

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 10, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via <https://www.regulations.gov>

Re: RIN 0938-AU84; 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

Justice in Aging appreciates the opportunity to comment on the above referenced notice of proposed rulemaking (NPRM). We are in support of the Centers for Medicare & Medicaid Services' (CMS's) commitment to advancing health equity.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults nationwide. We use the power of the law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources, particularly populations that have been marginalized and excluded from justice, such as people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicare and Medicaid and working with advocates who represent low-income older adults.

Our comments focus on CMS's proposals regarding the Hospital Readmission Reduction Program; climate change; and the Request for Information (RFI) on Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs. We also endorse the comments submitted by *Consumers First*.

I. CMS Must Consider Other Factors in Addition to Dual Eligible Status in the Hospital Readmissions Reduction Program.

We thank CMS for its commitment to reducing excess hospital readmission, and for its continued efforts toward value-based care. We understand that the 21st Century Cures Act requires CMS to compare hospitals with respect to their numbers of readmissions among Medicare-Medicaid dual-eligible beneficiaries (dual eligibles).¹ However, we want to emphasize that dual eligibility alone is not synonymous with social risk factors.²

¹ Social Security Act § 1886(q)(3)(D); <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>.

² Centers for Medicare & Medicaid Services (CMS), Notice of Proposed Rulemaking RIN 0938-AU84 (hereinafter "NPRM"), 850, available at <https://public-inspection.federalregister.gov/2022-08268.pdf> ("In this peer grouping methodology, dual-eligibility status is used as it is an indicator of beneficiaries' social risk. . . . However, this peer



While dual eligibility should be a factor in comparing readmissions rates of patients with social risk factors, other data points are necessary to more accurately understand health care quality and inequities. These factors include, but are not limited to, race, age, disability, sexual orientation and gender identity (SOGI), limited English proficiency, and primary language. Dual eligibility can serve as a proxy for certain income and wealth disparities;³ however, it does not reflect anything about other identifiers that give rise to systemic barriers to accessing health care. Dual eligibility status alone cannot accurately reflect health care inequities across race, SOGI or other nonclinical factors that impact experiences and outcomes in health care because those factors pose discrete barriers to care and quality of health outcomes not associated with dual eligibility status.

For example, when evaluating the CMS Medicare COVID-19 data, disparities based on race are evident regardless of income.⁴ Within the dual eligible population, Black, American Indian, and Alaska native dual eligibles were hospitalized at rates at 1.5 times higher than white dual eligibles, and within the Medicare only population, American Indian and Alaska natives were hospitalized at rates 2 times higher than white Medicare enrollees. This data demonstrates that dual eligible status alone cannot serve as a proxy for social risk and adequately address the inequities in hospital readmissions.

Moreover, none of these identifiers capture the discrimination in health care that individuals who live at the intersection of multiple identities experience, and neither does dual eligibility. Individuals with intersecting identities are more likely to experience compounded or different forms of inequities, and enhanced gathering and use of intersectional data will reveal those inequities for intersecting populations where the single demographic data does not. For example, again turning to the COVID-19 data, dual eligibles with end state renal disease (ESRD) were hospitalized at the very highest rates.⁵ While the data demonstrates the compounding impact of income status and disability, the data does not provide the complete picture because it does not examine race, age, or other factors within the ESRD population.

As CMS mentioned in this NPRM, other non-clinical, non-demographic factors—such as housing and food security—can also be important indicators of health quality and inform health equity efforts for marginalized populations. We support the use of an Area Deprivation Index (ADI) that identifies and targets communities with the greatest need in terms of access to plan and support delivery services.⁶ However, we caution CMS against relying solely on ADIs because, much like dual eligibility status, ADI does not fully represent systemic disparities for historically marginalized communities. For example, an ADI may identify as rural communities as needing greater support, but without specific measures around race and ethnicity, health systems may ultimately focus their support on White individuals in rural counties without addressing the needs of Black, Latino, Asian American and Pacific Islander (AAPI), and

grouping methodology does not directly measure or account for disparities in health care quality between beneficiary groups with heightening social risk and groups with less social risk.”).

³ NPRM at 851 (“Beneficiaries’ dual eligibility for Medicare and Medicaid is a widely used proxy for a beneficiary’s financial risk.”); American Council on Aging, Dual Eligibility for Medicare and Medicaid: Requirements & Benefits for Long Term Care (Feb. 11, 2022), available at [\(https://www.medicaidplanningassistance.org/dual-eligibility-medicare-medicaid/#:~:text=Persons%20who%20are%20eligible%20for,Part%20B%20\(medical%20insurance\)\)](https://www.medicaidplanningassistance.org/dual-eligibility-medicare-medicaid/#:~:text=Persons%20who%20are%20eligible%20for,Part%20B%20(medical%20insurance)) (noting average income and asset requirements for Medicaid);

⁴ CMS, “Preliminary Medicare COVID-19 Data Snapshot,” Dec. 17, 2021, available at <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.

⁵ *Id.*

⁶ NPRM at 853 (mentioning use of the University of Wisconsin School of Medicine and Public Health and Health Resources and Services Administration’s Area Deprivation Index).

American Indian/Alaskan Native (AI/AN) populations in those rural counties. Additionally, the use of any ADI models should be paired with analyses to ensure that the use of the ADI does not further any racial or other disparities.

While we understand that data about dual eligibles is readily available to CMS, lack of sufficient data around health care for marginalized populations continues to be a barrier in achieving health equity. We urge CMS to make efforts to gather and use data in addition to dual eligibility.⁷ Not gathering and using this information perpetuates structural racism and other forms of discrimination within the hospital system because CMS and hospital administrators are unable to accurately identify gaps in services and tailor solutions. For example, LGBTQ individuals have more barriers to health care and experience poorer outcomes due to discrimination and uninformed care providers, and thus understanding health care quality based on SOGI information is vital to understanding and remedying systemic health disparities.⁸

We also encourage CMS to make the data collected for the purposes of the Hospital Readmission Reduction Program to be publicly available, as both trend reports and raw data. Trend reports and comparisons by CMS are valuable as they allow advocates, providers, and consumers to see health care inequities and monitor improvements in an easy-to-understand form. Additionally, the raw data would allow advocates and researchers to work the information themselves and perform the analyses that CMS may not have the capacity to conduct (e.g., intersectional reports).

In incorporating other demographic identifiers in addition to dual eligibility into the Hospital Readmission Reduction Program, CMS should compare this data in multiple ways to understand disparities. For example, data about health inequities across race, SOGI and other identifiers within one hospital should be compared with the same data in other hospitals (both locally and nationally) and compared within the same hospital. This comparison may expose inequity trends by region, community type (e.g., rural), and medical practice or procedure, and can allow for collaborative solutioning across regions and practices.

II. CMS should deliberately address inequities related to climate change, enforce planning for climate-related emergencies in nursing facilities, and protect access to care while incorporating climate-change influenced policies.

- a. We support CMS's efforts to assess climate change impacts on outcomes, care, and health equity and encourage CMS to develop strategic plans to address the immediate and long-term impacts of climate change on health inequities for marginalized populations

Research shows that marginalized populations are more impacted by the negative effects of climate change. We recommend that CMS engage broadly with a variety of advocates and experts to better understand the role of climate change in health outcomes for marginalized populations. Specifically, we recommend that CMS engage with local advocates, providers, and consumers to understand specific concerns in different regions and counties. Given that the effects of climate change are most apparent at the local level, engaging with local advocates—for example through conversations with regional

⁷ KFF, Advancing Health Equity Requires More and Better Data (Oct. 2021), available at <https://www.kff.org/policy-watch/advancing-health-equity-requires-more-better-data/>.

⁸ SAGE, Disrupting Disparities: Solutions for LGBTQ New Yorkers Age 50+, 38-40, at 38-40 (2021), available at <https://www.sageusa.org/wp-content/uploads/2021/01/disrupting-disparities-lgbtq-new-yorkers.pdf>.

offices—would be most beneficial to support impacted communities. We believe engaging with on-the-ground advocates will help CMS identify specific measures to gauge current impacts of climate change (e.g., Asthma rates, mortality due to extreme temperatures) on specific populations and examine trends over time.

CMS should leverage its position to develop measures to examine climate change from a health equity perspective, and analyze impacts both within different regions and nationally. As hospitals and providers develop interventions to address clinical conditions caused or exacerbated by climate change, CMS should analyze the impact of interventions in health outcomes for marginalized populations. We also encourage CMS to make all the population-specific and intervention data publicly available when it is collected so advocates and researchers can better understand the impacts of climate change on health equity.

Similarly, CMS should incorporate or extrapolate climate change health impacts in their regular data gathering, screening, and referrals for social services. For example, CMS should modify existing social needs assessments (e.g., the AHC Health-Related Social Needs Screening Tool⁹) to better understand or predict whether an individual is likely to be affected by extreme high or low temperatures, asthma or conditions resulting from exposure to pollution, and other factors that may be related to climate change.¹⁰ In communities or counties where there are unique or high incidence of climate change impacts, CMS can encourage hospitals can develop more in-depth screenings to record and assess these impacts. Impact data would be useful in more accurately accounting for the costs of climate change and for correspondingly driving changes in public policy.

Additionally, providers can use patient needs assessments relating to climate change to develop specific interventions or make referrals to social services (e.g., housing programs for individuals experiencing homelessness during extreme heat waves). Data about these hospital-level screenings, interventions, and referrals should also be reported publicly so advocates can view trends across counties and learn from successful interventions across the country.

b. CMS should improve emergency-preparedness regulations for nursing facilities.

The federal regulations on nursing facility emergency preparedness issued in 2016¹¹ do not adequately protect residents, both because they were vague and because they do not mandate broad coordination for community-wide emergency-preparedness. The nursing facility regulations for each of the five areas of emergency preparedness (emergency plans, facility procedures, communications plans, training and testing, and emergency power systems) leave considerable discretion to individual nursing facilities and emphasizes flexibility for the facilities over the safety and wellbeing of residents.

Given the impact of climate change on dangerous climate conditions,¹² CMS should improve emergency preparedness regulations to protect nursing facility residents using the following measures:

⁹ CMS, The Accountable Health Communities Health-Related Social Needs Screening Tool, available at <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

¹⁰ For example, the assessment can ask additional questions regarding housing security and housing conditions.

¹¹ 81 Fed. Reg. 63,860 (Sept. 16, 2016).

¹² The insufficiency of the existing standards was demonstrated during the Hurricane Irma tragedy when a Florida nursing facility lost air conditioning for numerous days and twelve residents died due to the high temperatures. Eric Carlson, “Why Many Nursing Facilities Are Not Ready for Emergency Situations,” (Sept. 2017), available at

- Clearly require emergency generators sufficient to maintain safe temperatures;
 - Require advance coordination among facilities, other health care providers, and relevant government agencies;
 - Require contractual arrangements for evacuation procedures;
 - Maintain relevant information on an ongoing, community-wide basis;
 - Develop resources to assist in emergency plan development;
 - Require review of emergency plans by knowledgeable agencies or persons; and
 - Assess meaningful sanctions for violations of emergency preparedness requirements.¹³
- c. CMS should avoid unintentionally incentivizing providers to burden patients when enacting climate-change related regulations and should put safeguards in place to protect patient access.

As CMS shapes strategies to address climate change causes and impacts, it should consider potential unintended consequences that may burden patients—particularly patients belonging to marginalized populations. For example, while telehealth services may be an environmentally friendly alternative in some cases, it should not replace in-person services for the individuals who cannot access telehealth services or who need or want in-person services.¹⁴ To prevent unintended burdens, CMS should ensure it places patient protection safeguards to accompany any climate-change related initiatives that affect the patient experience (e.g., maintaining in-person visit options for all patients, and adequately informing patients of the option) and regularly reviews climate change-related policies to ensure that implementation does not exacerbate or fail to address existing health disparities.

III. The overarching principles for measuring health care quality disparities across programs should prioritize collecting, analyzing, and publicly reporting health care access, quality, and outcomes by patient demographics, and specifically intersecting identities.

As mentioned previously, lack of data on the quality of care, health care experiences, and health outcomes for marginalized populations (including intersections of marginalized populations) continues to be a barrier in advancing health equity. Including demographic factors such as race and disability in stratified data collection in Medicare Part C and D is an important step, but it alone is insufficient. We urge CMS to collect data on SOGI, limited English proficiency, and primary language as well.¹⁵ Again,

<http://www.justiceinaging.org/wp-content/uploads/2017/10/WHY-MANY-NURSING-FACILITIES-ARE-NOT-READY-FOR-EMERGENCY-SITUATIONS.pdf?eType=EmailBlastContent&eld=b57801d5-9367-4939-b269-eeaca1b9543e>

¹³ To read more details about the impact of these proposed changes, see *id.* at 4-8.

¹⁴ HHS, Improving access to telehealth, available at <https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth/#:~:text=Some%20older%20patients%20can%20have,making%20patient%20resources%20more%20accessible> (last visited May 31, 2022) (noting that telehealth services may be inaccessible for older patients due to “hearing and/or vision challenges, low skill or comfort level with technology, or cognitive impairment”); California Initiative for Health Equity and Action, “Tackling the Digital Divide by Improving Internet and Telehealth Access for Low-Income Populations” (2020), available at <https://healthequity.berkeley.edu/sites/default/files/tacklingthedigitaldivide.pdf> (noting that many Americans do not have access to broadband or smartphones, and arguing that telehealth contributes to the digital divide and health inequities).

¹⁵ To read more about our recommendations on health equity measures for Medicare Part C and D, see Justice in Aging, Comment on Advanced Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare

needs assessment tools have the potential to be valuable in measuring health inequities, and so we encourage CMS to mitigate biases in these tools, to report stratified data collected through the tools, and to require providers to pursue appropriate interventions and referral if the tools indicate a social need.¹⁶

Justice in Aging supports several of CMS’s proposed priorities and recommends the following guiding principles in response to the NPRM’s request for feedback on prioritizing measures to evaluate health inequities¹⁷:

- a. *Prioritize Information Collection on Health Inequities Among Historically Marginalized Populations and Intersecting Identities.* While we understand CMS’s desire to focus on the measures that it has already implemented in other CMS programs,¹⁸ we encourage CMS to collect more information that fully represents the health care experiences, quality, and outcomes for all marginalized groups—ideally, from patient reports. For example, health equity efforts in Medicare Part C and D have incorporated race and disability measures, yet they do not address SOGI, language proficiency, or any intersecting identities. CMS should add other demographics and social risk factor measures that have been shown to correlate with poorer health outcomes and make these measures consistent across all CMS programs. Capturing race and disability data at the exclusion of these other identities will be insufficient in advancing health equity for all older adults.

Justice in Aging emphasizes that, although we understand CMS’s sentiment that health disparities based on patient demographics are not innately based on identities such as race,¹⁹ those health disparities are still a direct result of structural racism in all areas of life, including health care. Collecting and analyzing health outcomes based on demographics does not “place the driver of poorer health outcomes on the patient,” but rather gives the agency, advocates, and other stakeholders a tool to combat such health inequities. In measuring health disparities, we again urge the agency to specifically consider patient demographics when collecting and reporting information, and to not solely rely social risk factors or proxy data (such as dual-eligibility) as this information does not necessarily represent health inequities among different patient demographics and does not reflect disparities based on intersecting identities.

Self-reporting of demographics and health care access, quality, and outcomes should be pursued as the “gold standard” of health equity information collection and reporting because it removes the possibility of making harmful assumptions based on stereotypes and allows people to meaningfully self-identify. Again, while the use of some proxy data

Advantage (MA) Capitation Rates and Part C and D Policies (March 4, 2021), available at <https://justiceinaging.org/wp-content/uploads/2022/03/Final-Comments-to-2023-Part-C-and-D-ANPRM.pdf>.

¹⁶ To read more about our concerns regarding implicit bias in needs assessment tools and the need referrals to social needs services see *id.* page 4-5.

¹⁷ NPRM at 1029 *et seq.* We encourage CMS to engage with diverse stakeholders, researchers, and advocates with personal and professional experience in health equity measures to identify specific measures that will have accurate results and can lead to tangible policy efforts to achieve health equity.

¹⁸ NPRM at 1030.

¹⁹ NPRM at 1033.

such as dual eligibility status or ADIs can be very useful in identifying some health disparities, they should not be the sole form of data used and should not dissuade CMS from seeking accurate and reliable demographic information, especially concerning intersecting identities. Similarly, Justice in Aging cautions against solely using Imputed Sources of Social Risk Information and Patient Demographics²⁰ as it only provides an indirect statistical estimate of a patient’s race, ethnicity, and other demographic data using inferences about the person’s name, address, and “administrative data.” Not only does the imputed sources method not account for intersecting identities or changes in neighborhood demographics (e.g., as a result of rapid gentrification, or refugee resettlement), it both relies on and perpetuates some stereotypes of race and ethnicity using non-self-reported data.²¹ As mentioned earlier in regards to biases in algorithm based determinations, the imputed sources method relies on historical data collected by federal agencies (that was not fully representative of marginalized populations then), which can perpetuate bias in health systems today.²²

- b. *Prioritize Intersectional Identities in Regards to Health Disparities:* As CMS reviews research studies to identify health disparities in regards to social risk factors and patient demographics,²³ we urge CMS to prioritize considering intersectional data (e.g., health disparities for women of color). Studies have consistently shown that people with intersecting marginalized identities experiences poorer health outcomes, yet health measures and reports and CMS programs and interventions rarely address these documented disparities.²⁴
- c. *Prioritize Transparency and Data Sharing Around Health Disparities:* We understand and appreciate the importance of sample sizes in order to reliably perform comparisons and stratifications.²⁵ However, certain health equity data has been historically under reported—for example, health equity data for American Indian and Alaskan Native (AI/AN) populations—which continues be a barrier for researchers and advocates.²⁶ In situations where CMS has some data relating to health inequities, we urge that the agency make it publicly available with the appropriate disclosures about its level of reliability.

²⁰ NPRM at 1040.

²¹ For example, the source cited in the NPRM states that “Analytic weights post stratified respondents to match the Medicare population within state (FFS) or contract (MA) on an extensive list of variables, including CMS race/ethnicity, gender, dual eligibility, zip code-level distributions of income, education, and race/ethnicity using iterative proportional fitting.” Ann Haas et al., *Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity* 14 (2019), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338295/pdf/HESR-54-13.pdf>, page 2.

²² *E.g., id.* at 3 (noting that the imputed sources method uses data from before 1980, when data on Hispanic and Asian/Pacific Islanders (API) were not collected).

²³ NPRM at 1031.

²⁴ *See, e.g.,* SAGE, *Disrupting Disparities: Solutions for LGBTQ New Yorkers Age 50+, 38-40*, at 38-40 (2021).

²⁵ NPRM at 1031-32.

²⁶ Justice in Aging, *Comment on Advanced Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and D Policies 2* (March 4, 2021), available at <https://justiceinaging.org/wp-content/uploads/2022/03/Final-Comments-to-2023-Part-C-and-D-ANPRM.pdf>.

IV. Conclusion

Thank you again for the opportunity to comment. If any questions arise concerning submission, please contact Sahar Takshi at stakshi@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Amber C. Christ". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Amber C. Christ
Directing Attorney
Justice in Aging