HEALTHCARE REGULATORY ROUND-UP - Episode #26

Pursuing Health Equity Through Regulation and Reimbursement

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Introductions

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Why Now?

Biden Administration priority

- Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*
- Executive Order 13995, *Ensuring an Equitable Pandemic Response and Recovery*
- Formation of HHS Office of Climate Change and Health Equity
- In 2021/2022, 81 references to 'health equity' in CMS press releases; 22 references in prior 15 years

Unequal impact of COVID-19

- Racial minorities experience higher incidence of infection, hospitalization, death
- Death rate for rural populations is double the rate for urban populations

Unequal maternal health outcomes

- Black and American Indian women's pregnancy-related mortality rate is 2-3 times higher than the rate for non-Hispanic White women – regardless of other socioeconomic factors
- Rural women experience poorer maternal health outcomes, including higher mortality rates

Defining ‘Health Equity’

“[E]veryone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography preferred language, or other factors that affect access to care and health outcomes.”

“To attain the highest level of health for all people, we must give our focused and ongoing attention to address avoidable inequalities and eliminate health and health care disparities.”

https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity

Related Terms

- **Social Determinants of Health** (SDOH) or **Social Drivers of Health** (SDH)
  - Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
  - Generally grouped in 5 domains: economic stability; education access and quality; healthcare access and quality; neighborhood and built environment; social and community context
- **Social Risk Factors** (SRF) or **Health-Related Social Needs** (HRSN)
  - Specific adverse social conditions that are associated with poor health, e.g., social isolation, housing instability, food insecurity
- **Population Health**
  - Health outcomes of a group of individuals, including distribution of such outcomes within the group
- **Population Health Management** (Improvement)
  - Approaches to improve health that focus on defined groups

CMS Priorities

01
Expand collection, reporting, and analysis of standardized data

02
Access causes of disparities within CMS programs and address inequities in policies and operations to close gaps

03
Build provider capacity to reduce health and healthcare disparities

04
Advance language access, health literacy, and provision of culturally tailored services

05
Increase all forms of accessibility to healthcare services and coverage

CMS Principal Deputy Administrator Jonathan Blum

"This is not a side project for CMS….This is the fabric for the whole agency."

HFMA's Voice in Healthcare Finance Podcast (May 17, 2022)

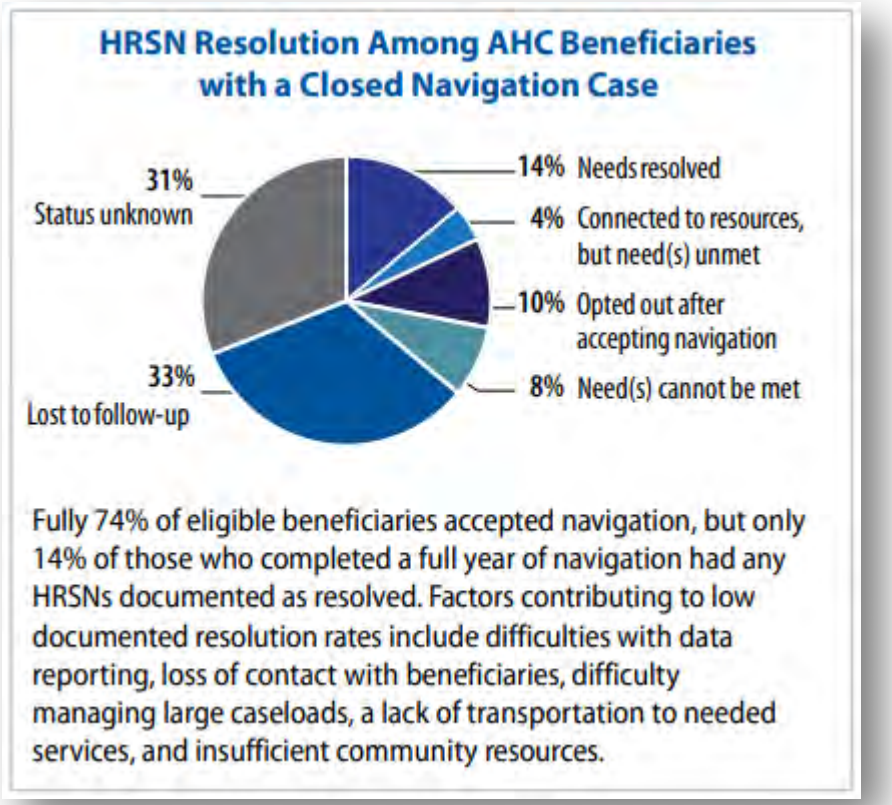
Available at https://hfma.podbean.com/

Regulatory and Payment Levers

1. CMMI Accountable Health Communities Model
2. Hospital Readmission Reduction Program – Peer Group Stratification
3. Standardized Patient Assessment Data Elements (SPADEs) for post-acute providers
4. Health Equity Scoring System (HESS)
5. CMMI ACO Reach Model
6. Request for Comment - Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs
7. Proposed Hospital IQR Measure – Hospital Commitment to Health Equity
8. Proposed Hospital IQR Measures – Social Risk Factor Screening
9. Request for Comment – Additional adjustments to Hospital Readmission Reduction Program
10. Request for Comment – Inclusion of Z-Codes on claims; potential payment adjustments

1. Accountable Health Communities Model

- CMMI model launched in 2017 with 29 participants to test whether identifying and addressing core HRSNs impacts costs, utilization, and outcomes
  - Used 10-item AHC Health-Related Social Needs Screening Tool to identify food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety
- Participants screened all Medicare/Medicaid beneficiaries, offering navigation services to those with ≤ 1 HRSN + ≤ 2 ED visits in prior 12 months
- Alignment track participants also partnered with key stakeholders to align community resources



https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt-fg

2. Hospital Readmission Reduction Program

- Beginning in FY 2013, hospitals subject to payment reduction due to higher-than-average readmission rates
- Since FY 2019, CMS has stratified hospitals into 5 groups based on # of dual eligible patients rather than using national averages
- Stratification associated with decrease in penalties for safety net hospitals
  - By −0.09 percentage points at hospitals with highest proportion of dual enrollees
  - By −0.08 percentage points at rural hospitals
  - By −0.06 percentage points at hospitals with large share of Black and Hispanic patients

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01448

3. SPADEs for Post-Acute Care Providers

- IMPACT Act of 2014 requires CMS to collect standardized patient assessment data elements (SPADEs) for post-acute care providers
- CMS is adding following SDOH-related elements to patient assessments
  - Admission: Race, Ethnicity, Language Preference
  - Admission and discharge: Health Literacy, Social Isolation, Transportation Barriers
- Codified in the FY/CY 2020 Quality Payment Program rules for each respective setting with following start dates for data collection:
  - Home Health Agencies - January 1, 2022
  - Long-Term Care Hospitals - October 1, 2023
  - Inpatient Rehabilitation Facilities - October 1, 2023
  - Skilled Nursing Facilities - October 1, 2024
- CMS now considering additional SPADEs to address gaps in health equity

4. Health Equity Scoring System (HESS)

- Stratification/group differences measurement tool developed by CMS OMH and then applied to data from MA contracts as proof-of-concept exercise
  - Increase visibility of health care quality disparities for quality improvement and for disparity reduction
  - Provide mechanism for targeting incentives to achieve equity in quality of care across groups
- CMS presently evaluating HESS refinements to apply to hospitals, other providers

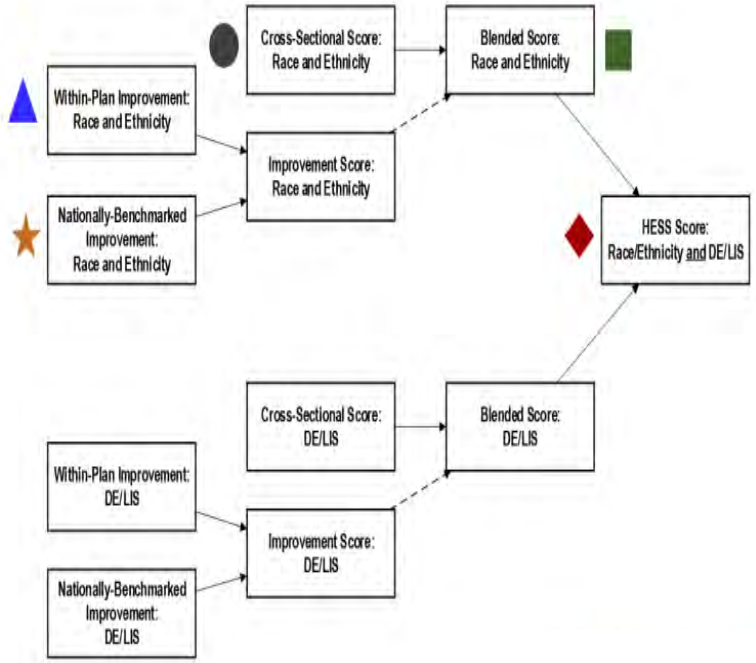
▲ Within-plan improvement: examining standardized (i.e. z-score) differences between leading (group with highest score) and lagging groups during each time period

★ Nationally benchmarked improvement: absolute improvement over time

● Cross-sectional score: difference between leading and lagging groups during most recent time period only

■ Each grouping variable's blended score combines cross-sectional and improvement scores (and gives more weight to improvement when cross-sectional performance is low).

◆ The final, overall HESS score combines blended results (and allows analysis of multiple grouping variables simultaneously).



https://vimeo.com/showcase/7096580/video/522143612

5. ACO REACH Model

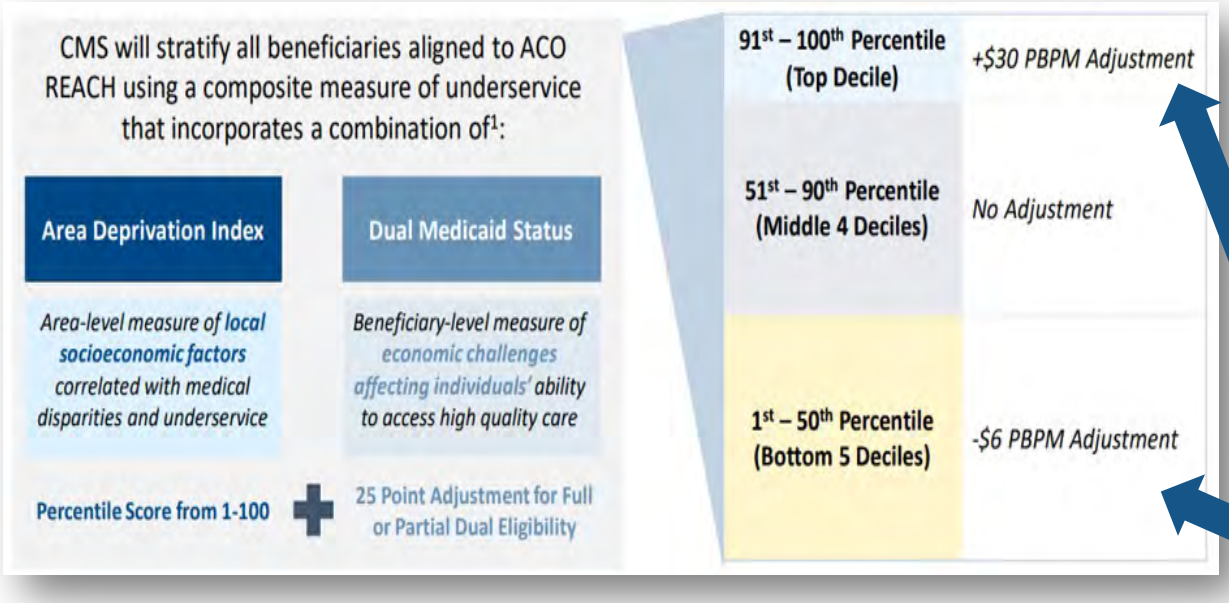
- CMMI announced new model on February 24, 2022, as replacement to Direct Contracting Model in CY 2023
  - Applications were due April 22, participants announced later this month
- Five program requirements addressing health equity -
  1. Health Equity Plan Requirement
  2. Health Equity Benchmark Adjustment
  3. Health Equity Data Collection Requirement
  4. Nurse Practitioner Services Benefit Enhancement
  5. Health Equity Questions in Application and Scoring for Health Equity

Health Equity Plan Requirement

- REACH ACOs must submit to CMMI in early 2023 a plan to identify underserved patients and to pursue initiatives to measurably reduce health disparities
- CMMI expects to release template later this year based on CMS Disparities Impact Statement
  - Detailed information on underserved populations within attributed beneficiaries
  - Proposed interventions with action steps
  - Outcomes measures

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

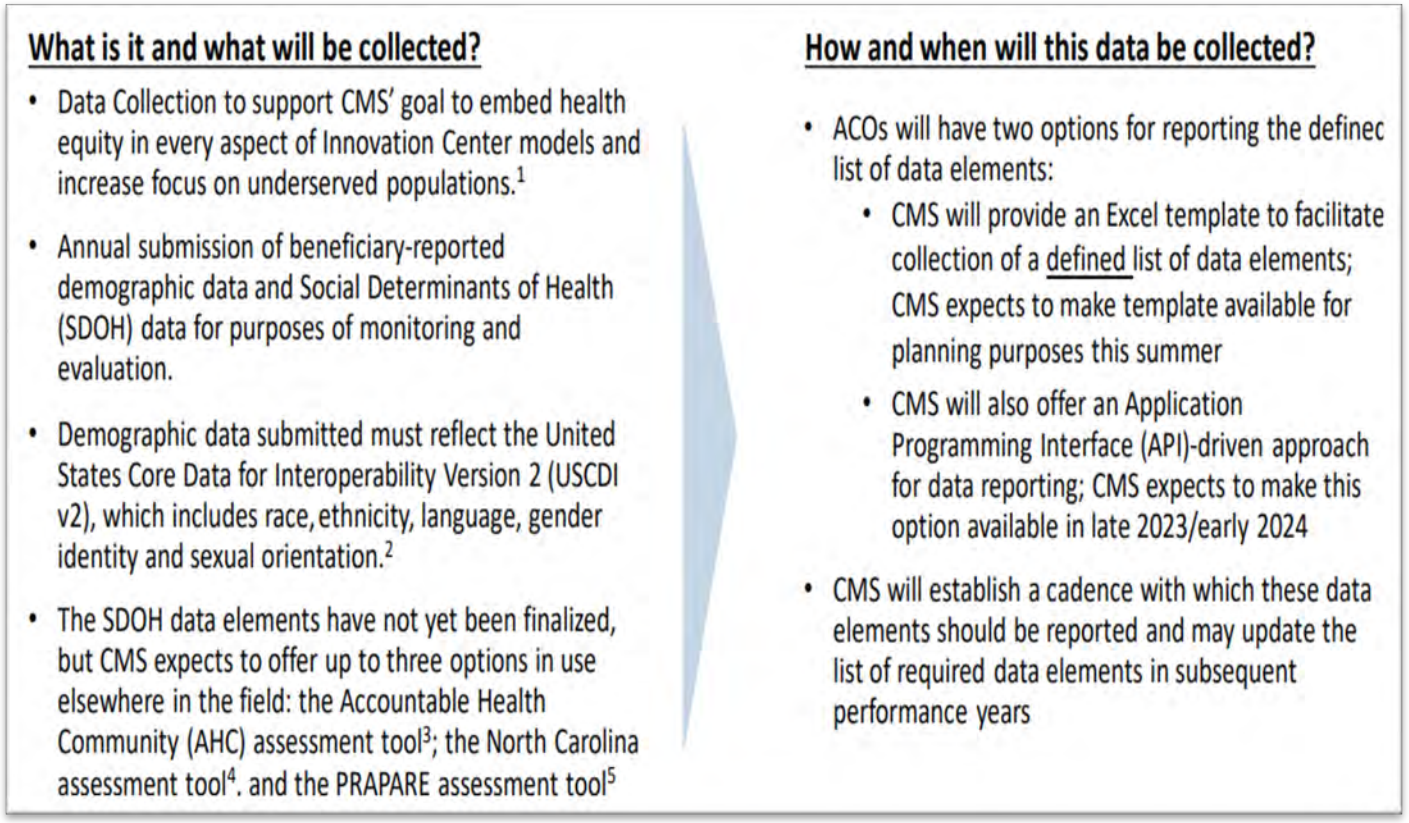
Health Equity Benchmark Adjustment



https://innovation.cms.gov/media/document/aco-reach-health-equity-slides

- Shared savings models use historical benchmarks which can entrench historical underspending for underserved beneficiaries
  - Areas with lower socioeconomic status have lower rates of ACO participation
- Eliminate disincentive for ACOs to align and serve these beneficiaries
  - Also eliminate advantage enjoyed by ACOs in areas with higher socioeconomic status

Health Equity Data Collection Requirement



What is it and what will be collected?

- Data Collection to support CMS' goal to embed health equity in every aspect of Innovation Center models and increase focus on underserved populations.[1]
- Annual submission of beneficiary-reported demographic data and Social Determinants of Health (SDOH) data for purposes of monitoring and evaluation.
- Demographic data submitted must reflect the United States Core Data for Interoperability Version 2 (USCDI v2), which includes race, ethnicity, language, gender identity and sexual orientation.[2]
- The SDOH data elements have not yet been finalized, but CMS expects to offer up to three options in use elsewhere in the field: the Accountable Health Community (AHC) assessment tool[3]; the North Carolina assessment tool[4]. and the PRAPARE assessment tool[5]

How and when will this data be collected?

- ACOs will have two options for reporting the definec list of data elements:
  - CMS will provide an Excel template to facilitate collection of a defined list of data elements; CMS expects to make template available for planning purposes this summer
  - CMS will also offer an Application Programming Interface (API)-driven approach for data reporting; CMS expects to make this option available in late 2023/early 2024
- CMS will establish a cadence with which these data elements should be reported and may update the list of required data elements in subsequent performance years

https://innovation.cms.gov/media/document/aco-reach-health-equity-slides

- For PY2023, bonus to ACO's Total Quality Score for submission of *demographic* data; no downside
- CMS still deciding on requirements/impact for PY2024 and thereafter
  - What SDOH data to be collected?
  - Impact of not submitting data?
- *CMS Framework for Health Equity*: All future CMMI models will include similar data collection requirements

6. RFI - Measuring Disparities in Quality Reporting Programs

- Included in all 2023 Proposed Rules published to date – CMS seeking comment on how to improve data collection to better measure and analyze disparities across programs and policies

1. Identification of goals and approaches for measuring health care disparities and using measure stratification across CMS quality programs
2. Guiding principles for selecting and prioritizing measures for disparity reporting across CMS quality programs
3. Principles for social risk factor and demographic data selection and use
4. Identification of meaningful performance differences
5. Guiding principles for reporting disparity results

7. Hospital IQR Measure – Commitment to Health Equity

"While many factors contribute to health equity, we believe this measure is an important step toward assessing hospital leadership commitment, and a fundamental step toward closing the gap in equitable care for all populations."

"[T]his measure is not intended to encourage hospitals to take action on any one given element of collected data, but instead encourages hospitals to analyze their own data to understand many factors, including race, ethnicity, and various social drivers of health, such as housing status and food security, in order to deliver more equitable care."

https://www.govinfo.gov/content/pkg/FR-2022-05-10/pdf/2022-08268.pdf

CY23 Reporting Period/FY25 Payment Determination

Domain	Elements
Equity is a Strategic Priority	Our hospital strategic plan – (A) Identifies priority populations who currently experience health disparities (B) Identifies healthcare equity goals and discrete action steps to achieving these goals (C) Outlines specific resources which have been dedicated to achieving our equity goals (D) Describes our approach for engaging key stakeholders
Data Collection	(A) Our hospital collects demographic information, including self-reported race and ethnicity and/or SDOH on the majority of patients (B) Our hospital has staff training in culturally sensitive collection of demographic and/or SDOH information (C) Our hospital inputs demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified EHR technology.
Data Analysis	Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards
Quality Improvement	Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities
Leadership Engagement	(A) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our hospital senior leadership (including executives and trustees) annually reviews key performance indicators stratified by demographic and/or social factors.

8. Hospital IQR Measures – Screening for HRSNs

- #1 - Percentage of inpatients age 18+ screened for one or more or the following: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
  - Use self-selected screening tool (e.g., AHC Health-Related Social Needs Screening Tool)
  - Exclude from denominator (1) patients who opt-out of screening; and (2) patients unable to complete screening during inpatient stay who have no guardian/caregiver able to complete on patient's behalf
- #2 - Separately report positive screening rate for each of 5 domains
- Voluntary Reporting in CY23 Reporting Period; Mandatory Reporting in CY24 Reporting Period/FY26 Payment Determination

9. RFI – Additional Adjustments to HRRP

- What measures or indices of social risk (in addition to dual eligibility) should be used to measure hospitals' performance in achieving equity in HRRP?
  - Examples of indices to identify socially at-risk populations
    - Area Deprivation Index - https://www.neighborhoodatlas.medicine.wisc.edu/
    - Social Vulnerability Index - https://www.atsdr.cdc.gov/placeandhealth/svi/index.html
- What are benefits and potential risks, unintended consequences, and costs of incorporating hospital performance for beneficiaries with social risk factors?

10. RFI – Reporting Z-Codes

- Set of ICD-10-CM codes used to report social, economic, and environmental determinants known to affect health and health-related outcomes
- Data identified during any encounter and documented in patient record
  - Identification of conditions can be completed by any care team member (health risk assessments, screening tools, person-provider interaction, self-reporting)
- Reporting on claim forms presently voluntary

Figure 1. Change in Total Number of Z Code Claims, 2016 to 2019.

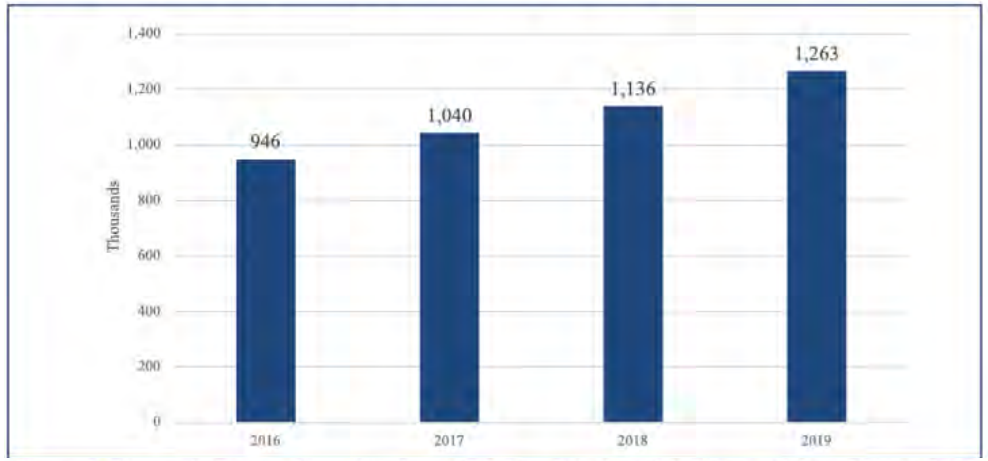
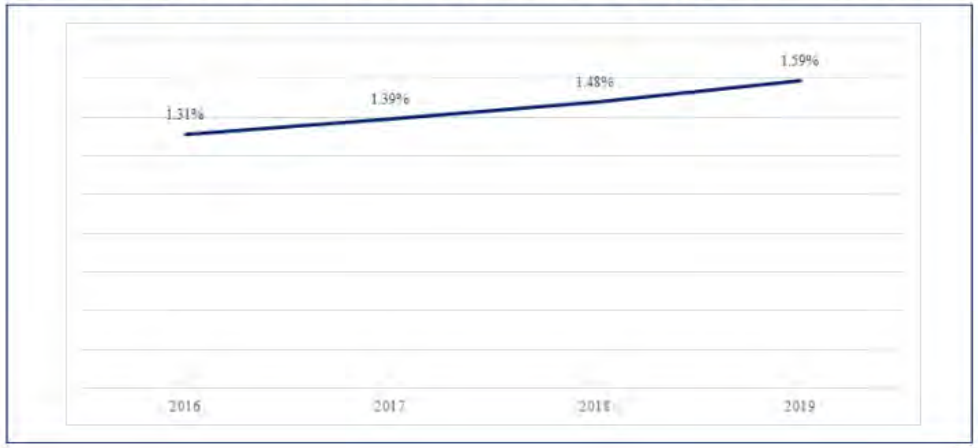


Figure 2. Change in Proportion of Medicare FFS Beneficiaries with Z Code Claims, 2016 to 2019.



https://www.cms.gov/files/document/z-codes-data-highlight.pdf

Z-Code Categories

Problems related to:

Z55 – education and literacy

Z56 – employment and unemployment

Z57 – occupational exposure to risk factors

Z59 – housing and economic circumstances

Z60 – social environment

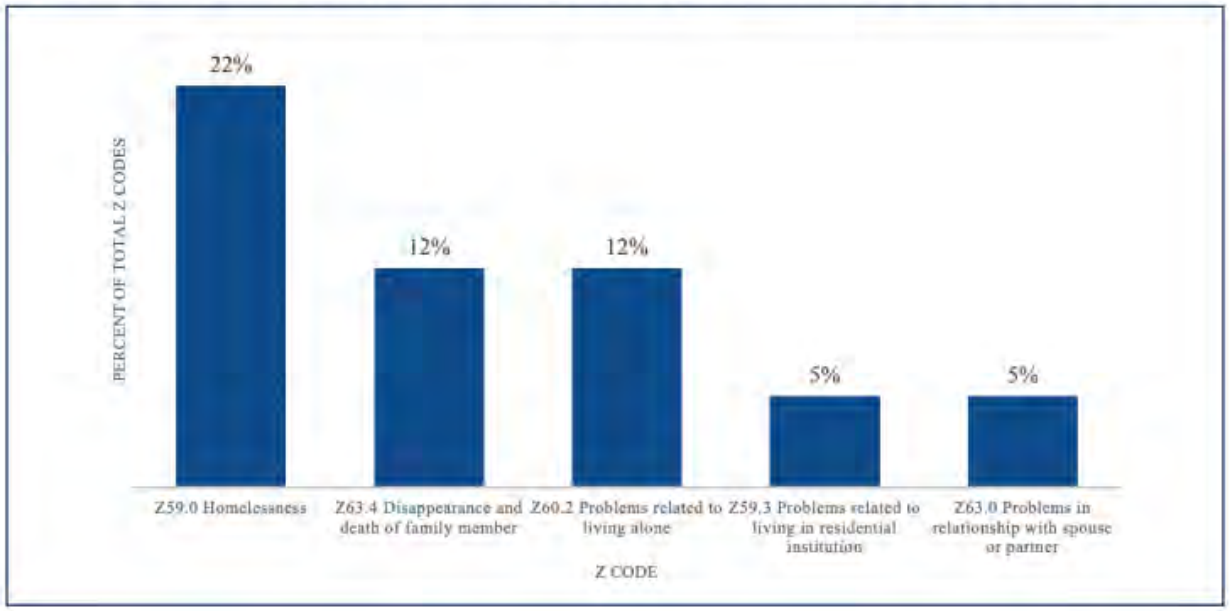
Z62 – upbringing

Z63 – primary support group, incl. family circumstances

Z64 – certain psychosocial circumstances

Z65 – other psychosocial circumstances

Figure 3. The Top Five Z Codes Representing the Largest Shares of All Z Code Claims, 2019.



https://www.cms.gov/files/document/z-codes-data-highlight.pdf

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- **Identify individuals'** social risk factors and unmet needs.
- **Inform health care** and services, follow-up, and discharge planning.
- **Trigger referrals** to social services that meet individuals' needs.
- **Track referrals** between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] cms.gov/medicare/icd-10/2021-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

https://www.cms.gov/files/document/zcodes-infographic.pdf

USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

This list is subject to revisions and additions to improve alignment with SDOH data elements.

https://www.cms.gov/files/document/zcodes-infographic.pdf

Reporting Z-Codes on Inpatient Claims

- CMS believes such reporting could -
  - Enhance quality improvement activities
  - Improve care coordination
  - Track factors that influence people's health
  - Provide further insight into existing health inequities
- Impact on resource use (and thus payment?)
  - All Z-Codes presently designated as NonCC (no payment impact)
  - In FY20 IPPS proposed rule, CMS proposed changing severity level designation of code Z59.0 (Homelessness) to CC based on available data
  - CMS making available data describing impact on resource use when Z-codes reported as a secondary diagnosis

Specific Requests for Comment

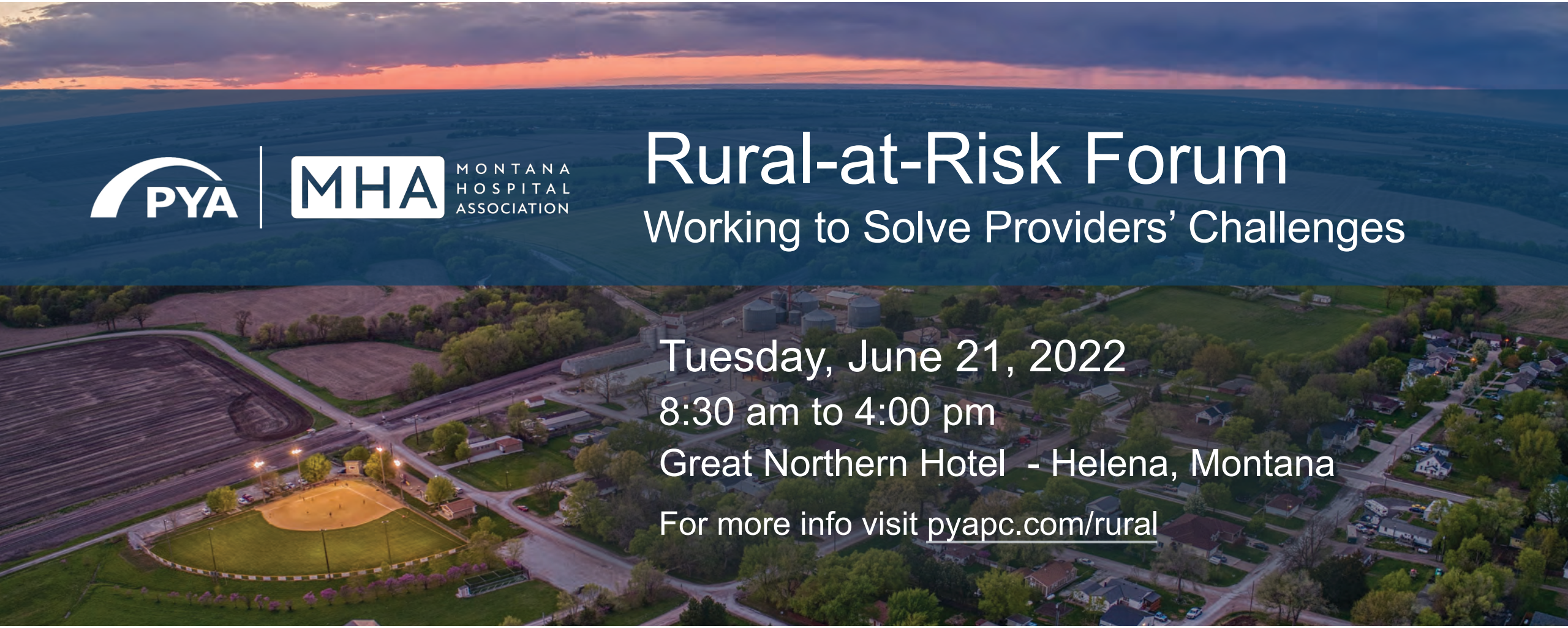
- How could reporting of certain Z codes improve ability to recognize severity of illness, complexity of illness, and utilization of resources under MS–DRGs?
- Should CMS require reporting of certain Z codes on hospital inpatient claims to strengthen data analysis?
- What protocols should be required to standardize the screening for SDOH for all patients?
- Additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries?
- Has homelessness have been underreported and, if so, why?
  - How do factors such as hospital size and type potentially impact hospital's ability to develop standardized consistent protocols to better screen, document, and report homelessness?

Our Next Healthcare Regulatory Round-Up:

No Surprises Act at 6 Months:

Your Questions, Answered

June 15, 2022


PYA
MHA
MONTANA
HOSPITAL
ASSOCIATION
Rural-at-Risk Forum
Working to Solve Providers' Challenges
Tuesday, June 21, 2022
8:30 am to 4:00 pm
Great Northern Hotel - Helena, Montana
For more info visit pyapc.com/rural

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A national healthcare advisory services firm providing consulting, audit, and tax services