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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: [CMS-1771-P](#)
P.O. Box 8016
Baltimore, MD 21244-8016

Re: 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. [CMS-1771-P]

Community Catalyst submits these comments in response to the Department of Health and Human Services (“HHS”, “Department”) and the Center for Medicare and Medicaid Services (“CMS”) Notice of Proposed Rulemaking (“proposed rule,”) CMS-1771-P.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That’s why we work every day to ensure people’s interests are represented wherever important decisions about health and healthcare are made: in communities, state houses, and on Capitol Hill. We share your goals of making the healthcare system work for those not currently well-served, especially people of color, individuals with low-incomes, older adults, and those with chronic conditions or disabilities.

We appreciate your dedication to improving the lives of individuals through affordable, accessible and equitable health coverage and thank you for the opportunity to comment on these proposals. For ease of use, our comments are segmented in the following areas:

- 15. Proposed Changes to the Medicare Code Editor (MCE)
- IV. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) For FY 2023 (§ 412.106)
- H. Hospital Readmissions Reduction Program: Proposed Updates and Changes (§§ 412.150 Through 412.154)
- Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

- B. Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs—Request for Information
- Overarching Comments to CMS Health Equity Strategies
- Additional recommendations to address the burden of medical debt

15. Proposed Changes to the Medicare Code Editor (MCE)

We have concerns about the continued existence of ICD codes that are sex specific. The designation of certain codes as being “male-only” or “female-only” can cause denial of services to patients whose gender markers conflict with sex-specific categorizations of certain services. For example, a transgender man whose gender marker is now male, may still need treatment for cervical cancer or surgery to remove fibroids. When the ICD codes for such services are categorized as “female-only” the patient could encounter a denial or delay of treatment, or be subjected to a stigmatizing and traumatic effort to demonstrate eligibility for such care. Similarly, a transgender woman with a female gender marker may still need such services as treatment for prostate cancer. Although we understand the need to align an individual’s historical health data with that of their gender identity and personal anatomy, while ensuring interoperability, removal of sex specific ICD codes would also benefit transgender and non-binary people who would select an X gender marker. We applaud the Biden/Harris Administration with its State Department Gender “X” policy, but in the wake of Executive Order 13985 – Advancing Racial Equity and Support for Underserved Communities Through the Federal Government – we also welcome any opportunity to usher a “whole of government” strategy.

IV. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) For FY 2023 (§ 412.106)

Disproportionate Share Hospital adjustments compensate hospitals for the additional resources required to care for patients who have low incomes, including those with no health insurance or who are covered by Medicaid. The proposed rule continues the general framework for computing a hospital’s Medicare DSH adjustment, which includes accounting for the hospital’s uncompensated care, as reported in Worksheet S-10 of the Medicare cost report. We recommend that the Medicare DSH method be strengthened so that, in addition to DSH policy compensating hospitals for treating all Medicare beneficiaries, it also improves access and equity for the people whom DSH is explicitly designed to benefit.

We recommend that the DSH methodology include requirements for all hospitals (including non-profit, government-owned, and for-profit hospitals) that would serve to reduce the occurrence of medical debt among hospital patients, by promoting the use of best practices for patient accounts and by strengthening incentives for hospitals to offer financial assistance to eligible patients.

Medical debt, even in relatively small amounts, is a barrier to health care access that disproportionately affects people with limited means who are without health insurance or whose insurance requires significant out-of-pocket contributions. About 17 percent of U.S. households

held at least \$195 billion in medical debt in 2019, according to the Census Bureau.¹ As a result of discriminatory barriers to affordable coverage and care, some people are at greater risk. Indeed, there is a disproportionate effect on Black and Brown people and other oppressed or excluded populations, with nearly 27 percent of Black households and just under 19 percent of Latinx families having medical debt. In addition, households with income of less than 133 percent of the federal poverty level are more likely to have problems paying medical bills. Families in households with children are far more likely to have medical debt than those with no children in the household. Families in which a member has a disability are nearly twice as likely to have medical debt as those families in which no family member has a disability.² Other data show that concern about health care costs causes people not to receive care they need. About nine percent of all adults in 2020, including 10 percent of Black adults and 13 percent of Latinx adults, delayed or went without care because of cost concerns.³

Evidence shows people facing unaffordable medical bills may then be subjected to aggressive billing and collection practices. Some of the nation's largest, most prestigious and financially sound non-profit hospitals and health systems provide significantly less in community investment than they receive in tax breaks.⁴ Some of these same health systems are among those that have taken legal action against thousands of patients with limited incomes,⁵ who often lack legal representation to defend themselves in court.⁶ In at least one state, it was documented that large health systems were commonly the source of medical debt for those filing for bankruptcy.⁷ Interest added to medical debt makes the cost of health care even more unaffordable for people with low and moderate incomes. Medical bills account for 58% of collection accounts on credit reports, and it is estimated that \$88 billion in medical debt sits on people's credit reports. The reporting of medical debt in arrears has an oversized detrimental effect on people's credit scores.

In order to address the burden of medical debt for many individuals and families and ensure community economic stability, we strongly urge CMS to keep in mind these following principles:⁸

¹ Kaiser Family Foundation (2022). The burden of medical debt in the United States. <https://www.kff.org/health-costs/press-release/1-in-10-adults-owe-medical-debt-with-millions-owing-more-than-10000/> accessed 6/14/22

² U.S. Census Bureau (2021). <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html> accessed 6/14/22

³ Peterson-KFF Health System Tracker. How does cost affect access to care? <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#Percent%20of%20adults%20by%20self-reported%20health%20status%20and%20insurance%20status,%202020%C2%A0>, accessed 6/14/22

⁴ The 41 Hospitals Costing Communities \$4 Billion, The Lown Institute Hospital Index, August 5, 2021 <https://lownhospitalsindex.org/publication/the-41-hospitals-costing-communities-4-billion/>

⁵ 'There's no way I can pay for this:' One of America's largest hospital chains has been suing thousands of patients during the pandemic, CNN, May 198, 2021 <https://www.cnn.com/2021/05/17/us/hospital-lawsuits-pandemic/index.html>

⁶ St. Dominic Knew Patients Couldn't Afford Care. It Sued Them Anyway, Mississippi Center for Investigative Reporting, August 6, 2021 <https://www.mississippicir.org/news/st-dominic-knew-patients-couldnt-afford-care-it-sued-them-anyway>

⁷ Unhealthy Debt-Medical Costs and Bankruptcies in Oregon, OSPIRG, Fall 2021 https://ospirg.org/sites/pirg/files/reports/OSPIRG_Unhealthy-Debt%20FINAL%20%281%29.pdf

⁸ For additional detail, see Community Catalyst, Principals for Improving Community Economic Stability Through Hospital Billing Policies. <https://www.communitycatalyst.org/resources/tools/the-advocates-resource-community->

- *Equity*: hospitals should examine their financial assistance policies to ensure they do not discriminate based on age, sex at birth, gender identity, race or ethnicity, disability status, health status, language, immigration status, sexual orientation, or religious affiliation and implement a concrete action plan to address health disparities, advance health equity and improve community health.
- *Transparency*: Hospitals should make their policies easily available to the public, proactively inform patients of their policies and screen them for eligibility and make the application process simple and flexible.
- *Affordability*: Hospitals should avoid excessive charges, adopt policies that protect patients of limited means from financial burdens, and eschew all billing and collection practices that impoverish patients and worsen economic inequities.
- *Inclusivity*: Hospitals should be responsive to community needs by soliciting, listening to, and incorporating patient feedback, and by partnering with community organizations to identify and provide focused outreach and support to demographic and geographic communities most likely to need financial assistance.
- *Accountability*: Hospitals should educate staff about financial assistance policies, institute internal processes to ensure compliance with the policies, and conduct annual reviews to address evolving community needs based on inclusive feedback practices.

To that end, we specifically recommend:

1. ***Requiring that hospitals meet certain Conditions of Participation (CoPs) and Conditions of Coverage (CfCs) to receive all or part of their Medicare DSH adjustment***, including:
 - Proactively and universally screening *all* patients for coverage options, including the financial assistance programs offered by the hospital;
 - Developing a formal financial assistance policy that is extended to the underinsured as well as all uninsured patients; disseminating and making it available and known to the public;
 - Limiting fees at the Medicare or Medicaid rate, for patients eligible for financial assistance;
 - Prohibiting unfair, unethical, and questionable billing and collection actions that impoverish patients. Those include, but are not limited to, liens on homes, since a home is the only asset for many low-income people, wage garnishments for low-and moderate-income people, and body attachments or civil actions that lead to arrest or incarceration.
2. ***In working with patients to meet standards for their financial assistance and billing policies, requiring hospitals to attest to adoption of the industry-based Health Care Financial Management Association’s (HFMA) “Best Practices for Resolution of Medical Accounts.”***⁹ These best practices emphasize the importance of screening for coverage and financial assistance as well as meaningful and culturally responsive engagement with patients, and caregivers when appropriate, at every stage of a hospital inpatient experience (pre-service, pre-discharge, and post-discharge) and build on HFMA’s past work in patient-

[power-leading-the-charge-to-improve-community-benefit-and-economic-stability/pdf/Principles-for-Improving-Financial-Assistance-0615-FINAL.pdf](https://www.hfma.org/content/dam/hfma/Documents/industry-initiatives/best-practices-medical-resolution-financial-assistance-0615-FINAL.pdf), accessed 6/14/22.

⁹ <https://www.hfma.org/content/dam/hfma/Documents/industry-initiatives/best-practices-medical-resolution-medical-accounts.pdf>, accessed June 10, 2022.

friendly billing [in a manner understandable by patients with low health and financial health literacy], culturally appropriate patient communication, and price transparency. Consulting with patient representatives to reach agreement on policies will ensure a hospital's adherence to best practices and increase the likelihood that patients eligible for financial assistance will be informed about the availability of assistance and apply for it, and that billing and collections policies will meet IRS standards.

3. ***Conducting a Community Health Needs Assessment (CHNA) every three years and adopting an implementation strategy to address identified community health needs.*** Section 501(r)(3) of the Internal Revenue Code requires that not-for-profit hospitals conduct a CHNA to retain tax-exempt status under Section 501(c)(3). We strongly urge CMS to extend or mirror a version of this requirement to for-profit hospitals. Many hospitals will undoubtedly approach their assessment and planning with an eye for minimally complying with the federal regulations. However, at Community Catalyst, we see CHNAs as opportunities for community-based organizations to forge strong partnerships with hospitals, and meaningfully engage in the process to ensure that hospitals' limited community benefit resources are appropriately targeted to achieve equity and rectify longstanding injustices. Implementing such a policy would benefit hospitals in making steps towards screening for social risk factors. CMS' Accountable Health Communities Model found that leveraging community partnerships was key to advancing screening, referral, and navigation efforts. The model also critically included Community Advisory Boards, that were pivotal in identifying community needs, utilizing data to assist with planning for a gap analysis, and considering how to develop quality improvement processes. We encourage CMS to capitalize on its investments and lessons learned by developing guidance on meaningful community engagement for hospitals to use in their CHNA process. In addition, the issue brief "Centering Racial Justice in Hospital Community Benefit Investment: Authentic Community Engagement Strategies in Community Health Needs Assessments"¹⁰ provides two examples of best practices for meaningful engagement in community health needs assessments.

4. ***Redefining "uncompensated care" to align with the definitions used to determine community benefit spending under the Internal Revenue Code.*** The rule proposes continuing to use Line 30 from Worksheet S-10 of the Medicare cost report as the hospital-specific value of uncompensated costs ("Factor 3") in computing a hospital's DSH adjustment. In addition to the cost of charity care, Line 30 includes the costs of non-Medicare bad debt and non-reimbursable Medicare bad debt. In contrast, the IRS definition of financial assistance counted toward a hospital's community benefit obligation excludes "bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing such care to such patients."¹¹ We recommend that Factor 3 be revised to be consistent with this definition, which refers to a related aspect of a hospital's mission and a similar patient population. This modification will also have a policy benefit of interest to CMS, in that it will incentivize hospitals to apply their financial assistance policies more assertively, as bad debt would no longer be reimbursable through DSH, but charity care (financial assistance) would. Further, any resulting reduction in hospitals' bad debt would mean a reduction in consumers' medical debt, which imposes

¹⁰ <https://www.communitycatalyst.org/blog/text/Centering-Racial-Justice-Medical-Debt.pdf>

¹¹ <https://www.irs.gov/instructions/i990sh>, accessed 6/14/22.

outsized financial burdens and inhibits access to care and health outcomes. This is especially desirable in instances where bad debt should in fact be charity care, were financial assistance policies to be conscientiously applied.

H. Hospital Readmissions Reduction Program: Proposed Updates and Changes (§§ 412.150 Through 412.154)

Community Catalyst fully supports CMS' overall goal of achieving equity in healthcare outcomes for all patients, for your interest in encouraging providers to improve health equity and reduce health care disparities through the Hospital Readmissions Reduction Program, and for your specific request for information on potential social risk measures and indices. At Community Catalyst, we build the power of people to create a health system rooted in race equity and health justice, and a society where health is a right for all. We are confident that this is a value shared by CMS, considering the prominent role of advancing equity in the CMS Strategic Pillars. Currently, there are a few composite measures to of area or neighborhood social disadvantage and deprivation. Example variables include poverty, unemployment, education, and wealth. We would encourage CMS to consider one of these composite measures: area deprivation index, social deprivation index, neighborhood deprivation index, multidimensional deprivation index, etc. However, we would encourage CMS to incent researchers to explore a variable not included in any of the existing indices – the role of segregation, gentrification, and hypersegregation in US cities. [Recent research](#) indicates that although American cities are diversifying, segregation persists. And, Americans are not only segregated in where they live, but where they eat, drink, shop, socialize, travel, and likely where they seek and can access healthcare services. Considering hypersegregation is vital for a few important reasons: residential segregation [whether codified or the effects of codification] gives rise segregated healthcare facilities, often associated with worse access to and quality of medical care. In addition, poorer health decreases individuals' abilities to leave disadvantaged communities and recent research indicates that gentrification may be harming population health. A public health solution is imperative, given public health's role in codification of racial zoning. [Baltimore officials used public health data to justify racial segregation. Health officials quarantined Black people in their neighborhoods during tuberculosis, cholera, and yellow fever outbreak.](#) Segregation continues to play a striking role in developing and exacerbating existing health disparities and to ignore its role would be ignoring the root causes social risks for many minority communities.

Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

We join with the Georgetown Center on Children and Families, the National Birth Equity Collaborative, the Center for Reproductive Rights, the National Partnership for Women and Families and other allied organizations working to improve birth equity in expressing our deep appreciation for the unprecedented attention of the Biden-Harris Administration to maternal health and efforts to take a whole-of-government approach to advance health equity and improve maternal health outcomes. These proposed rules represent important first steps towards greater public transparency and accountability for hospital-based birth care and outcomes. We have signed on to a separate set of more extensive comments on these rules from birth equity organizations and allies, but want to lift up some elements of those comments here.

Strong support for greater transparency relating to hospital maternity care performance

The quality of maternity care varies between hospitals, and can vary greatly within a hospital's pregnant patients, often associated with their race or ethnicity. Studies have shown that Black women have disproportionately high rates of maternal mortality and morbidity. We strongly support the development of initiatives to make greater transparency about relevant hospital performance available to the public and especially to people who are planning pregnancy or currently pregnant. The aim is to provide information that assists in making care arrangements that align with the person's values and preferences. An important aim of such initiatives is to build awareness about practice variation, so as to help pregnant people – especially those who are Black, Latinx, Indigenous and other people of color – avoid labor and delivery at hospitals with poor quality and consumer experience ratings.

Proposed creation of a “birthing-friendly” hospital designation

We are supportive of CMS' initiative to create a “birthing friendly” designation that would help pregnant people identify higher-quality facilities. Such a designation should be based on a basket of measures that together meaningfully distinguish between facilities and indicate where one might confidently expect to have a better experience and attain better outcomes compared with non-designated facilities. Such designations require careful thought about measures to be included, thresholds or benchmarks indicative of higher quality, weighting of the various components, data displays and effective communication of the meaning of the designation to the general public and health care community. It would be appropriate to glean lessons from and build upon efforts of other entities that have engaged in similar health care designation efforts, such as U.S. News and World Report and the National Committee for Quality Assurance.

We caution, however, that it would be premature and misleading to immediately confer a “birthing-friendly” designation on any hospital that for the Maternal Morbidity Structural Measure simply attests “yes” to participating in a perinatal quality collaborative (PQC) and “yes” to implementing a quality improvement (QI) project, without actually being required to demonstrate quality. Reasons for this caution include:

- Many consumers would reasonably assume that such a designation indicates an exceptional facility with better quality, equity and outcomes of care, whereas “yes/yes” merely indicates some level of participation in a PQC and in at least one QI initiative. It does not indicate whether quality actually improved in the facility in at least that one area (e.g., hemorrhage, pre-eclampsia), and whether this had any impact on care in the many other areas that could be important to birthing people and more directly relevant to their care.
- In states in which the vast majority of birthing facilities participate in PQC QI projects, such a designation would not help distinguish among possible birth setting options in many communities. Additionally, because this designation will only be awarded to hospitals, this designation could harm the reputation and standing of birth centers, and other non-hospital birth settings, despite meeting the same criteria of participating in PQC QI projects.

- Given the nation’s inequitable, underperforming maternity care system, we should expect PQC and QI participation to be routine and to be a floor rather than treating these as exceptional.
- Many hospitals could lose the designation in the future with the addition of other measures reflective of actual care experiences and outcomes, yet predictably would continue to prominently feature the previous recognition in their facilities and communities. This may offer a false assurance of quality to consumers.
- It is important to ensure that eventual users of the proposed CMS website listing “birthing friendly” hospitals have faith in the integrity of the initiative.

In developing and launching the “birthing friendly hospital” program, including the planned website that patients can use to gain information about hospital maternity care quality, we encourage CMS to:

- Consult with birth justice leaders and consumers from most affected communities to understand community-informed factors that would be associated with a “birthing friendly” designation.
- Foster the greatest uptake and impact by consulting the considerable body of research about the most effective ways to present performance data to consumers
- Create and implement a campaign to inform consumers of the variation in maternity care quality, access and equity by hospital and the availability of the designation, and to encourage and support their use of this information when making maternity care arrangements; provide tips for a safe and healthy birth, including for those who don’t have access to a designated facility or who are committed to a care provider who doesn’t attend births in a designated facility
- Encourage local health departments and regional Medicaid and Medicare offices to provide information on maternity care and the “birthing friendly” designation to pregnant and postpartum consumers and beneficiaries in their region. This information should be made available in multiple formats and languages.

Concern About Addressing Hospital Refusals of Pregnancy-Related Care

Rulemaking to establish the designation of qualifying hospitals as “birthing friendly” is coming at a time when abortion care is under unprecedented attacks, the Supreme Court is on the precipice of dismantling federal Constitutional protection for abortion access, and lawmakers are seeking to target other forms of reproductive health care, including contraception. Given these developments, it is even more important for CMS to ensure that pregnant and postpartum patients are able to receive a full spectrum of quality, respectful pregnancy-related care, when and where they need it. In addition to encountering state restrictions on abortion care, pregnant patients may face unexpected hurdles when seeking treatment for pregnancy emergencies, such as ectopic pregnancies and miscarriages, at hospitals that refuse to provide prompt, best practice medical treatment for such patients based on non-medical policies.¹² Or, if giving birth, patients

¹² See, e.g., the case of Tamesha Means, a pregnant Michigan resident denied prompt and appropriate medical care when suffering a pregnancy emergency. *Tamesha Means v. USCCB*, No. 1:15-cv-00353-RHB (W.D. Mich. June 30, 2015); Court Cases: Tamesha Means v. USCCB, ACLU, <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops> (last accessed June 13, 2022). Katharine Stewart, *Why was a Catholic hospital*

may be refused desired post-partum tubal ligations or provision of effective contraception at hospitals with non-medical restrictions on such care.¹³ Studies have shown that patients often are unaware of the existence of such policies at some hospitals. Moreover, patients may not be informed of all their potential treatment options if some options conflict with hospital prohibitions.¹⁴

When formulating requirements for “birthing friendly” hospitals, CMS should carefully consider ways to safeguard pregnant patients’ rights to fully informed consent, with knowledge of all potential treatment options, and ensure their access to prompt, appropriate medical treatment for pregnancy emergencies. Any facilities seeking the “birthing friendly” designation should commit to ensuring full transparency with patients, inform them that the facilities will not provide certain types of care that they might need during their pregnancy, and during their first interaction with the facility staff or physician, they should provide patients with a clear and concise list of pregnancy-related services that will not be provided. Patients should also be made aware of their rights - and hospitals of their obligations - under EMTALA. We encourage CMS to implement the following requirements for any “birthing friendly” designated hospital facility:

- Requirement that “birthing friendly” hospitals be transparent about any non-medical restrictions on the care they will provide, such as bans on post-partum tubal ligations or post-partum offering of effective contraception, and a commitment to reporting the number of patients who are denied those forms of care each year for public use.
- Requirements that “birthing-friendly” hospitals not be allowed to simply send away people who show up with emergency medical conditions, including premature rupture of membranes or ectopic pregnancies, in compliance with the Emergency Medical Treatment & Labor Act (EMTALA).¹⁵ Physicians have both a professional and legal duty

willing to gamble with my life?, N.Y. Times (Feb. 25, 2022),

<https://www.nytimes.com/2022/02/25/opinion/sunday/roe-dobbs-miscarriage-abortion.html?searchResultPosition=1>.

¹³ Zarina J. Wong et al., *Why you don't can hurt you: Patient and provider perspectives on postpartum contraceptive care in Illinois*, 107 *Contraception* 62 (Mar. 2022); Lee Hasselbacher et al., “My Hands Are Tied”: *Abortion Restrictions and Providers’ Experiences in Religious and Nonreligious Healthcare Systems*, 52 *Persp. on Sexual and Repro. Health* 107 (July 2020); Am. Coll. of Obstetricians and Gynecologists, *Comm. on Health Care for Underserved Women Opp. 827 Access to Postpartum Sterilization* (June 2021),

<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/06/access-to-postpartum-sterilization> (“Patients who desire postpartum sterilization who are receiving maternity care at religiously affiliated hospitals, or from clinicians with religious objections, should be informed early in prenatal care of any restrictive policies or personal objections and should be referred to a practitioner or hospital that will be able to accommodate their request.”).

¹⁴ See Debra B. Stulberg et al., *Women’s Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals*, 51 *Persp. on Sexual and Repro. Health* 135 (Sept. 2019); Jocelyn M. Wascher et al., *Do Women Know Whether Their Hospital is Catholic? Results from a National Survey*, 98 *Contraception* 498 (Dec. 2018).

¹⁵ See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1986); Ctrs. for Medicare & Medicaid Servs. Ctr. for Clinical Standards and Quality, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (Sept. 17, 2021), <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfopolicy-and-memos-states-and/reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy> (“The regulation defines dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it holds itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. Based on this definition, it

to provide stabilizing medical treatment to pregnant patients who present at hospitals with emergency medical conditions.¹⁶ Facilities should commit that they will at least stabilize and transfer such patients elsewhere. If possible, CMS should encourage “birthing friendly” facilities to treat such patients in a prompt and medically-appropriate manner so long as the facility has the technological capabilities.

We also encourage CMS to utilize both Beneficiary and Family Care Quality Improvement Organizations (BFCC-QIOs) and Quality Innovation Network (QIN) QIOs to help patients better understand the quality of care they are entitled to, work with hospitals to improve delivery of care, assist patients with complaint processes, and help patients understand their rights under EMTALA and hospitals their obligations.

Finally, as CMS establishes criteria for data analysis, we encourage the inclusion of comparisons of the performance among hospitals with different ownership structures and affiliations, e.g. public vs. private hospitals, with patient data disaggregated by race, ethnicity, age, sex (including sexual orientation, gender identity, and intersex traits), disability status, and insurance status.

Strong support for adding ePC-02 Cesarean Birth and ePC-07/SMM Severe Obstetric Complications to IQR program, including rapid mandatory reporting and public reporting

Cesarean Birth measure. We strongly support the addition of ePC-02 to the IQR program and the proposal to mandate reporting by all birthing hospitals after a one-year period of voluntary reporting. We welcome public reporting of this measure through the Care Compare and successor websites. In 2014, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine issued a statement of Obstetric Care Consensus concluding that the steep, rapid increase in the national cesarean rate between 1996 and 2011 was not associated with any discernible improvement in maternal or newborn morbidity or mortality; the statement called for lowering the cesarean rate and identified effective approaches. This statement was reaffirmed in 2016 and 2019, yet the national cesarean rate has been essentially flat for a decade, at the disturbingly high level of about one birth in three. While this procedure can avert harm and even save lives in selected situations, current levels of overuse of this major surgical procedure pose a broad range of avoidable risks to birthing people and babies. A series of evidence-based practices would, if routinely implemented, avert many unwarranted cesareans.

Severe Obstetric Complications measure. We strongly support the addition of ePC-07/SMM to the IQM program and the proposal to rapidly mandate reporting by all birthing hospitals. We welcome public reporting of this measure through the Care Compare and successor websites. Severe maternal morbidity (SMM) – often referenced as a “near miss” of dying – is closely

is possible that the labor and delivery unit of a hospital could meet the definition of dedicated emergency department.”). *See also* Protecting Pregnant Patients Act, SSB 5140, 67th Leg., 2021 Reg. Sess (Wash. 2021).

¹⁶ Ctrs. for Medicare & Medicaid Servs. Ctr. for Clinical Standards and Quality, Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (Sept. 17, 2021), <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfo/policy-and-memos-states-and/reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy> (“A physician’s professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment.”).

related to maternal mortality, but much more common and therefore more feasible to measure and track. For every maternal death, many dozens of birthing people experience SMM. Like maternal mortality, SMM has been rising in recent years, and a large proportion is preventable. Adverse physical and psychological effects may be profound and long-lasting, with implications for others in the family as well as the birthing person. Black, Indigenous, Latinx and Asian birthing people experience elevated SMM relative to white birthing people. Inclusion of ePC-07/SMM in IQR with mandated hospital reporting and public reporting on Care Compare has the potential to halt and reverse the deeply troubling trend of increase.

Longer-term development of a basket of meaningful measures for assessing and reporting on maternal health and health equity

The NPRM clearly identifies CMS’s commitment to advancing equity and states that the maternity-related proposals are intended to advance equity. We commend CMS’s commitment, but question whether these proposals by themselves will advance equity. The three quality measures discussed above are not currently specified to collect, measure and track results by race and ethnicity, language, disability status, sexual orientation and gender identity, or other dimensions that consistently involve inequity. Without equity-forward design, it is highly probable that the status quo will persist or inequities will worsen. We strongly encourage CMS to intentionally build equity into its maternity performance measure efforts in the future and to foster accountability for advancing equity. CMS should ensure whenever possible that specifications for maternity and other measures include appropriate stratification and risk adjustment to enable inequities to be measured, tracked, and improved, and to ensure fairness to safety net and other health care entities

The NPRM asks for recommendations for maternity measures beyond Cesarean Birth and Severe Obstetric Complications. At present, reports of birthing people being ignored, not listened to, spoken to harshly, and being subjected to other forms of interpersonal and structural racism and mistreatment are widespread and are often a feature of stories with tragic results. Systems acknowledging the ways racism affects birth outcomes requires exploring innovative anti-racist models and tools for quality improvement. Despite the prevalence of racist microaggressions and bias fueling disrespect in labor and delivery care in the U.S., there are limited tools that can measure disrespect or that support provider behavior change. Urgently needed are standardized birthing-person-reported measures of the experience of maternal and newborn care, inclusive of respect and mistreatment, specified for disaggregation at minimum by race and ethnicity. Health systems are ready for accountability and quality improvement measures for racism, starting with obstetric racism.

We hope that through the sixth CAHPS (Consumer Assessment of Healthcare Providers and Systems) development cycle, the Agency for Healthcare Research and Quality will create maternity adaptations of CAHPS surveys. Disrespectful care leads to high health care costs from maternal morbidity and high social costs from maternal death. The concept of Respectful Care, “care provided ... in a manner that maintains dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth” is globally accepted.

e. Additional Activities to Advance Maternal Health Equity—Request for Information

We are committed to advancing equity for all, including those in underserved communities (American Indian or Alaska Native, Asian or Pacific Islander, Black, Hispanic, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality).

We applaud The Biden-Harris Administration and [HHS Secretary Xavier Becerra's announcement](#) of actions to protect patients and providers in response to Texas' SB8 with three important actions: (1) Title X Grant Support for Providers - Title X grantees received nearly \$19 million to support expansion of family planning services, (2) Enforcement of Nondiscrimination Against Health Care Providers – The HHS Office for Civil Rights (OCR) now enforces the Church Amendments, which protect health care personnel from employment discrimination who object to performing abortion, sterilization, and biomedical or behavioral research activities because of their religious beliefs or moral convictions, and also protects health care personnel from discrimination related to their employment because they performed or assisted with a lawful abortion, and (3) Enforcement of Emergency Medical Treatment and Labor Act (EMTALA) and Medicare Conditions of Participation – The Centers for Medicare & Medicaid (CMS) issued a memorandum to providers reinforcing EMTALA and legal obligations specific to pregnant patients or patients experiencing pregnancy loss. The EMTALA statute requires that all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures. The CoPs are the health and safety standards that Medicare-certified providers and suppliers must meet to receive Medicare and Medicaid payment. CMS has broad statutory authority to establish health and safety regulations for various providers and suppliers; that statutory authority is usually found within the statutory definition of each provider and supplier type. In the case of hospitals, section 1861(e)(9) of the Act defines “hospital” as in institution that, among other things, “meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.” Given the urgent need to fortify people’s rights to access safe, equitable and quality reproductive health services, we strongly advise Secretary Becerra and CMS to use broad mechanisms to protect the rights of all Americans, particularly minority and underserved communities, by expanding the scope of its announcement to all US states and territories.

B. Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs—Request for Information

Community Catalyst appreciates CMS’ thoughtful approach to key elements that we intend to be considered in advancing the use of measurement and stratification as tools to address healthcare disparities and advance healthcare equity. We also agree that measuring healthcare disparities and reporting these results to healthcare providers, and publicly, is an integral approach to advancing healthcare equity. Hence, we offer suggestions on the following considerations:

Prioritize Measures with Identified Disparity in Treatment or Outcomes for the Selected Social or Demographic Factor

We certainly appreciate CMS' efforts to prioritize meaningful measures to identify disparities in treatment or outcomes for selected social or demographic factors, but we also encourage CMS to consider other ways in which health disparities impact minority and underserved populations. Research has shown that beyond access to treatment and outcomes of treatment, minority populations face disparities throughout every step in the healthcare delivery system. For example, in a Community Catalyst Medicaid focus group, we found, "Racism is experienced at all levels and settings of health care. It has caused a number of those in the focus groups to avoid doctors and hospitals, to always distrust, to be vulnerable to misinformation, and to expect the worst." These experiences are not unique to the focus group participants. Other studies revealed similar experiences, which were highlighted during the COVID-19 public health emergency. For these reasons, we strongly recommend that CMS also consider prioritizing quality of care and disparate impact, particularly from hospital mergers and acquisitions.

Prioritize Measures with Sufficient Sample Size to Allow for Reliable and Representative Comparisons

Contending with sufficient sample sizes is always a challenge, when trying to balance stratification of data among sociodemographic variables, while also ensuring reliability. So, without doubt, we understand CMS' efforts to prioritize measures with sufficient sample sizes to allow for reliable and representative comparisons. However, uncounted often means unserved. Unintended consequences of this approach could allow for disparities to go unnoticed in already undeserved communities. Hence, we suggest that CMS consider [innovative applications](#) of statistical methodologies for the design and analysis of small sample data: (1) research designs and analytic methods that can maximize statistical power for analyses of interventions conducted with small, culturally distinct samples—examples include dynamic wait list research designs, Bayesian approaches, matching, and imputation; (2) strategies for reducing error and bias in measures applied in studies with culturally distinct samples, and (3) use of qualitative methods and mixed methods combining qualitative and quantitative data. CMS already proposes imputation methods to increase sample sizes. Additionally, CMS may consider psychometric approaches as Rasch Measurement Model, which can sufficiently produce precise measurement properties with smaller sample sizes. Lastly, there is extraordinary value in mixed methods approaches. One promising possibility using qualitative data involves the use of cluster analysis to assist qualitative researchers in deeper understanding of interrelations in their coded data. In this case, prioritization and standardization can not only hide disparities, but can also introduce bias. Rather than standardizing exclusion, a more inclusive solution would be to add more interdisciplinary methods to the table. Patient interviews, focus groups, and listening sessions could supplement small sample size data, and yield insights that are as rich as large-scale descriptive studies.

Prioritize Outcome Measures and Measures of Access and Appropriateness of Care

We are eager to see how CMS plans to prioritize measures of access and appropriateness of care. This is incredibly important, as a recent [Community Catalyst and LeadingAge LTSS Center @UMass Boston study](#), with support from the SCAN Foundation showed that one-third of people 50 and older report rarely or never having their care preferences taken into account by their clinicians, with more people of color and lower-income individuals saying so. Our researchers report that whether older adults' preferences are taken into account by health care providers is heavily dependent upon race, insurance, and income level, specifically:

- Black and Hispanic older adults are more likely to report never having their health preferences considered versus White adults. Twenty-four percent of Hispanic adults report never having their preferences considered, compared to 17% for Black and 7% for White older adults respectively.
- Individuals who report their clinicians never account for their preferences are twice as likely to have incomes below the Federal Poverty Level (\$12,140 for an individual) compared to those who report clinicians always take their preferences into account (23.5% to 12.3% respectively).
- Higher numbers of people on Medicaid report clinicians sometimes or never consider their care preferences (8.7% to 5.0% respectively).

Our research shows that when people's preferences are at the center of care, outcomes improve. People who received person-centered care: have higher satisfaction with their care, have better control of chronic conditions, receive more preventative care, and have lower projected healthcare costs.

This is important, because research also shows that when patients are able to select providers that share sociodemographic concordance, specifically race and ethnicity, patient experience and health outcomes increase. This suggests that increasing minority, particularly racial/ethnic minority, provider numbers may help reduce persistent racial/ethnic disparities. Accordingly, we encourage CMS to consider diversity within the hospital's workforce as an appropriateness measure.

Imputation Source of Social Risk Information and Patient Demographics

The NPRM notes that CMS is considering three sources of social risk and demographic data to allow for reporting of stratified measure results. One of these sources is imputing race, ethnicity, and language data using indirect estimation based on a person's surname and address. We do have concerns about the accuracy of indirect estimation methodology for imputing demographic data, and urge CMS to invest in collection of "gold standard" self-reported data. This is particularly problematic as correlation between self-report and the MBSIG 1.0 or 2.0 are both lacking in regards to AI/AN and Multiracial populations. However, when self-reported data are not available or collection efforts are unsuccessful, then imputing data is acceptable provided that it is done on more than just surname and there are reasonable verification attempts undertaken.

Along with The Health Care Transformation Task Force, Community Catalyst also recognizes the value of a defined, time-limited period of using imputed data, coupled with contemporaneous efforts to gather patient self-reported data, to be used in developing interventions aimed at improving care equity, when the only alternative is to substantially delay deployment of these programs.

In the long term, if self-reported race and ethnicity data are persistently missing for a proportion of patients, Community Catalyst, along with the Health Care Transformation Task Force offers the following recommendations:

- Leverage the rich R/E data being collected via the National Health Interview Survey (NHIS), the Medical Expenditure Panel Survey (MEPS) and the 2020 Census. These efforts have gone beyond the minimum data collection of R/E data to include categories such as Mexican, Cuban, Puerto Rican, Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese categories, among others. Disaggregating by subgroup is critical because the common demographic groups used in the United States aggregate many distinct communities with widely different experiences with health and health care, structural inequities, and the social influencers of health. For example, data that combines all Hispanic or Asian American and Pacific Islanders often mask deep inequities between subgroups.
- Continue working with ONC to establish data exchange supports that allow CMS to access electronic health record (EHR) data. Private sector EHRs are successfully collecting demographic data – in many cases going beyond R/E to include data on other social determinants of health – with high volume and high levels of accuracy.
- Invest in strategies to improve more robust self-reporting of R/E data at point of service. Such efforts, as reflected by health systems that have implemented such systems successfully, are marked by several characteristics, including:
 - Training all patient-facing staff – including registration staff and those doing care delivery – on how to respectfully ask patients about their background. This training includes a focus on building trust with patients by communicating how the data will or will not be used, with whom it will be shared, and what how it will be protected. As noted in the NPRM, self-reported data is considered the gold-standard.
 - Requiring registration staff to request demographics information each time a patient enters the system, which has been shown to improve overall accuracy.
- Look to the processes used by Medicaid Managed Care Organizations (MCOs) to collect demographic data and consider ways to apply these methods to Medicare in the interest of driving consistent data collection across payers.

If the only alternative is to exclude patients' data from accountability programs altogether or assign them as “unknown race” or similar missing data values, the Community Catalyst, along with the Health Care Transformation Task Force views imputation as preferable. However, we recommend that CMS include a flag for any race, ethnicity, and language data derived from

imputation so that users (providers, researchers, etc.) know what proportion of data are self-reported versus imputed.

Overarching Comments to CMS Health Equity Strategies

We strongly support CMS' efforts to strengthen measures of health equity commitment and performance for hospitals. We are, however, concerned that in the initial reporting year (2023), hospitals may receive a top score on commitment to health equity simply by declaring their commitment, without offering any proof of how that commitment is being fulfilled. We have offered a similar comment on the proposed designation of hospitals as "birthing friendly" based solely on attestations in the initial reporting year.

We recognize that CMS is attempting a phased-in plan aimed at first enticing hospitals into declaring their commitment to health equity, and then following up in subsequent years with required submission and evaluation of various quality measures related to health equity. However, we fear patients and communities may be misled by hospital pronouncements that they have been declared "health equity hospitals" or "birthing-friendly hospitals" by CMS, when that designation initially would reflect only attestations of commitment, not actual performance.

We suggest an alternative approach, in which all hospitals would be required to attest to the hospital commitment to health equity measures as a condition of receiving federal funds, and provide documentation of how the various equity domains are actually reflected in hospital policies and procedures. No declaration that a hospital is a "health equity hospital" would be made based solely on attestations. After several years of data collection and analysis, CMS would be in a much better position to actually reward some facilities with designation as "health equity hospitals" based on demonstrated performance.

We have some specific comments on elements of the proposed domains to which hospitals would be asked to commit. Those are shown below. In addition, we have some suggestions about incorporating elements pertaining to provision of uncompensated care, and have included those following this initial set of comments.

Domain 1: Equity is a Strategic Priority

- (A) "Our hospital strategic plan identifies priority populations who currently experience health disparities." This is an extremely vague requirement. We suggest providing a checklist of populations typically experiencing health disparities, and asking hospitals to check which ones are found in their service area (based on census data or other demographic data). This could be similar to one already promoted by HHS – the [CMS Disparities Impact Statements](#), which is a tool used by all health care stakeholders to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.
- (B) "Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals." We suggest adding this phrase: "...and metrics or performance indicators by which we will measure our progress in achieving these goals."

- (C) “Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.” We suggest adding “including commitments of financial support, human resources and, when applicable, physical facility capacity.
- (D) “Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.” Again, this is quite vague. We suggest requiring an approach for “meaningful engagement” of staff and leadership at all levels, patients and their caregivers if appropriate, and diverse community-based organizations that represent the diverse identities of the service area, providing a checklist of desired approaches and asking each hospital to indicate which items on the checklist they have already accomplished or plan to accomplish, such as 1) having a community advisory board and engaging members of that board in development and execution of the hospital’s strategic plan for advancing health equity; 2) sponsoring listening sessions or community forums at which people from groups experiencing health disparities can provide feedback and suggestions on how to advance the hospital’s work on health equity; 3) plans for continuous staff engagement to tie the strategic plan to the hospital’s mission, vision and values across departments 4) dedicated trainings to empower staff at all levels to contribute to discussions on how racism and bias affect them and their patients and how to take action in implementing health equity in all aspects of their work and build their skills (e.g. trainings on implicit bias, cultural humility, and creating psychologically safe environments and caring for the needs LGBTQ+ BIPOC and Immigrant patients)

Domain 2: Data Collection

The wording of this domain is generally good. We suggest the following improvements:

- (A) “Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.” We suggest adding collection of voluntarily-provided data on patients’ disability status, sexual orientation and gender identity. We also suggest that hospitals be asked to detail their specific plans to improve collection of Race, Ethnicity and Language Data (REaL data) in more meaningful and purposeful ways, such as using a community participatory process in designing collection tools that will enhance capturing and using data, as well as provide help in finding gaps in data. Hospitals could also be encouraged to utilize community partners in the interpretation and communication of data about their community. Lastly, CMS may consider ways that it may incent hospitals to more rapidly adopt [USCDI v.3](#) data classes and elements, once adopted by ONC.
- (B) “Our hospital has training for staff in culturally-sensitive collection of demographic and/or social determinant of health information.” We suggest CMS provide examples of such training that have been found to be effective, such an update to [National CLAS Standards resources](#), by and with community members represented in each demographic category.

Domain 3: Data Analysis

In addition to the recommended stratification of key performance indicators by demographics or other variables, we suggest that hospitals be encouraged to compare the demographics of the patients they are actually serving with the demographics of the people residing in the hospital’s service area. Such an analysis would help identify groups of people who reside in the hospital’s

service area and experience health disparities but are not being served by the hospital. Such an analysis could help guide hospital outreach to under-served groups in the community.

Hospitals committed to advancing health equity are positioned to help change erroneous and harmful narratives about the inequities observed in health outcomes and access to care in racially and ethnically diverse groups. Thus, we further suggest that data analysis plans incorporate steps for including an intersectional, anti-racist health equity lens in the interpretation, presentation and communication of the data with opportunities for hospitals' community advisory boards to review. This should include proactive steps to explicitly name anti-black racism and long-standing structural racism as root causes of inequities when interpreting and communicating findings, and whenever possible, make clear that observed health inequities are not due to biological traits, gender identities or other characteristics of ethnically and racially diverse individuals or groups.

Domain 4: Quality Improvement

The sole requirement in this section is very general: “Our hospital participates in local regional or national quality improvement activities focused on reducing health disparities.” We suggest requiring hospitals to specify which activities they are participating in. CMS might also provide a few examples of such quality improvement activities that are recognized as effective. For example, an updated and targeted dissemination of [AHRQ’s systematic review of quality improvement interventions to address health disparities](#) may be warranted. As mentioned above, the CMS Disparities Impact Statement – as tested in the CMS Accountable Health Communities Model, is one such tool that employs a quality improvement approach to reducing health disparities.

Domain 5: Leadership Engagement

We strongly suggest that the attestation of Leadership Engagement go beyond annual reviews of a strategic plan and key performance indicators. “Routine and thorough attention to equity” and “setting an organizational culture of equity” require more frequent engagement and a more active role for hospital leaders. At a minimum, this should include:

- Meaningful engagement with patients, characterized by transparency and inclusivity, a respect for different cultures, significant and ongoing investment of hospital resources, and acknowledgment and efforts to correct historic power imbalances. Community forums and other methods of engagement can reality-test the strategic plan for achieving health equity and give the hospital an opportunity to receive direct feedback and testimonials from individuals regarding their perception of progress towards improved equity.
- More frequent reviews of the strategic plan and key performance indicators; we recommend quarterly.
- Regular communication from leadership to hospital employee – via employee newsletters, participation in departmental staff meetings, and similar means -- about health equity as an institutional value, progress on the strategic plan, and the importance of following through on activities to improve equity.

Additional comments on analysis of data on health disparities

We applaud CMS for its *within* and *between* analysis of health disparities data in select quality measures and quality improvement data. We urge that CMS require analysis of health disparities data *within* hospitals and also perform such analysis *across* groups of hospitals, with all hospital data, where appropriate. Within-in hospital data will reveal disparities among patients of the hospitals by race, ethnicity and other demographic variables, and provide important guidance about how the hospital should address identified disparities and potential inequities. Analysis *across hospitals* is critical to identifying patterns of disparities and inequities existing between and among groups of hospitals. We suggest such analysis could compare all of the hospitals in a particular geographic region on their performance in addressing the health care needs of medically-underserved populations within that region. A separate analysis could compare the performance of different types of hospitals, such as comparing public hospitals with for-profit hospitals and non-profit hospitals in their performance on key health equity measures.

Additional recommendations to address the burden of medical debt should be included in hospital health equity strategies

Domain 1: A strategic plan for advancing health care equity should affirmatively include strengthening policies around financial assistance programs (FAP) and protecting patients from medical debt.

The overall statistic of U.S. households burdened with medical debt masks significant racial and ethnic disparities. Despite the passage of the Affordable Care Act, 30 million people remain uninsured—more than one third of them have medical debt.¹⁷ This is the result of racist policies that create barriers or outright exclusion for specific population groups from accessing public health insurance programs. As a result, many uninsured people are immigrants and low-income people of color living in states that continue to refuse expanding Medicaid.¹⁸ Additionally, 22 percent of insured people have outstanding medical bills. This means just about anyone is at risk of incurring medical debt, especially as insurance deductibles, copayments and coinsurance increase year after year.¹⁹ It is well documented that many people saddled with high medical debt delay needed care to avoid incurring more bills. The implications of this problem were made obvious over the past two years, as we have encouraged people to seek testing and treatment for COVID-19. Living with outstanding medical bills also creates health problems, causing stress that can lead to poor physical and mental health.

As anchor institutions in communities, hospitals are in a unique position to advance health justice, promote economic security and preserve access to care for all. Hospitals' commitment to health equity should therefore make certain that their policies do not burden community residents

¹⁷ Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020

<https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>

¹⁸ Raymond Kluender, Neale Mahoney, Francis Wong and Wesley Yin. Medical Debt in the US, 2009-2020. JAMA. 2021; 326(3):250-256. doi:10.1001/jama.2021

¹⁹ Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020

<https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>

and employees.²⁰ In addition to requiring hospitals to adopt: (1) [Best practices for resolution of medical accounts as developed by the Healthcare Financial Management Association](#), and (2) [Community Catalyst’s five principals for hospital financial assistance, billing and collection policies](#), we call on CMS to adopt elements of model laws passed recently in California, Colorado, Illinois, Maryland, and New Mexico.²¹ The laws vary in specifics but have in common statewide requirements, such as:

- Screening and providing free or discounted care to low-income patients regardless of their immigration status.
- Clearly notifying all patients about hospital policies regarding financial assistance programs, billing, and collections.
- Setting limits on charges to uninsured patients and the terms of payment
- Clearly restricting the use of extraordinary collection actions
- Complying with reporting requirements that aim to explore disparities.
- Soliciting feedback from patients and patient advocates on notification of patient’s rights.

For example,

- Colorado requires health care facilities to screen each uninsured patient for public health insurance programs, the Colorado Indigent Care Program and hospital financial assistance programs and caps charges for uninsured patients at approximate rates paid by public payers.
- Illinois²² addresses equity by mandating that financial assistance policies be available to “any person living in Illinois and who intends to remain living in Illinois indefinitely,” and requires hospitals to describe activities that aim to address health disparities, advance health equity, and improve community health through their community benefit plans.
- Maryland²³ requires health care facilities to collect and report data on patient groups based on based on race, ethnicity, and primary language spoken to help evaluate hospitals’ compliance with the required screening, discounted care, payment plan, and collections practices.
- New Mexico prohibits Health care facilities and third-party health care providers and medical creditors from pursuing collection actions, i.e., selling debt and filing lawsuits to collect medical debt, against patients who are determined to be indigent patients (with income at or below 200% FPL) over charges for health care services and medical debt.

Domain 2: Collecting data allows measurement, which can highlight a hospital’s strength and its areas for improvement.

One driver of health inequities is medical debt, which is unevenly distributed across people of different races and ethnicities – Black people and people of Hispanic origin are more likely to have medical debt than white, non-Hispanic people. Disparities in medical debt can lead to disparities in health care access and outcomes, because medical debt is a financial barrier to care.

²⁰ Community Catalyst, Blog: Hospital Billing and Financial Practices: “First Do No Harm.”

<https://www.communitycatalyst.org/blog/hospital-billing-and-financial-practicesfirst-do-no-harm#.Yqj7LnbMKUk>

²¹ Robertson CT, Rukavina M, Fuse Brown EC. [New State Consumer Protections Against Medical Debt](#). JAMA. 2022;327(2):121–122. doi:10.1001/jama.2021.23061

²² <https://legiscan.com/IL/text/SB1840/2021>

²³ https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=202120220AB1020&showamends=false

Collecting data about hospital practices that are associated with the accumulation of medical debt will advance equity by allowing hospitals to identify where their policies are and are not being properly applied, whether there might be bias in how the policies are applied, and how they can improve their service to patients by limiting their exposure to medical debt. Therefore, we recommend that hospitals collect and report these data, stratified by race and ethnicity. *See Appendix 1 for our recommendations on types of data to be collected.*

Domain 3: Analysis of KPIs by demographic characteristics and social determinants of health should include multi-variate analyses that examine KPI by demographic and SDOH to illuminate equity gaps that result from interactions of factors.

For example, variations in performance between patient groups with lower and higher incomes might be anticipated (poverty being a SDOH), but analyses should also include variations across and within racial and ethnic groups among the patients with low income. In addition, we recommend that the performance indicators analyzed for equity include adherence to best practices for financial assistance and billing and collections policies, such as completed and accepted applications for financial assistance, and the use of extraordinary collection actions.


Further, we recommend that hospitals be encouraged and financially incented to routinely use ICD-10 Z-codes (Z-55 to Z-65) to document social determinants of health, which will allow for a richer analysis of disparities and health equity. The benefit of using Z codes to address social determinants and improve outcomes is explained clearly in CMS’s document “Using Z Codes: The Social Determinants of Health (SDOH); Data Journey to Better Outcomes.”²⁴ In particular, to align with the Biden-Harris Administration’s health equity priorities spelled out in EO 13985, Community Catalyst recommends that hospitals be required to collect and regularly report data for the income-related codes Z59.5 (extreme poverty), Z59.6 (low income), and Z59.7 (insufficient social insurance and welfare support). Absent a specific code for medical debt, these codes, when analyzed with other demographic and coverage information, can demonstrate the numbers of patients who are susceptible to burdensome debt and can reveal racial and ethnic disparities within those numbers. The codes can also be used to measure performance on indicators such as those suggested above: completed and accepted applications for financial assistance and the use of extraordinary collection actions.

More consistent use of Z codes would allow CMS and other payers to better analyze the clinical outcomes, utilization, and costs associated with the codes, so that payers can confidently incorporate the codes into reimbursement. Community Catalyst also recommends that a new code be created that would allow medical debt to be analyzed directly for its influence on outcomes as a social determinant of health, and welcome an opportunity to partner with CMS on all of the above-mentioned recommendations.

Thank you for this opportunity to comment, as we continue supporting you as thought-partners, as you continuously develop effective and impactful policies.

²⁴ <https://www.cms.gov/files/document/zcodes-infographic.pdf>, accessed June 14, 2022.

Respectfully submitted,

DocuSigned by:

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Appendix 1: Recommendations on types of data to be collected and analyzed to address the economic and health impacts of medical debt

- Number of applications for financial assistance
 - Received
 - Approved
 - Denied (and reasons for denial)
- Number of accounts sent to third party collection agencies
 - Value of accounts
- Extraordinary collection actions authorized to be taken by the provider
- Number of patients whose care was deferred or denied or required to make a payment before providing medically necessary care due to nonpayment of a bill for previously provided care
 - Value of accounts
- Number of patients who have had adverse information reported to consumer credit reporting agencies or credit bureaus
 - Range of account values
- Number of accounts sold to debt buyers
 - Value of accounts
- Number of patients provider has filed lawsuits against
 - Number of wage garnishments
 - Value of garnishments
 - Range of garnishment amounts
 - Number of liens on primary residence or other property
 - Value of liens
 - Range of lien amounts
 - Number of bank accounts attached or seized
 - Amounts attached or seized
 - Range of amounts
 - Number of civil actions resulting in:
 - The arrest of an individual
 - An individual being subjected to a writ of body attachment
- Financial product offerings
 - Name of vendor, type of loans, rate of interest, terms
 - Process for informing patients of financial products to ensure that proper vetting takes place to determine whether patient qualifies for financial assistance of coverage.
 - Number of loans originated
 - Value of loans
 - Range of loan amounts
- Debt Sales
 - Name of vendor, terms of the sale
 - Process for informing patients of debt sale
 - Number of accounts sold
 - Age of accounts

- Total value of the accounts sold
- Range of amounts for accounts sold