

June 17, 2022

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave, S.W.  
Washington, DC 20201

Submitted electronically via Regulations.gov for 

Re: Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) and Proposed Policy Changes and Fiscal Year 2023 Rates

Dear Administrator Brooks-LaSure

On behalf of Velatura Health Information Exchange Corporation (VHIEC), which consists of health information exchanges and networks (collectively HIEs) across the nation, we appreciate the opportunity to provide feedback on the proposed changes to requirements around the sharing of payer data.

The health interoperability landscape is dynamic and constantly evolving. To maintain relevance and sustainability, health information exchange organizations must regularly pivot to meet the multifaceted demands of customer needs, technological change, and regulatory requirements. VHIEC is a not-for-profit organization serving to meet those needs. Through affiliation, collaboration, and integration opportunities, VHIEC is dedicated to facilitating the exchange of electronic health information and building the technical and collaborative partnerships between healthcare stakeholders across their geographic regions. Further, VHIEC offers the ability to affiliate to achieve national economies of scale while maintaining localized stakeholder alignment and focus.

VHIEC applauds CMS' continued dedication to improving the healthcare setting through required reporting and metrics. Interoperability, or the sharing of information across multiple systems, guarantees the entities have pertinent information necessary to create accountable care that will improve healthcare systems as a whole. VHIEC is committed to supporting IPPS success and looks forward to continuing to be an active partner in this process.

In large part, VHIEC and its stakeholders are extremely pleased with the release of the 2023 IPPS Policy Changes; however, in our role as the convener for many of our healthcare stakeholders, we gathered comments and feedback on improvements to be made. As a result, we have suggested

ways to improve the 2023 IPPS Policy Changes even further, as described herein. VHIEC encourages CMS to review the following comments and recommendations to maximize the positive impact of the 2023 IPPS Rules on healthcare stakeholders.

For your convenience, we present our comments below:

**Key Proposed Medicare Maternal Health Policies Comments:**

- VHIEC supports the adoption of the Cesarean Birth eCQM in the Hospital IQR Program measure set, to be available for hospitals to select for reporting beginning in the Calendar Year (CY) 2023 reporting period and the FY 2025 payment determination. VHIEC further supports a mandate, requiring reporting of the Cesarean Birth eCQM beginning in the CY 2024 reporting period and the FY 2026 payment determination, except for hospitals without an obstetrics department that do not perform deliveries. While these metrics will place additional requirements on hospitals, the utilization of data to create an accountable care system will serve to resolve the issue at the root cause and will outweigh the effects of a new requirement. Additionally, we encourage CMS to identify community partners who may alleviate the burden on hospitals submitting these metrics. Health Information Exchanges (HIEs), such as those who make up VHIEC are well equipped to help hospitals and providers capture and share data in a centralized manner and help with sharing with CMS, which would mitigate the effects of increased reporting.
- VHIEC supports the adoption of the Severe Obstetric Complications eCQM in the Hospital IQR Program measure for reporting beginning in the Calendar Year (CY) 2023 and the FY 2025 payment determination. VHIEC further supports a mandate on reporting of the Severe Obstetric Complications eCQM beginning in the CY 2024 reporting period and the FY 2026 payment determination, except for hospitals that do not perform deliveries or do not have an obstetrics department. While this metric would be beneficial to increase awareness on complications and improve adherence to clinical guidelines, our next comment advocates for preventative care, to decrease the likelihood of these health outcomes.
- VHIEC respectfully requests CMS to consider the effect of preventative medicine and information sharing on severe maternal morbidity (SMM) or adverse health outcomes including, but not limited to hemorrhage, embolism, severe hypertension, and stroke. While reporting of adverse outcomes such as the two aforementioned are undoubtedly important, it is well documented that upstream social determinants of health or health related outcomes play a role in the likelihood of occurrence. HIEs and EHRs have actively worked to create standardized fields to capture these data elements and standardized mechanisms to share this information. Reporting on the occurrence of these incidents is important, but it is reactionary. By working alongside HIEs and EHRs to capture information pertinent to preventative medicine, and further educating on the how this information should be utilized by providers, it will lead to positive health outcomes for the population at large and halt adverse health outcomes before they can come to fruition. We encourage CMS to consider as a part of the IPPS program incentives for participation in health sharing networks such as HIEs, who are able to share the information necessary for preventative care.
- VHIEC supports the maternity care quality hospital designation, which would be publicly reported on CMS's website beginning in Fall 2023. While entities would need to show

participation in a state or national Perinatal Quality Improvement (QI) Collaborative and the implementation patient safety practices or bundles as part of these QI initiatives, we encourage CMS to list resources for entities who may be subject to this moving forward. From our stakeholders in the space, many of whom participate in various quality initiatives, most state their participation would not be possible without their community partners, such as HIEs. For example, Michigan Health Information Network has created the Physician Payer Quality Collaborative forum or PPQC to engage government and commercial payers in an effort to focus quality improvement efforts around a core set of measures and standardize performance report and feedback with health plans. PPQC was created as a reaction to the transition from traditional fee-for-service to the rigorous reporting requirements from a number of quality improvement incentive programs. Between initiatives like Physician Quality Reporting System (PQRS), Meaningful Use (MU), the Healthcare Effectiveness Data and Information Set (HEDIS) and others, physicians were required to monitor and report several hundred performance measures to multiple sources with little to no alignment nor intersection. The burden of complying with several hundred performance measures was compounded by the volume and variety of health information technology (HIT) vendors in the market. The lack of interoperability and standardization across vendor platforms added significantly to the costs and effort needed to share quality data. PPQC resolved these errors and allowed participation in quality initiatives and reporting to become much simpler by collaboration in the statewide forum, which has participation in the hundreds. We encourage CMS to reference these community partners and initiatives to help entities understand how to meet these requirements with less burden.

### **Request for Information to Advance Maternal Health Equity, VHIEC Comments**

- Throughout the request for information, there is frequent inquiry into best practices or quality improvement initiatives that are utilized by hospitals. One mechanism that may be helpful in terms of quality improvement initiatives are the way individuals are matched into an initiative they may benefit from. For example, patient matching may be a preferable method than requiring individuals to actively enroll in an initiative. VHIEC has been parsing out a two- part patient scaffolding process in which an HIE would use deidentified or limited data sets to match individuals into quality initiatives based on their health information. Once they are matched and confirmed to be eligible, they would be enrolled and their complete information and data set would be used for the quality initiative. This takes the burden off of individuals to find these initiatives, but still allows them to benefit from them. To preserve patient autonomy and control over their information, detailed Notice of Privacy Practices (NPPs) and additional notifications can be used by practices.
- In the request for information, there was also a question on which additional Conditions of Participation should be utilized to advance Maternal Health Equity. As a health information exchange corporation, our insight into the clinical environment is supplemented by the voice of our stakeholders, and many have relayed to us that Conditions of Participation are increasingly costly in terms of time and monetary resources. This is because CoPs usually involve a combination of technology solutions, technology training, clinical training, and ongoing compliance. In the past, Health Information Exchanges (HIEs) have been able to alleviate the impact of CoPs on hospitals by continuing or building on existing services they offer. For example, a CoP within the past few years was for all hospitals to begin

sending encounter notifications. Building off the existing admissions, discharge, and transfer use case; alert use case; and others, many HIEs were able to help the hospital community, who already participated in their network, meet the CoPs with relatively little to no additional impact. For those who were not a part of the network, becoming a part of the network was as easy as a two-part legal and technical onboarding process. While the burden was low for hospitals, it resulted in increasing sharing of information across health systems, increased care coordination, and collaboration on individuals who providers may have in common, and more. This is an example of a low impact but high reward Condition of Participation, and we encourage CMS to use this approach to model the requirements around healthcare disparities as well. For example, perhaps the Conditions of Participations for this issue begins with requiring the appropriate data fields for the collection of SDOH or health related social needs. Further, perhaps the next step would be requiring information to be collected and shared in a standardized manner across the country so receivers of the information could use it to bring about population and even public health related solutions. Lastly, a CoP may require training for all staff on how to input and track these fields.

- In the request for information, there is a question of what types of measurable activities targeting maternal health outcomes may demonstrate a reduction in healthcare disparities and delivery. There is also mention of how to improve the quality of postpartum care and support for behavioral health support. This topic ties closely with an increased interest in sharing health information with community based organizations (CBOs) who may be able to supplement the care the mother receives during child birth. Utilizing HIEs for referrals to other providers or community based organizations is an essential component to making this a reality. While the Department of Health and Human Services has released updated language on sharing health information with CBOs, there is still hesitation from entities to share with any organization who may not be considered a Covered Entity or Business Associate traditionally under the HIPAA Privacy Rule. Along with this sentiment, is an ongoing reluctance to share any behavioral health information outside of a provider's office, even behavioral health information that is not covered by 42 CFR Part 2. Much of this is caused by confusion surrounding the multiple regulations surrounding the sharing of health information and uncertainty on which regulation applies to which entities and which information. While we undoubtedly condone the sharing of health information, we request CMS to release clarification, guidance, or joint statements with the entities in charge of crafting the language on how this language is to be interpreted in order to allow entities to create referrals, share information, and continue care post-delivery.
- While rural providers or hospitals have sometimes been entirely exempt from regulations in the past, these practices and providers are oftentimes the ones that we need in compliance—far more than other entities in metropolitan areas because they are facing disproportionately adverse health outcomes during childbirth. They deserve to receive the same information and should be held liable for reporting out the same information to determine if rural populations are adversely affected in maternal care. In place of an exemption, we suggest CMS pose alternative, less burdensome methods for those rural hospitals who are currently unable to comply. This may be an alternative method for reporting to CMS, alternative to receiving information (e.g. direct secure messaging), and others. Further for those rural or underserved areas who need access to resources, which speak to healthcare disparities, we suggest requiring in statewide forums to grant them

access to the same resources other hospitals may benefit from. HIEs, such as VHIEC hold a series of statewide and even national presentations on a variety of topics from consent, to social determinants of health, to health equity, and beyond. Rural communities could benefit from this information by participation in the network or even participation in other statewide forums.

- Communicating with family members on an individual's care is closely tied to the barriers we see with sharing information with CBOs and behavioral health organizations: there is a hesitation on providers' part to share health information that may be protected under HIPAA, 42 CFR Part 2, or another privacy regulation or requirement. Much of this hesitation stems from confusion on what privacy regulations apply and what their obligations are to share or not share information during a maternal health event or emergency. We highly encourage CMS to release guidance on how to interpret regulations that govern the sharing of information with family members. Receiving information from family members could result in a life being saved and sharing information with family members may impact the patient's rights over the sharing of their own health information. Until there is a general consensus on how this is interpreted, there will continue to be a barrier to sharing this information.
- On the question of hospitals may review and monitor aggregate data on the maternal health risks of the patient population that they service, and on what data sharing best practices are required for hospitals to share data with external entities, no one requirement is more important than a requirement for hospitals to participate in a health information exchange (HIE), health information network (HIN), health data utility (HDU), or similar organization. No longer are HIEs and HINs the entity responsible for merely getting information from Point A to Point B, these organizations extract data for disparate health data sources-- including providers, health plans, patients, state agencies and registries, community based organizations, supply chain manufacturers, emergency management agencies and organizations, and other relevant stakeholders-- to generate data output and payloads that are meaningful and relevant to healthcare stakeholders and policymakers. The data output they are able to provide is crucial to proving insight into the how the public healthcare landscape can be improved to maximize care through analytics, reporting, quality enhancement recommendations, real-time information at point of care for improved clinical decision making, and more. On the provider side, the benefits of participation could include more informed clinical decision making, policy making, resource allocation, care coordination, and assessment activities. These entities also have the ability to deliver public health information to providers in a digestible format which is distinct from the stand alone information sharing that clinicians rarely use. On the public health side, benefits from participation could include facilitating mandatory reporting, calculating quality measures, hosting selected registry data, interfacing with Advanced Directive registries, compiling resource directories, data visualization and reporting for stakeholder and policy makers, aggregating EMS and policy reports for overdose events, and tactical support through technical expertise. HIEs, HINs, and HDUs are undoubtedly a key component of supporting maternal care and other public health related issues. We encourage CMS to call them out as partners in this space explicitly in the final draft.
- In terms of collecting race and ethnicity information, the largest hurdles CMS will face is having a data field present for all providers, requiring standardized collection and input of



information into the data field, and ensuring it is able to be sent across a community. HIEs are able to help with this sharing, however, hospitals may face hesitation with collecting and sharing this information in line with the privacy concerns referenced previously.

### **Proposed Medicare Policies to Broadly Advance Health Equity**

- VHIEC supports the proposed Hospital Commitment to Health Equity Measure through the following five key domains: strategic planning that prioritizes equity; improved data collection; effective data analysis; quality improvement efforts; and leadership engagement on fostering a culture of equity. Hospitals would need to attest to their activities in each of these domains. We suggest more detailed information on improved data collection, effective data analysis, and quality improvement efforts. We also request CMS clarify in which instances a hospital's participation in a regional framework, such as an HIE and related use cases, would constitute evidence of data collection, data analysis, and quality improvement. Many hospitals currently would meet these areas by participation in use cases they participate in and the ability to use participation as evidence would allow for a meaningful, supported evidence.

### **Proposed Measure to Improve Screening for Social Drivers of Health**

- VHIEC supports Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. While we support the collection of these measures, we caution against use for discriminatory pricing or purposes. Often times social determinants of health (SDOH) or health related social needs (HRSN) information such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety might be considered sensitive information to the individual providing the information, though it may not have the regulatory classification of specially protected information. For this reason CMS should specify how this information is collected, how it is protected, and with whom the information is shared in their Notice of Privacy Practice (NPP). CMS should also put in place Conditions of Participation, requiring hospitals to train their staff on how this information can and cannot be used to prevent information being used from discriminatory pricing, care, or other purposes. Particularly when viewing a metric, such as health care utilization, there may be an implication that this information will be used to penalize the individual and prevent them from seeking care further, which only serves to exacerbate the problem. We encourage CMS to create Conditions of Participation around the sharing of this information to encourage training and education to their staff. We additionally encourage CMS to identify community partners or entities to help with the collection of this information (e.g. HIEs), and as mentioned previously, place emphasis on how to collect (data fields, standardization, aggregation).
- While VHIEC is in support of Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health, VHIEC respectfully requests that CMS consider the discrepancies between how organizations screen in healthcare as compared to identifying and codifying specific issues or diagnoses. Evidence has shown that when organizations screen a population, they will generally identify 10-15 percent of that population with HRSNs. However, evidence has also shown that the screening of people in this manner does not accurately predict or identify actual HRSNs. We encourage CMS to also put in

place secondary surveys, while utilizing human interaction, to accurately identify HRSNs through screening information.

- VHIEC supports the goal of these measures to identify specific risk factors emphasizes the need for data quality (i.e. validity) over data quantity. While the collection of data is important, health care providers and health care institutions must be cautious about asking patients about these needs when the community service providers needed to supply assistance in the community to meet those needs are overwhelmed, underfunded, and understaffed. We encourage CMS to not only focus on the quantification of HRSNs, but how to address them and mitigate them through coordination and support of work in the community setting.
- VHIEC cautions that the proposed voluntary and mandatory reporting periods will take significant effort and may result in an administrative burden that distracts organizations from improving the care that only they can provide.

### **Proposed Supplemental Payment for Indian Health Service, Tribal Hospitals, and Puerto Rico Hospitals**

- While VHIEC is generally in support of payments for Indian Health Service, Tribal Hospitals, and Puerto Rico Hospitals, particularly when those hospitals are absorbing the costs of unpaid services, we are not in support of discontinuing the use of a past payment without the mechanism for receiving the supplemental payment in place fully. Instead, we suggest a phased approach where hospitals are able to submit on information for the both previous metric and the new metric (but only receive payment on the prior until they have met the requirements for new). This would give them the time and flexibility to resolve any issues with the new information required over a period of time and eventually phase out the past payment once the hospital is able to report with the new information and receive the new supplemental payment. To not allow this phased approach, or a similar approach, would result in a scenario in which these hospitals are not receiving any supplemental payment and entirely absorbing the costs, which is converse to the purpose of creating and improving on this item.

### **Proposed Approaches to Addressing Drivers of Health Care Quality Disparities and Developing Measures of Healthcare Equity in the LTCH QRP**

- VHIEC is in support of the Health Equity Summary Score (HESS) measure and the proposed Hospital Commitment to Health Equity measure for the LTCH QRP; however, we do not believe CMS has provided enough information to truly determine if a provider is treating is demonstrating good performance in providing care to one with social needs nor how an incentive would work to discourage the opposite. While we see the value in an incentive for a provider who is treating an individual with social needs in a positive way, we caution against the use of penalties for providers who may also be operating in good faith. Instead, we suggest more productive methods that might allow for training from those providers who are treating utilizing best practices.
- VHIEC supports the use of a regression decomposition to identify and calculate the specific impact of SDOHS and other factors on disparities, but cautions that LTCH's span of control is limited to care within their walls to figure out how to address care needs that exist outside

of them. VHIEC encourages considering community organizations and navigation, which could be provided to assist and meet the needs not considered in the equation.

### **Request for Information on LTCH QRP Quality Measure Concepts under Consideration for Future Years**

- While it is important to determine leadership commitment to Health Equity, that is by no means a measure in and of itself; it is supported by data and metrics on how the entity chooses to address health equity as a whole. Depending on what technology, training, education, resources, etc. an entity dedicates toward health equity, and how they choose to pivot based on the results of these area, is a subjective measure. It may be difficult to have a measure that can be used for all entities. Perhaps CMS may instead point to a certain level of progress on specified areas.
- We encourage CMS to state an adequate sample size and representation for disparity reporting in order to have a more accurate metric.
- We suggest guidance for entities who are collecting information, which may be considered sensitive to a patient such as certain demographic categories, social determinants of health categories, health related social needs categories, and others.
- We suggest CMS hold quarterly meeting to help entities understand what these metrics may teach them about their existing practices and areas for improvement. We also encourage CMS to shed light on results that may be counterintuitive, and provide updated metrics throughout the years to account for lessons learned and which metrics may speak more clearly to measuring health disparity.

### **Request for Information on Reporting Social Determinants of Health**

- How the reporting of certain Z codes – and if so, which Z codes<sup>24</sup> – may improve our ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs?
- Whether CMS should require the reporting of certain Z codes – and if so, which ones – to be reported on hospital inpatient claims to strengthen data analysis?
- The additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries.
- Whether codes in category Z59 (Homelessness) have been underreported and if so, why? In particular, we are interested in hearing the perspectives of large urban hospitals, rural hospitals, and other hospital types in regard to their experience. We also seek comments on how factors such as hospital size and type might impact a hospital's ability to develop standardized consistent protocols to better screen, document and report homelessness.
- VHIEC supports the encouragement of feedback on how to improve documentation and reporting of diagnosis codes detailing a patient's social and economic circumstances, as well as on how to increase the reliability and validity of the code data. However, VHIEC cautions that so much time, energy, and resources will go into screening that the problem will be that much more difficult and complex by the time it is addressed. VHIEC encourages CMS to not only focus on the screening, documenting, and reporting of homeless, but also on how to resolve the issue.
- VHIEC cautions that the additional provider burden of documenting and reporting certain Z codes may be significant, given that patients may not believe or trust that the information



will be used appropriately. In addition, there are limitations of EMR systems to capture diagnostic codes and those with complex medical conditions can likely fill the capacity of codes. As a result, any Z codes that get entered may be bumped off. To address these concerns, VHIEC encourages CMS to consider information sharing via the collection of data at the community level and then its subsequent surfacing to clinicians, such as through health information networks.

### **Additional Requests for Information Relating to Health Equity**

- VHIEC supports the encouragement of providers to improve health equity and reduce healthcare disparities without disincentivizing or disproportionately penalizing hospitals that treat socially at risk beneficiaries; but, we urge CMS to clearly define how social risk is calculated and how they can ensure the disincentive and penalizing will not occur.
- In terms of climate change, we undoubtedly agree this is a crucial topic to cover; however, during a pandemic time in which healthcare entities are already overworked and understaffed, we do not believe this should be a priority over other areas of concern that also help to support the existing healthcare landscape. For example, it may not make sense to prioritize hospitals reporting out on their own emissions, but it would be relevant and timely to require a business continuity and emergency preparedness plan on how to care for patient populations during pandemics and other natural emergencies.

Please reach out to Tim Pletcher [tim.pletcher@mihin.org](mailto:tim.pletcher@mihin.org) or Shreya Patel [shreya.patel@mihin.org](mailto:shreya.patel@mihin.org) if you have further question or comment on this letter.

Sincerely,

Velatura Health Information Exchange Corporation