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CMS Focus on Health Equity Infuses Reporting, Payment; 'This Is Not a Side Project'

By Nina Youngstrom

CMS is pulling out all the stops on health equity, and providers will increasingly feel it in reporting requirements, payment policy and coverage decisions, experts said. This is apparent from both words and deeds, as CMS revises existing programs to incorporate health equity measures, such as the social determinants of health (SDoHs), and proposes new requirements, such as adding measures to the Inpatient Quality Reporting (IQR) program. CMS also is edging closer to making Z codes—which capture social, economic and environmental factors affecting health outcomes—a comorbidity, an act that would increase hospital reimbursement.

Jonathan Blum, principal deputy administrator at CMS, indicated how embedded health equity is in its policy and operational decisions during a May 16 Healthcare Financial Management Association podcast.[1] "This is not a side project for CMS" or "a separate thought process," he said. "It is front and center for everything we do."

CMS has already pulled some "regulatory levers" to address health equity, and "the focus will continue and become more intense and more directly tied to reimbursement in Medicare and Medicaid," said Martie Ross, a consulting principal at PYA.

Recently, health inequities have been in the headlines in two areas, Ross said. They are (1) the impact of COVID-19, with racial minorities experiencing more infections, hospitalizations and deaths, and rural populations having twice the death rate of urban populations; and (2) maternal health outcomes, which are significantly worse for Black and American Indian women and in rural areas. "It's become evident something in our system is driving the inequity," Ross said at a June 1 webinar sponsored by PYA.[2]

CMS published its *Framework for Health Equity* in April 2022.[3] It has five priorities. They include expanding the collection, reporting, and analysis of standardized data and building the "capacity of health care organizations and the workforce to reduce health and health care disparities." Ross described the health equity moves as "a whole new world." It will be a new experience for hospitals in how they will collect data, among other things, and require decision-making around who will be responsible for it.

10 Top 'Regulatory and Payment Levers'

Here's a brief description of CMS's top "regulatory and payment levers" for health equity, Ross said. The first five are existing programs that have been revised, and the second five are what's coming your way:

1. Accountable Health Communities Model, which CMS's Center for Medicare & Medicaid Innovation (CMMI) launched in 2017 as a payment model for screening for the SDoHs. CMS paid 29 organizations to screen patients for the SDoHs (e.g., food and housing insecurity) and evaluated them on two tracks: outcomes when the organizations referred patients in need to outside agencies and outcomes when the organizations went further, partnering with key stakeholders to arrange community resources for people in need. "The

results aren't stellar," Ross said. After a year, only 14% of the patients who agreed to be screened "had their needs resolved." There were various factors affecting this, but "it highlights the waters we are now entering are going to be challenging."

2. The Hospital Readmissions Reduction Program, which imposes a financial penalty on hospitals with higher-than-average readmission rates based on national averages. CMS revised the methodology in 2019 because of complaints about apples-to-oranges comparisons (e.g., trauma centers were in the same pool as small rural hospitals). Hospitals are now stratified into five groups based on their number of dual eligibles (patients on both Medicare and Medicaid), which is a proxy for people with more socioeconomic challenges, Ross said. "If you have a high percentage of dual eligibles, you will be compared to hospitals with a high percentage of dual eligibles."

3. CMS is already required to collect standardized patient assessment data elements (SPADEs) from post-acute care (PAC) providers, but now CMS is adding data elements on race, ethnicity, language preference, health literacy, social isolation and transportation barriers. They take effect in 2022 or 2023, depending on the type of PAC provider (e.g., home health agencies, skilled nursing facilities). Ross added that CMS is contemplating more SPADEs to address gaps in health equity.

4. CMS is now evaluating refinements to the Health Equity Summary Score (HESS), which was developed by the Office of Minority Health to analyze the performance of a Medicare Advantage (MA) plan in terms of race and ethnicity and compare it to other MA plans. "This analysis produces a score in terms of internal performance improvement," Ross said. It also provides a mechanism for targeting incentives for providers to address inequities.

5. Accountable Care Organization Realizing Equity, Access, and Community Health (ACO Reach) Model, which will replace the direct contracting model in 2023. Ross said there are five requirements related to health equity for participating in the ACO Reach Model: a health equity plan requirement, a health equity benchmark adjustment, a health equity data collection requirement, a nurse practitioner services benefit enhancement, and health equity questions in the application and scoring for health equity. For example, accountable care organizations accepted into the model are required to submit a plan to identify underserved patients and reduce health disparities.

6. Request for information (RFI) about measuring disparities in quality reporting programs. All 2023 proposed Medicare payment rules published so far include an RFI on improving data collection to better measure and analyze disparities in programs and policies, Ross said. CMS wants to know how it can do a better job understanding what hospitals and other providers are reporting. For example, if providers dig deeper into their mammogram reporting, would it show they do very well with certain populations and very poorly with other populations? The RFI "is an invitation for us to be part of the conversation," Ross said. But providers are not stepping up. For example, of 467 comments submitted so far on the proposed 2023 inpatient prospective payment system (IPPS) regulation, "only two mention equity," she said. Comments are due by June 17.

7. CMS's Inpatient Quality Reporting (IQR) program has new measures. Starting in 2023, CMS will require hospitals to report on their commitment to health equity. Reporting is accomplished by an attestation that hospitals will make annually in the portal for IQR reporting, Ross said. They will be attesting across five domains, including "equity is a strategic priority" and "data analysis." For now, payment isn't linked to hospital performance, "but they're getting you on record about where your organization is," she explained. "Reporting on this measure will impact payment in 2025."

8. Another new hospital IQR measure is screening patients for hospital-related social needs (HRSNs). The measure focuses on screening patients for HRSNs, which means hospitals aren't penalized if patients are unable or unwilling to be screened. The new measure is voluntary in 2023 and mandatory in 2024, and will affect payment in 2026, Ross said.

9. An RFI asks hospitals about other possible adjustments to the Hospital Readmissions Reduction Program. For example, CMS wants feedback on whether to consider factors besides dual eligibles, such as the area deprivation index, to identify patients with social risk factors.

10. A big area to watch is reporting of Z codes, which are ICD-10-CM codes for social, economic and environmental determinants that affect health outcomes. For now, reporting is voluntary and Z codes are non-complications and comorbidities and therefore don't generate additional payment, but that may change, said Kathy Reep, a consulting senior manager at PYA, during the webinar. CMS in the 2020 proposed IPPS rule asked whether Z59.0 (homelessness) should be a comorbidity, and the 2023 IPPS proposed rule is soliciting input on all Z codes and other implications of payment around health equity, with comments due June 17. For example, should reporting of certain Z codes be mandatory on inpatient claims? What are the burdens vs. the benefits? "When you start looking at claims submitted to Medicare, there aren't very many with Z codes," Reep said. "We have to get better at reporting this data, but we also have issues with the ability to report the data." One is the limit on fields to report diagnosis codes, she said. CMS accepts 25 diagnosis codes on the 837i (institutional) electronic claim form. "Are we going to hit the point where we have exhausted the capacity on the electronic claim to submit additional codes?" Although there are 96 Z codes, "when we identify a patient with one of these codes, they have multiple conditions that need to be reported," Reep said.

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1 Jonathan Blum, "CMS Principal Deputy Administrator Jonathan Blum discusses price transparency, surprise billing and the future of value-based payment," podcast, Healthcare Financial Management Association, May 16, 2022, https://hfma.podbean.com/.
2 Martie Ross and Kathy Reep, "Pursuing Health Equity Through Regulation and Reimbursement," webinar, PYA, June 1, 2022, https://bit.ly/3PWjqnF.
3 Centers for Medicare & Medicaid, *CMS Framework for Health Equity 2022–2032*, accessed June 2, 2022, https://go.cms.gov/3GJytNf.
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