CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

June 7, 2023

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-1785-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 2024 Rates (CMS-1785-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 encouraging responsiveness to those needs in a manner that does not exacerbate inequity. We urge continued momentum toward a comprehensive strategy to address unmet needs that includes screening, referral, and meaningful access to responsive services.

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.[1] Food insecurity is particularly prevalent among Medicaid/Medicare dual enrollees, approximately one third of whom report experiencing this challenge.[2] As the severity of food insecurity increases, so too do healthcare costs associated with inpatient care, emergency care, surgeries, and drug costs.[3] 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.[4]

These costly outcomes are a predictable byproduct of coping strategies brought on by food insecurity: when

[1] James P. Ziliak and Craig Gunderson, The State of Senior Hunger in America 2019: An Annual Report, Feeding America (2021).
[2] 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
[3] Seth Berkowitz et al., Food insecurity, health care utilization, and high cost: a longitudinal cohort study. AM J MANAG CARE, (2018).
[4] Su Lin Lim et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality. CLINICAL NUTRITION, (2012).

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.[5]

Accordingly:

1. **CMS should incorporate the proposed Health Equity Adjustment (HEA) into hospitals' Total Performance Score (TPS) in the Hospital Inpatient Quality Reporting (IQR) program.**

CHLPI applauds the development of the HEA as an innovative strategy to encourage high quality care of patients in underserved populations. Too often, hospital performance measures risk creating perverse incentives to avoid the provision of care to higher-needs patients. We see this adjustment as an important step toward ensuring that safety net hospitals contending with fewer resources while serving higher-needs patients are not more heavily penalized than other hospitals.

In the future, we encourage CMS to consider ways to factor patients' HRSN into the HEA, in addition to dual eligibility status as a measure of underserved populations. Past quality and performance initiatives have demonstrated that stratifying outcomes by HRSN can support a more clear and accurate picture. As an example, studies on the Hospital Readmissions Reduction Program (**HRRP**) demonstrate that HRSN characteristics of a hospital's patient population contributes significantly to variation in 30-day readmission rates.[6] A hospital with a higher percentage of dual eligible patients who also have unmet HRSN may perform more poorly across performance scaler domains than another hospital with a similar underserved multipler, but the latter's HEA would be higher. 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 to provide additional nuance to these innovative programs.

2. **CMS should include Medicare Advantage patients in the cohort of the Hybrid Hospital-Wide All-Cause Readmission (HWR) Measure beginning with the FY 2027 payment determination.**

Medicare Advantage (MA) enrollment has grown rapidly in recent years, with MA plans serving half of Medicare beneficiaries in 2022.[7] As enrollment shifts, we are encouraged by CMS's efforts to adapt data collection to effectively measure readmission outcomes across the entire Medicare beneficiary cohort.

We hope that the collection of these data will also shine a light on key equity concerns in the ability to address HRSN between fee-for-service Medicare and Medicare Advantage that may account for differences in readmission between the two programs. For example, average inpatient hospitalization costs are 24% higher and readmission within 15 days is nearly twice as likely for malnourished patients as compared to their properly nourished counterparts.[8] To address these concerns, Medicare Advantage plans have made significant inroads into coverage of nutrition through general supplemental benefits, Special Supplemental Benefits for the Chronically Ill (SSBCI), and Value-Based Insurance Design: the number of Medicare Advantage plans offering meals beyond a limited basis under SSBCI has ballooned from 71 in 2020 to 422 in 2023.[9] Without similar tools to address HRSN, disparities in the quality of care for traditional Medicare and Medicare Advantage patients will deepen. The collection of readmission data across both programs may help to illuminate this concern.

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[5] Chadwick K. Knight et al., Household food insecurity and medication "scrimping" among US adults with diabetes. PREVENTIVE MEDICINE, (2016).
[6] Kathleeen Carey and Meng-Yun Lin, Hospital Readmissions Reduction Program: Safety Net Hospitals Show Improvement, Modifications to Penalty Formula Still Needed. HEALTH AFFAIRS (2016).
[7] Erin Trish et al., Substantial Growth in Medicare Advantage and Implications for Reform. HEALTH AFFAIRS (2023).
[8] Su Lin Lim et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality. CLINICAL NUTRITION, (2012).
[9] ATI Advisory, New Non-Medical Supplemental Benefits in Medicare Advantage in 2023 (2023).

3. **CMS should extend the Hospital Inpatient Quality Reporting (IQR) measures on screening for social drivers of health and screen positive rate for social drivers of health to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program.**

Although there has been growing recognition of the impact of HRSN 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. CHLPI was supportive of the inclusion of screening and screen positive rates for social drivers of health in the Hospital IQR program, and we share CMS's hope that extending these measurements to PPS-exempt hospitals will encourage these hospitals to focus attention and resources on responding to patients' needs, including through fostering stronger referral networks with CBOs. We note, however, that without funding and technical assistance to build capacity, it will be increasingly difficult for CBOs to meet the demand that accompanies CMS's encouragement of CBO collaboration. Furthermore, where referral capacity is strained by a lack of available community resources, providers may be hesitant to screen for needs they cannot help their patients address.

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.[10] 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. Similarly, the Association for Clinical Oncology noted that physicians in under-resourced practices are often hesitant to ask questions about HRSN due to a lack of resources to assist with these challenges.[11] 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. As CMS extends the reach of screening for social drivers of health, we encourage similar momentum for technical assistance and funding pathways to meaningfully connect patients to responsive services.

4. **In general, we are supportive of increasing the severity level of three Z Codes related to homelessness; however, we hope that CMS will consider methods of encouraging hospitals to engage meaningfully with community-based organizations to address patient needs.**

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. Adjusting the severity level designation of these Z Codes to reflect the enhanced complexity of inpatient care and discharge planning they necessitate is an important step toward meaningfully addressing HRSN. However, stronger incentives for hospitals to meaningfully engage with community-based organizations are needed to continue this momentum. It is not clear that any enhanced payment accompanying this increased severity designation 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. By relying on hospitals' voluntary action, 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.

[10] 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).
[11] Association for Clinical Oncology, Letter to CMS on 2023 Hospital Inpatient Prospective Payment System Proposed Rule (CMS-1771-P) (June 17, 2022).

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CHLPI applauds CMS for its efforts to better understand the prevalence of unmet social needs in the Medicare population, and for encouraging responsiveness to those needs in a manner that 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

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Clinical Instructor and Director, Whole Person Care

on behalf of

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