Collecting, verifying, submitting this data in a weekly manner would require substantial resource, which may be challenging for providers, especially those in less-resourced settings, who are dealing with the ongoing pressures plaguing health systems, including workforce shortages and financial constraints. We recommend CMS consider a monthly reporting cadence, which strikes a balance between timely and relevant data reporting while not unduly contributing to administrative burden on healthcare staff. Given that this will be a new standard that hospitals and CAHs will have to electronically report these data elements on, there is not sufficient time by October 1, 2024, for hospitals and CAHs to operationalize requirements. OCHIN urges CMS to reconsider the timeline to begin reporting and delay the start until CY 2025.

Please contact me at **stollj@ochin.org** if we can provide any additional information.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer