CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

June 28, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–1850

Submitted via regulations.gov

RE: CMS –1752-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 2022 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program. (Vol. 86, No. 88), May 10, 2021

Dear Administrator Brooks-LaSure:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care providers to change the fundamental economic incentives and design of the health care system and ensure it truly delivers the health and high-value care that all families across the nation deserve.

Consumers First appreciates the opportunity to provide comments on the Medicare Inpatient Prospective Payment System (IPPS) for Calendar Year 2022. Medicare payment policy establishes a standard that is often adopted by other payers, including commercial insurers and Medicaid. Changes made through the Hospital IPPS rule offer an important opportunity to both strengthen the Medicare program and to signal to other payers the need to realign the economic incentives of health care payment and delivery.

The following policy recommendations would go a long way to catalyze the transformational change needed in our payment system to drive high-value care in health care markets throughout the U.S. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety. Given our focus on transforming health care payment and delivery systems to provide high-value care to consumers, our comments focus on the following sections of the proposed rule:

- Section V.L. of the Preamble: Market-Based MS-DRG Relative Weight Policy – Proposed Repeal
- Section V. J. of the Preamble: Proposed Payments for Indirect and Direct Graduate Medical Education Costs - Distribution of Additional Residency Positions Under the Provision of Section 126 of Division CC of the Consolidated Appropriates Act, 2021 (CAA)

- Section IX B: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information

Section V.L. of the Preamble: Market-Based MS-DRG Relative Weight Policy – Proposed Repeal

The proposed rule would repeal a policy that was finalized in the FY 2021 IPPS rulemaking cycle which determined a new market-based methodology for estimating Medicare Severity Diagnosis Related Groups (MS-DRG) relative weights based on median payer-specific negotiated charge information collected on Medicare cost reports. The new methodology was scheduled to begin in FY 2024. CMS is also proposing to repeal the corresponding requirement that hospitals report on the Medicare cost report, the median payer-specific negotiated charge by MS-DRG that hospitals negotiate with all Medicare Advantage payers.

Consumers First strongly supports the proposed repeal of the market-based methodology, but urges CMS *not* to repeal the corresponding requirement on hospital reporting. We detail our position below, and offer additional comments on how to strengthen CMS efforts to address market consolidation and improve transparency.

Repealing the Change in Methodology for Calculating MS-DRG Relative Weight

Consumers First strongly supports CMS's proposal to repeal the policy which changed the methodology for calculating MS-DRG relative weights to include market-based rates. As we stated in our comment letter pertaining to the FY 2021 IPPS proposed rule[1], using rates that are a product of highly consolidated markets will serve only to further embed the economic distortions that currently plague the U.S. health care system. Given that 90% of metropolitan statistical areas (MSAs) have highly concentrated hospital markets, 65% of MSAs have highly concentrated specialty physician markets, and 57% of MSAs have highly concentrated insurer markets, there is little doubt that few truly competitive health care markets remain.[2] As a result, negotiated rates between hospitals and insurers are not the result of competitive market negotiations. Instead, they are the results of rates negotiated based on relative market power between hospitals and insurers, where hospitals are able to leverage their market power over insurers in negotiations for higher prices on services in which the payment would far exceed underlying costs. ***Consumers First* applauds CMS for repealing this policy.**

In addition, we are proposing a solution to address the distorted market rates which are the direct result of consolidation across and within health care markets. **We strongly recommend that CMS consider regulatory approaches to address market consolidation and anticompetitive behavior within and across health care markets to begin to restore competitive health care markets in the U.S. Specifically: As a condition of Medicare participation for hospitals, CMS should prohibit the use of anticompetitive contracting terms in provider and insurer contracts that limit access to higher-quality, lower-cost care, including "anti-steering", "anti-tiering" and "all or nothing" clauses.**

[1] Consumers First, FY2021 Hospital Inpatient Prospective Payment System Comment Letter. Available at: https://familiesusa.org/wp-content/uploads/2020/07/Consumers-First-IPPS-Comment.pdf

[2] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs 36, no. 9 (September 2017): 1530–38, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556

Market-Based MS-DRG Relative Weight Data Collection Proposed Repeal

Consumers First strongly supports CMS's efforts to increase transparency in how hospital systems set prices in order to help make health care more affordable. In that vein, we strongly urge CMS *not* to repeal the policy which requires hospitals to report median payer-specific negotiated charges through the Medicare cost report.

While we believe that the median negotiated rate, alone, is not sufficient to reveal the price of hospital services, we do think this policy – with modifications - marks an important step forward toward driving value into the health care system. Importantly, we encourage CMS not to regress on any efforts that require hospitals or health plans to disclose pricing information. The lack of price transparency in our health care system is a significant factor in increasing health care costs, and real transparency in the actual prices paid by purchasers is critical to engaging in meaningful cost containment. We also support the goal of creating more functional, and therefore competitive health care markets to improve the value of health care.

Consumers First believes that disclosing price and quality data represents a bold and critical step in providing meaningful transparency in the quality of care and the prices paid for hospital system care, and ultimately the health care system more broadly.[3] The pricing information that is most critical to achieve price transparency is the specific rate that is negotiated between specific payers and each specific hospital.

But it is important to emphasize that we believe the disclosure of the median negotiated rate alone does not sufficiently unveil underlying prices. The median rate does not take into account the full range of variation in prices for a service and therefore won't provide an accurate reporting of price. To make the median negotiated rate meaningful, it should be accompanied by the full distribution of negotiated rates between hospitals and insurers by individual hospital. *Consumers First* also believes that pricing information must be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers and purchasers.

While health plans are directly negotiating prices with hospitals, it is consumers and employers that are ultimately paying for health care through insurance premiums, deductibles, and copays. The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change. To effectively analyze price and understand where high-cost and low-cost care is occurring across and within health care markets, ***Consumers First* recommends that CMS:**

- **Require hospitals to report in the Medicare cost report each payer-specific negotiated rate at the 10th, 25th, 75th, and 90th percentiles, in addition to the median negotiated rate, in order to get the full distribution of negotiated rates.**

Additional Recommendations for Related CMS Efforts toward Price and Quality Transparency

In addition to the FY22 IPPS rule, *Consumers First* strongly supports ongoing efforts to increase price and quality transparency for consumers, researchers, and purchasers through implementation of various regulations such as the Hospital Price Transparency Rule and the Transparency in Coverage Rule.

[3] The Secret of Health Care Prices: Why Transparency is in the Public Interest. California Health Care Foundation. https://www.chcf.org/publication/secret-health-care-prices/#related-links-and-downloads.

Under the Hospital Price Transparency rule, hospitals are now required for the first time, effective January 1, 2021, to publicly disclose pricing information including negotiated rates, through machine-readable files so that researchers, consumers, and policymakers can make informed decisions about the costs of health care. Unveiling health care prices, specifically negotiated rates, is a critical step toward driving value into the health care system and empowering consumers, employers and policymakers with the information needed to make informed decisions about health care purchasing. We strongly urge CMS to continue with price transparency efforts through implementation of the Hospital Price Transparency rule and to make critical improvements to that regulation. The enforcement mechanism in the existing regulation does not adequately incentivize hospitals to comply with the requirement to disclose pricing information. Numerous reports[4,5] have indicated that hospitals have failed to fully comply with the regulation and are making it difficult for the public to access the pricing information. **To strengthen enforcement of the Hospital Price Transparency Rule, *Consumers First* recommends that CMS:**

- **Impose a stricter penalty of $300 per day per licensed bed in each hospital (an increase from the current penalty of a flat $300). Enacting a stronger civil monetary penalty will increase hospital compliance with the new regulation and appropriately scale the monetary penalty based on hospital size.**

The Hospital Price Transparency rule also requires hospitals to post the payer-specific negotiated charges for 300 "shoppable" services. Of those, 70 services would be mandated by CMS and 230 would be decided upon by the hospital system. While we support the intent to provide consumers with actionable information, we urge CMS to take a different tack. Evidence suggests that health care price transparency, alone, has little impact on consumer behavior.[6] There are several reasons for this, including difficulty in understanding even well-intended transparency information; lack of quality data against which to compare price; and the attenuated impact of prices on out-of-pocket costs.[7] Rather than focus on changing consumer behavior, we recommend HHS refocus the target of its price transparency efforts to change the behavior of providers and payers and to inform policymakers and regulators. Individual providers who direct most health care spending can effectively use price and quality information to encourage patients to access lower-cost, higher-value referred providers.[8] The same holds true for employers and other payers who can use price transparency information to drive care toward higher-value providers.[9] There also is evidence to suggest that high-cost providers may change their pricing behavior due to public scrutiny.[10] As a result, ***Consumers First* recommends that CMS:**

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[4] Morgan Henderson, Morgan Mouslim, "Low Compliance From Big Hospitals on CMS's Hospital Price Transparency Rule," Health Affairs, March 2021, Available at: https://www.healthaffairs.org/do/10.1377/hblog20210311.899634/full/

[5] Hannah Nelson, Hospital Price Transparency Rule Compliance Is Inconsistent, April 2021. Available at: https://revcycleintelligence.com/news/hospital-price-transparency-rule-compliance-is-inconsistent

[6] Mehrotra, Ateev, et al., "Promise and Reality of Price Transparency," New England Journal of Medicine, Vol. 378, No. 14 (April 5, 2018); and Whaley, Christopher, et al., "Association Between Availability of Health Service Prices and Payments for These Services," Journal of the American Medical Association, Vol. 312, No. 16 (May 3, 2018).

[7] Austin, D. Andrew and Jane G. Gravelle, Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector, Congressional Research Service, Washington, D.C. (July 2007).

[8] Carman, Kristen, et al., "Understanding an Informed Public's Views on the Role of Evidence in Making Health Care Decisions, "Health Affairs, Vol. 35, No. 4 (April 2016); and Levinson, et al., "Not All Patients Want to Participate in Decision Making-A National Study of Public Preferences, "Journal of General Internal Medicine (June 2005).

[9] Robinson, James, and Timothy Brown, Evaluation of Reference Pricing: Final Report, letter to David Cowling of CalPERS (May 15, 2013). Available at: https://kaiserhealthnews.files.wordpress.com/2014/05/reference-pricing-california-berkeley.pdf.

[10] Wu, Sze-jung, et al., "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition," Health Affairs, Vol. 33, No. 8 (August 2014).

- **Mandate transparency on a smaller, but nationally uniform set of high-cost and high-volume services provided in inpatient and outpatient settings. A reasonable requirement would be the publication of 100 total services from the following categories:**
    - **25 highest price inpatient services of the 200 highest volume DRGs**
    - **25 highest dollar value inpatient services in Medicare's annual IPPS payments**
    - **25 highest price outpatient services of the 200 highest volume DRGs**
    - **25 highest dollar value outpatient services in Medicare's annual OPPS payments**
- **Require all disclosed pricing information to be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers and policymakers.**

Section V.J of the Preamble: Proposed Payments for Indirect and Direct Graduate Medical Education Costs

The proposed rule would implement a critical component of the Consolidated Appropriations Act, 2021 which created 1,000 new Medicare-funded graduate medical education (GME) residency positions, expanded opportunities for rural residency training, and allows hospitals with low resident full-time equivalent (FTE) caps and/or per resident amounts (PRAs) due to short-term resident rotations to reset. These changes result in increased opportunities for hospitals to receive Medicare payment for resident training which is the first significant increase in Medicare funding for residency training in nearly 25 years.

Consumers First is supportive of CMS's proposal to implement the new GME slots but has specific recommendations for ensuring the increased funding for Medicare GME results in long-lasting, equitable changes in the composition and distribution of physicians in the U.S. health workforce. Our comments are detailed below.

Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the CAA

Consumers First strongly supports CMS's efforts to prioritize hospitals and residency programs that are located in Health Professional Shortage Areas (HPSAs) and serve population HPSAs when distributing new Graduate Medical Education (GME) positions to hospitals. Ensuring an adequate workforce is critical to achieving a high-value health care system that meets the needs of the people it serves, including ensuring access to health care services. However, the current supply, makeup, and distribution of the U.S. health workforce is not adequate to meet the needs of our nation's families, children, and seniors.[11] Primary care, behavioral health, and oral health represent the areas with the most significant shortages nationwide.[12,13] In addition, the COVID-19 emergency has led to disproportionate rates of deaths and infection in Black and Latinx communities, reinforcing the underlying disparities in the U.S. health care system that drive worse health outcomes for Black, Indigenous, and other people of color. Building an adequate health workforce that can meet the needs of all communities is a critical strategy to improve health equity and reduce disparities. The U.S. will face a shortage of between 54,100 and

[11] "The U.S. Nursing Shortage: A State-by-State Breakdown," NurseJournal.org, October 14, 2020, https://nursejournal.org/community/the-us-nursing-shortage-state-by-state-breakdown/.
[12] Sarah Mann, "Research Shows Shortage of More Than 100,000 Doctors by 2030," Association of American Medical Colleges, March 14, 2017, https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/.
[13] Institute of Medicine and National Research Council, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (Washington, DC: The National Academies Press, 2011), https://www.hrsa.gov/sites/default/files/publichealth/clinical/oralhealth/improvingaccess.pdf.

139,000 physicians by 2033.[14] Many researchers predict significant shortages of physicians and other health care workers that will grow over time,[15,16,17] and the need to address the distribution of physicians and other providers by specialty, care setting, and care location to ensure the right providers are in communities where they are most needed.[18,19]

The maldistribution of physicians and ongoing physician shortages has plagued the U.S. health care system for too long. While we are supportive of CMS's proposal to prioritize hospital and residency programs that are in HPSAs and care for underserved populations when distributing GME positions, we recommend that CMS also account for where trainees ultimately practice medicine in order to meaningfully mitigate physician shortages and maldistribution long-term. According to the most recent HRSA data, 15,361 additional physicians are needed fully address the need in all HPSAs, and close to 4,000 physicians are needed to fill the need in rural HPSAs.[i]

***Consumers First* strongly recommends that CMS include an additional factor in the methodology for prioritizing hospitals for new residency slots by prioritizing GME slots for hospitals based on the percentage of trainees who ultimately choose to practice medicine in HPSAs, not just be trained in HPSAs. By adding this additional factor to the proposed methodology for prioritizing applications, CMS would also help ensure that the physicians trained using these new residency positions ultimately go on to care for underserved populations throughout their career, not just for the duration of their residency training.**

Consumers First is also supportive of the proposed definition of qualifying hospitals that may apply for new residency slots, including: 1) hospitals located in rural areas; 2) hospitals in which the reference resident level of the hospital is greater than the resident limit; 3) hospitals in states with new medical schools and branch campuses; 4) hospitals located in HPSAs. **To ensure that smaller hospitals as well as those hospitals with less GME funding have equitable access to additional GME slots, *Consumers First* recommend that CMS add two additional qualifying categories to the existing eligibility categories:**

- **Small hospitals with less than 250 beds**
- **Hospitals with a single residency program**

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[14] Boyle, P. (2020, June 26). *U.S. physician shortage growing*. AAMC. https://www.aamc.org/news-insights/us-physician-shortage-growing

[15] Elaine K. Howley, "What Can Be Done about the Coming Shortage of Specialist Doctors?" *U.S. News and World Report*, May 2, 2018, https://health.usnews.com/health-care/patient-advice/articles/2018-05-02/what-can-be-done-about-the-coming-shortage-of-specialist-doctors.

[16] Mann, *Research Shows Shortage*.

[17] Tim Dall et al., *2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032* (Washington, DC: Association of American Medical Colleges, April 2019), https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf.

[18] Edward Salsberg, "Is the Physician Shortage Real? Implications for the Recommendations of the Institute of Medicine Committee on the Governance and Financing of Graduate Medical Education," *Academic Medicine* 90, no. 9 (September 2015): 1210–1214, https://journals.lww.com/academicmedicine/fulltext/2015/09000/Is_the_Physician_Shortage_Real__Implications_for.17.aspx.

[19] Erin Fraher, "North Carolina's Physician Training Programs Are Not Producing the Workforce Needed to Meet Population Health Needs," presentation to the Joint Oversight Subcommittee on Medical Education Programs and Medical Residency Programs, North Carolina General Assembly, February 12, 2018, http://www.shepscenter.unc.edu/download/16046/.

According to the Medicare Payment Advisory Commission (MedPAC), the majority of the 71 hospitals that closed in 2019 and 2020 were small and located in urban metropolitan areas.[20] During the same period, 30 hospitals opened, all of which were small and all but three were located in urban areas.[21] We believe that by adding a qualifying criterion for small hospitals, CMS could help to ensure their financial stability and prevent additional closures. If CMS does not add this eligibility criteria, we are concerned that many small hospitals will be precluded from receiving additional slots in the next five years. We are similarly concerned that hospitals with only one residency program could be excluded from eligibility for these slots, which would negatively impact the physician pipeline in certain areas of need.

Section IX B: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information

In line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," CMS is seeking public input on how to address health disparities through hospital quality programs. Specifically, CMS is seeking feedback on: 1) The potential future application of an algorithm to indirectly estimate race and ethnicity to permit stratification of measures (in addition to dual eligibility) for hospital-level disparity reporting, until more accurate forms of self-identified demographic information are available; 2) Collecting a standardized set of demographic data elements by hospitals at the time of admission and using electronic data definitions to enable nationwide interoperable health information exchange; and 3) Creation of a Hospital Equity Score to summarize hospital performance across multiple social risk factors and two disparity methods.

Consumers First strongly supports CMS's commitment to addressing health disparities and closing the health equity gap in CMS hospital quality programs, but offers alternative suggestions for policy change to better reach our shared goals.

Potential Future Application of an Algorithm to Indirectly Estimate Race and Ethnicity

Consumers First strongly supports CMS's efforts to stratify quality measures by race and ethnicity. Health care payment and delivery in the U.S. is designed to incentivize high volumes of clinically-based care for sick people rather than to improve all people's health. It does so at exceedingly high cost and at low value for consumers. Efforts to realign the system toward improved overall health and wellbeing are being tested through new payment and delivery models. While these new models of payment and delivery offer promise to reorient the health care system toward achieving better health at lower cost, they also risk exacerbating existing inequities if the goal of racial equity is not centered in the design and implementation of such reforms. Stratifying quality measures by race and ethnicity is a critical step to ensure value-based care initiatives focus on health equity and reducing inequities. Importantly, performance measures will need to be stratified by a broader list of sociodemographic factors to drive meaningful improvements in equity. As a result, it is critical for CMS to indicate both its short-term objectives to stratify performance measures by race and ethnicity, as well as the longer-term vision to stratify measures by additional demographic factors to reduce inequities through health care payment and delivery. ***Consumers First* recommends CMS to:**

- **Stratify all hospital quality measures by self-reported race and ethnicity initially, but to ultimately expand to a broader set of self-reported characteristics that include: primary**

[20] MedPAC Report to Congress: Medicare Payment Policy. Chapter 3: Hospital inpatient and outpatient services. March 2021. Available at: http://medpac.gov/docs/default-source/reports/mar21_medpac_report_ch3_sec.pdf?sfvrsn=0
[21] Ibid.

language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status.

- **Move measurement stratification efforts towards stratifying performance and outcomes measures by self-reported race, ethnicity, primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status.**

Consumers First is concerned about CMS's proposal to develop an algorithm that would indirectly estimate race and ethnicity to enable the stratification of quality measures until more accurate data sets with self-reported sociodemographic information become available. While we recognize that imputation is a commonly used process in statistics to replace missing data with substituted values, there is significant risk of further exacerbating existing disparities by using this approach.

While new methods for indirectly estimating race and ethnicity have emerged, there continues to be significant limitations in the reliability and accuracy of the estimated data sets. Indirect methods for estimating race typically only consider geocoded and surname data as predictors, can perform poorly among racial minorities, do not adjust for possible errors for specific datasets and are unable to provide race estimates for individuals missing some of this information.[22] The result is that there may be significant underestimates or overestimates within a data set of race and ethnicity information. The goal of stratifying quality measures by race, ethnicity and other sociodemographic factors is to enable providers, policymakers, researchers and other stakeholders to drill down to individual level quality information that illustrates where disparities are occurring in health care delivery. Importantly, complete data sets are critical to be able to do this accurately. While imputing data for population health level management may be used effectively to enable an individual hospital to gain insights into how it's managing disease-specific conditions within their system, *Consumers First* does not support the use of imputing data to estimate race and ethnicity data for the purpose of stratifying quality measures. Rather than relying on unreliable statistical methods to estimate race and ethnicity data, ***Consumers First* strongly urges CMS to:**

- **Require and incentivize the collection and use of self-reported disaggregated data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status. The Office of the National Coordinator for Health Information Technology's (ONC) 2015 Edition Health Information Technology Certification Criteria Final Rule, the "2015 Edition" establishes HIT certification requirements that include full disaggregation of race and ethnicity, language, sexual orientation, gender identify and social and behavioral risk factors.[23] CMS should immediately require and incentivize ONC's 2015 Edition standards for collecting disaggregated data for all hospitals and for all CMS quality programs, including all hospital payment reform programs.[24]**
- **As part of these efforts, CMS should require hospitals to engage in data collection methods that rely on self-reported data. Self-reported collection of data is the gold standard for**

[22] Gabriella C. Silva, Amal Trivedi, Roee Gutman, "Developing and evaluating methods to impute race/ethnicity in an incomplete dataset," Health Services and Outcomes Research Methodology (2019) 19:175-195, Available at: https://doi.org/10.1007/s10742-019-00200-9.

[23] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015)

[24] The use of these ONC standards is incentivized in CMS' Quality Payment Program, https://qpp.cms.gov/mips/promoting-interoperability

collecting disaggregated data.[25,26,27] To mitigate patient concerns that race and ethnicity or other demographic data may be used in a discriminatory way, providers should explain that the data will be used to improve the quality of care.[28] There are two key approaches hospitals should consider in operationalizing self-reported data methods:

- **Planned Procedures: Conduct surveys with patients prior to admission as part of the pre-contact, check-in process where patients are asked to complete and verify demographic information, medical history and insurance status;**
- **Emergency Visits: Conduct surveys with patients when patient is stable during the time of insurance verification.**

Hospital Collection of Standardized Demographic Data

Consumers First strongly supports CMS's efforts to collect a standardized set of demographic data elements by hospitals at the time of admission. As noted above, a critical first step in being able to identify underlying disparities in health care delivery - and to then to reduce these disparities - is collecting and reporting on disaggregated data including race, ethnicity, primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status. For too long, collecting disaggregated data has been identified as an insurmountable barrier in being able to hold the health care system accountable for reducing disparities and improving the health of all people. We applaud CMS for identifying the need to establish standardized data collection practices across hospitals as an essential part of this RFI.

A key element in establishing standardized data collection is to ensure a robust data system and health information technology infrastructure that is able to surface accurate insights about health disparities and to make data-driven and informed decisions about reducing disparities and advancing health equity. Comprehensive demographic data must be a core element of HIT and data exchange efforts to advance equity and reduce disparities across the CMS enterprise. This will require CMS to take an "equity in all programs and policies" approach and to leverage what other HHS agencies have already developed. The RFI accurately states that "while the ONC 2015 Edition supports certified health IT products to collect social determinant of health and SOGI data, the functionality is not part of the certified Electronic Health Record technology required by CMS's Promoting Interoperability program."[29] Indeed, the RFI acknowledged that "the technical functionality exists to achieve the gold standard of data collection."[30] **As a result, *Consumers First* urges CMS to adopt ONC's 2015 Edition certification standards across all CMS quality programs including CMS's Promoting Interoperability program.**

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[25] David Baker, Kenzie Cameron, Joseph Feinglass, et all, "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," American Journal of Public Health, Vol 96, No.3, 2006, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470520/pdf/0960532.pdf

[26] Sean Cahill, Robbie Singal, Chris Grasso, et al "Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identify Data in Four Diverse American Community Health Centers," PLoS ONE 9(9):e107104.doi:10.1371/journal.pone.0107104

[27] Haider A, Schneider E, Schuur J, et al. 2019. Comparing Ways to Ask Patients about Sexual Orientation and Gender Identity in the Emergency Room—The EQUALITY Study. Washington, DC: Patient-Centered Outcomes Research Institute (PCORI). https://doi.org/10.25302/7.2019.AD.110114IC.

[28] David Baker, Kenzie Cameron, Joseph Feinglass, et all., "Patient Attitudes Toward Health Care Providers Collecting Information About Race and Ethnicity," Division of General Internal Medicine, Department of Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Ill, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490236/pdf/jgi_195.pdf

[29] 86 FR 25560

[30] 86 FR 25560

Creation of a Hospital Equity Score

Consumers First applauds CMS for efforts to identify ways to hold hospitals accountable for reducing disparities and improving health equity across the health care system. While we believe holding hospitals accountable through an index hospital equity score has significant potential impact, we do not believe CMS is ready to construct an accurate equity index. Hospitals are not yet uniformly collecting disaggregated sociodemographic data or accurately stratifying quality and outcomes measures by social determinants of health or SOGI data. Collecting disaggregated data that leads to more complete data sets and stratifying quality and outcomes measures should be the focus of CMS's efforts initially, rather than jumping directly to a hospital equity score. *Consumers First* recognizes the utility of CMS developing an equity score, over time, and supports efforts to develop one as more accurate data become available.

In the immediate-term, CMS should consider holding hospitals accountable through equity standards that are already developed. For example, the Office of Minority Health at the US Department of Health and Human Services has already developed the National Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations. There are 15 standards across governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement and accountability. The National CLAS standards were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing policy and legislative landscape, including the Affordable Care Act.

HHS's Office of Minority Health contracted with RAND Corporation to develop a long-term evaluation framework and toolkit for implementing the CLAS standards across four settings: ambulatory care, hospitals, behavioral health and public health.[31] The evaluation framework provides a systematic approach to gather data to evaluate the effectiveness of the National CLAS Standards including a conceptual framework, setting-specific logic models, and process and impact measures that can be used to assess hospital performance on implementing the CLAS Standards across the health care system. The National CLAS Standards are a ready-to-use, validated framework and set of standards that CMS can move to implement and hold hospitals accountable for immediately, rather than building something new. ***Consumers* First urges CMS to require all hospitals to demonstrate how they are implementing the National CLAS Standards and report publicly on their CLAS implementation score.**

On behalf of *Consumers First*, we appreciate the opportunity to provide the above recommendations and feedback. Please contact Sophia Tripoli, Director of Health Care Innovation, at stripoli@familiesusa.org for further information.

Sincerely,

[31] Malcome V. Williams, Laurie T Martin, Lous M. Davis et al, Evaluation of the National CLAS Standards, US Department of Behavioral Health, Office of Minority Health, Available at: https://minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_Toolkit_PR3599_final.508Compliant.pdf

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Pennsylvania Health Access Network
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The ERISA Industry Committee
Universal Health Care Action Network of Ohio
Universal Health Care Foundation of Connecticut
Utah Health Policy Project

[i] HRSA. (n.d.). HRSA Shortage Areas. https://data.hrsa.gov/topics/health-workforce/shortage-areas.