



June 16, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850
(Submitted electronically to regulations.gov)

Attention: CMS-1771-P

Dear Administrator Brooks-LaSure,

The Center for Health Law and Policy Innovation of Harvard Law School (**CHLPI**) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (**CMS**) proposed rule on Hospital Inpatient Prospective Payment System (**IPPS**) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2023 Rates (CMS-1771-P) (**the Proposed Rule**).

CHLPI advocates for reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. We have an active portfolio dedicated to addressing unmet health-related social needs (**HRSN**) through health care delivery and financing. For a number of years, CHLPI has worked with stakeholders including health systems, private and public health plans, community-based organizations (**CBOs**), and government officials across the country to address the damaging impact of food insecurity on health outcomes and advance Food is Medicine interventions such as medically tailored meals and produce prescriptions.

We applaud CMS for its efforts to better understand the prevalence of unmet social needs in the Medicare population, and for its attention to ensuring that this information is used in a manner that does not exacerbate inequity. Especially in light of CMS's recent efforts to incorporate HRSN screening into Medicare Advantage¹, it is encouraging to see the Proposed Rule bring similar attention to HRSN in fee-for-service Medicare. We urge continued momentum toward a comprehensive strategy to address those unmet needs that includes screening, referral, and meaningful access to responsive services.

We applaud CMS for its efforts to better understand the prevalence of unmet social needs in the Medicare population, and to ensure this information is used in a manner that does not exacerbate inequity.

Research shows that millions of older adults struggle with a lack of consistent access to nutritious food. Nationally, 5.2 million older adults (1 in 14) were food insecure in 2019, meaning they did not have access to enough food for an active, healthy life.² Food insecurity is particularly prevalent among Medicaid/Medicare dual enrollees, approximately one third of whom report experiencing this challenge.³ As the severity of food insecurity increases, so too do healthcare costs associated with inpatient care,

¹ See generally Proposed Rule CMS-4192-P Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

² James P. Ziliak and Craig Gunderson, The State of Senior Hunger in America 2019: An Annual Report, Feeding America (2021).

³ Jeanne M. Madden et al., Risk Factors Associated With Food Insecurity in the Medicare Population, *JAMA Intern Med.* 2020;180(1):144–147. doi:10.1001/jamainternmed.2019.3900

emergency care, surgeries, and drug costs.⁴ Average inpatient hospitalization costs are 24% higher and readmission within 15 days is almost twice as likely for malnourished patients as compared to properly nourished patients.⁵

These costly outcomes are a predictable byproduct of coping strategies brought on by food insecurity: when resources are in short supply, patients may be forced to engage in cost-related medication underuse, choose between food and other basic needs, consume low-cost but energy-dense foods, and forego foods needed for special medical diets.⁶

Accordingly:

1. **CMS should adopt Hospital Inpatient Quality Reporting (IQR) measures on screening for social drivers of health, screen positive rate for social drivers of health, and the Global Malnutrition Composite Score.**

Although there has been growing recognition of the impact of HRSN like food insecurity on patient outcomes and cost of care, these areas have nonetheless remained a measurement gap in CMS quality programs for hospitals. IQR measures aimed at understanding the prevalence of HRSN in inpatient settings are a crucial first step toward more informed, comprehensive care and discharge planning. We share CMS's hope that screening patients for HRSN will encourage hospitals to focus attention and resources on responding to patients' needs, including through fostering stronger referral networks with CBOs.

These measures also represent a critical step in aligning fee-for-service Medicare with the Medicare Advantage program: CMS recently issued a final rule requiring HRSN screening as part of annual health risk assessments in Special Needs Plans and solicited feedback on potential future rulemaking regarding a HRSN-related Star Ratings measure.⁷ Absent attention to original Medicare, CMS policy inadvertently promotes disparities in capacity to respond to the HRSN of beneficiaries across Parts A/B and C.

2. **CMS should consider stratification by social risk factor data, in addition to Medicare-Medicaid dual eligibility, as a priority for disparity measurement or stratification guidelines suitable for overarching consideration across quality programs.**

As additional HRSN data, like Screen Positive rates, are incorporated into publicly reported IQR measures, there is an opportunity to build them into stratification guidelines. Past quality and performance initiatives have demonstrated that stratifying outcomes by HRSN can support a more clear and accurate picture. Studies on the Hospital Readmissions Reduction Program (HRRP), for example, demonstrate that HRSN characteristics of a hospital's patient population contributes significantly to variation in 30-day readmission rates.⁸ And, at least in the case of the HRRP, safety net hospitals serving higher-needs patients and

⁴ Seth Berkowitz et al., Food insecurity, health care utilization, and high cost: a longitudinal cohort study. *AM J MANAG CARE*, (2018).

⁵ Su Lin Lim et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality. *CLINICAL NUTRITION*, (2012).

⁶ Chadwick K. Knight et al., Household food insecurity and medication "scrimping" among US adults with diabetes. *PREVENTIVE MEDICINE*, (2016).

⁷ See Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704 (2022) (re: special needs plan risk assessments); Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (re: Star Rating measures).

⁸ Kathleen Carey and Meng-Yun Lin, Hospital Readmissions Reduction Program: Safety Net Hospitals Show Improvement, Modifications to Penalty Formula Still Needed. *HEALTH AFFAIRS* (2016).

contending with fewer resources to invest into solutions have been penalized more heavily than other hospitals.⁹ This outcome has raised equity concerns.

3. In general, we are supportive of efforts to increase uptake and application of Z codes across the health care system; however, we are concerned that the proposal to incorporate Z codes into the MS-DRG system is premature.

Especially as screening for HRSN becomes a routine component of inpatient care, it is critical that hospitals have – and effectively utilize – language to identify and name the impact that these unmet needs have on patient outcomes. The subset of ICD-10-CM diagnosis codes describing social and economic circumstances (**Z Codes**) facilitates this communication. However, as CMS indicated in the Proposed Rule, Z Code uptake has remained relatively low due to a number of factors including time pressure on providers, patients’ willingness to discuss social and economic matters, and the lack of consistent requirements or incentives to utilize Z Codes. If reporting can be improved to produce reliable data, then CMS (and the public) could more effectively consider how Z Codes should influence the severity level designation of diagnosis codes.

As to CMS’s request for feedback on what Z Codes should be considered if it moves toward inclusion in the MS-DRG, we note that food-insecure Medicare beneficiaries incur an estimated \$2,697 in additional health care costs per person annually as compared to their food-secure counterparts.¹⁰ Much of this additional spending takes the form of inpatient hospital nights and emergency department visits.¹¹ As previously noted, average inpatient hospitalization costs are 24% higher and readmission within 15 days is almost twice as likely for malnourished patients as compared to properly nourished patients.¹² Although we ultimately believe this proposal is premature, we would encourage CMS to consider lack of adequate food (Z59.4) as one code that may influence severity designations.

4. We encourage CMS to continue momentum toward a comprehensive strategy to address HRSN through screening, referral, and meaningful access to responsive services.

While we applaud CMS for its positive steps toward accurately identifying the impact of HRSN on the Medicare population and share in CMS’s hope that these measures will spur response on the part of hospitals to address unmet patient needs, we also urge CMS to more directly support and incentivize responsive action.

Our core reflections on the proposals thus far are as follows:

- As HRSN become an increasing area of focus, CMS must consider their approach not as a series of siloed policies, but as one cohesive system experienced and navigated by patients and healthcare providers. For example, studies have indicated that HRSN screening is considered most acceptable by patients who have been screened and received responsive services in the past, while patients with past experiences of discrimination in healthcare were more weary of the process.¹³ Simply put, patients who understand why they are being screened and trust that the screening will help them see their needs addressed are more willing to engage. The practice of screening for HRSN presents an opportunity to build a bridge of trust between patients and providers. However, without responsive action, it is a bridge to nowhere.

⁹ *Id.*

¹⁰ SA Berkowitz et al., Food insecurity and health care expenditures in the United States, 2011– 2013, Health Services Research (2017).

¹¹ Vibha Bhargava and Jung Sun Lee, Food insecurity and health care utilization among older adults in the United States, Journal of Nutrition in Gerontology and Geriatrics, 35(3), 177–192 (2016).

¹² Su Lin Lim et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality. CLINICAL NUTRITION, (2012).

¹³ Emilia H. De Marchis et al., Part I: A Quantitative Study of Social Risk Screening Acceptability in Patients and Caregivers. AM. J. OF PREV MED (2019).

- By relying on hospitals' voluntary development of action plans, CMS risks deepening inequities as hospitals with existing community connections and capacity to refer patients for HRSN continue to do so, while those with less capacity may be eager – but unable – to provide the effective referrals that high-risk patients critically need.
- As CMS policy more strongly emphasizes screening, healthcare providers will increasingly look to CBOs to connect patients with responsive services. Without funding and technical assistance to build capacity, it will be increasingly difficult for CBOs to meet demand.
- Overall, there is little attention to accountability to patients. By way of example, it is not clear that should MS-DRG severity level designations be enhanced by Z Codes any enhanced payment would be directed towards care coordination across health and social services sectors. (Yet such care coordination—reflecting increased resource needs—is an assumption underlying the payment rate.)
- Inequities between traditional Medicare and Medicare Advantage are also concerning. Over 60% of Special Needs Plans provide some meal benefit as part of inpatient discharge planning and 2% offer meals for extended periods of time.¹⁴ As Medicare Advantage plans continue to make inroads into coverage for nutrition and other HRSN-responsive services through Special Supplemental Benefits for the Chronically Ill and Value-Based Insurance Design, disparities in the quality of care for traditional Medicare and Medicare Advantage patients will deepen.
- As more data related to the impact of HRSN on patient outcomes and cost of care are produced, attention must be paid to the ways these data are reported and understood by stakeholders. For example, if a higher screen positive rate, reported without context on CareCompare, dissuades potential consumers from seeking care at a particular hospital, that hospital may be disincentivized to effectively screen higher-risk patients. CMS should consider how to educate healthcare consumers and providers to effectively interpret this nuanced landscape.

Ultimately, meaningfully addressing HRSN involves a continuum of interventions that includes screening, referral, and access to services and supports. With so much at stake and the potential for unintended consequences high it is therefore essential that there is greater strategic coordination across current policies to ensure commensurate capacity at every step. While proposals are to date largely presented in a silo, this kind of comprehensive vision would also empower the public to comment and provide feedback.

CHLPI applauds CMS for its efforts to better understand the prevalence of unmet social needs in the Medicare population, and for its attention to the matter of ensuring that this information is used in a manner that addresses and does not exacerbate inequity. We would be happy to work with CMS to further address any of the comments above. Please contact Kathryn Garfield at kgarfield@law.harvard.edu with questions.

Sincerely,

Kathryn Garfield

Kathryn Garfield
Clinical Instructor and Director, Whole Person Care

on behalf of

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¹⁴ Thomas Kornfield et al., Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment, Commonwealth Fund (2021). doi: 10.26099/345k-kc32.