# COMMENT SUBMITTED BY:


## Dr. Stanley Goldfarb, Chairman, Do No Harm


*Re: Notice of Proposed Rulemaking; Docket Number CMS-1771-P: 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*

Do No Harm

# INTRODUCTION

Do No Harm is a policy and advocacy organization committed to protecting the integrity of American healthcare. We represent a diverse group of physicians, healthcare professionals, medical students, patients, and policymakers united by a moral mission: Protect and promote the healthcare that improves the health and well-being of every individual patient. We oppose injecting political ideology into healthcare, which should always be apolitical and patient-focused. Do No Harm is dedicated to empowering patients, medical professionals, and a diversity of Americans to promote medical fairness and equal access to care.

# CLIMATE CHANGE AND HEALTH EQUITY

Through this proposed rulemaking, CMS is seeking strategies and approaches for addressing climate change, which it says directly impacts the medical community. CMS asserts without evidence that climate change disproportionately harms "underserved populations." (Underserved populations refers to: "racial and ethnic minority groups, indigenous people, members of religious minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, older adults, and rural populations."[1]) CMS asserts that "the healthcare sector should more fully explore how to effectively prepare for climate threats."[2] This new mission is both vague and all-encompassing.

CMS has requested comments from the public regarding: (1) the likely impacts of climate change on patients, residents and consumers so that they can develop plans to mitigate those impacts; (2) the understanding of exceptional threats that climate-related emergencies cause to patients so they can better address those issues; and (3) taking action on reducing emissions and tracking progress in this regard. CMS has indicated such action could apply to hospitals, nursing homes, hospices, health home agencies, and other providers.

1. CMS-1771-P, Proposed Rule: Medicare Program; page 28478 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
2. *Id.*

However, climate change is not even tangentially related to treating specific patients for specific illnesses. The healthcare industry should focus on improving the health and well-being of patients, including serving each patient's unique and individual needs. CMS should oppose any rulemaking that distracts from the basic mission of medical care and creates a barrier between medical professionals and their patients.

Under this new potential rule, healthcare entities will be asked and possibly compelled by CMS to divert their focus and resources from serving patients to tracking greenhouse emissions.[3] Medical professionals are not trained or equipped for this type of activity, and it strains credulity to believe that shifting time and attention to this contentious issue will do anything to benefit patients. It is far more likely to harm patients and therefore has no place in healthcare.

# HEALTH EQUITY APPROACHES

## Stratification Methods

In the build-up to this rulemaking process, CMS asserts without evidence that significant and persistent inequities in healthcare outcomes exist today for certain demographics. CMS asserts that the worst health outcomes are often associated with individuals that belong to a racial or ethnic minority group; are a member of a religious minority; live with a disability; are a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; live in a rural area; or live near or below the poverty level.[4] Through this proposed rulemaking, CMS hopes to attain an equitable society by "designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our beneficiaries need to thrive."[5]

3. CMS-1771-P, Proposed Rule: Medicare Program; page 28478 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
4. CMS-1771-P, Proposed Rule: Medicare Program; page 28479 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
5. *Id.*

In order to address healthcare disparities, CMS intends to use measurement and stratification methods, which are defined as calculating measure results for specific groups or subpopulations of patients.[6] In short, CMS wants to collect a wide-variety of personal data from patients to categorize individuals with heightened social risk or demographic characteristics with associations to poorer outcomes. They will be categorized according to their group identity, per the list above, instead of their individual characteristics and medical needs. Such stratification threatens the individualized treatment that healthcare is supposed to provide.

Additionally, CMS wants hospitals to report confidential patient information in an attempt to highlight potential gaps in care between groups of patients. Yet these "gaps in care" are not actually about care. Instead, CMS is seeking to identify information regarding racial, ethnic, income, geographic location, and sexual orientation. By labeling these characteristics as disparities, CMS could use this information to single out healthcare providers and take punitive action against them.

CMS claims to prioritize measures that focus on access to care. However, it appears CMS is using "access to care" as an attempt to collect more non-health related data from patients.

Additionally, CMS introduces the concept of "non-clinical drivers of health." These include "social risk factors such as socioeconomic status, housing availability, and nutrition, as well as marked inequity in outcomes based on patient demographics such as race and ethnicity, being a member of a minority religious group, geographic location, sexual orientation and gender identity, religion, and disability status."[7] This self-reported data, which by CMS's own admission complicates its ability to choose effective metrics to evaluate disparity, will be used as indicators for health inequity. This means CMS is creating a reporting system with acknowledged flaws. Such a flawed system should not be used as a basis for rulemaking or policies of any kind.

CMS is inappropriately seeking to restructure how the healthcare system approaches patient care. It asserts that "attributing differences in outcomes to race may inappropriately place the driver of poorer health outcomes on the patient, rather than on structural factors, such as racism in society and the healthcare system that drive the provision of lower quality care."[8] Rather than addressing individual symptoms and lifestyle choices to

6. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
7. CMS-1771-P, Proposed Rule: Medicare Program; page 28482 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
8. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

treat a patient, CMS sees health equity as an opportunity to address the supposed "racism in society and the healthcare system." By hijacking the medical relationship between a healthcare provider and his or her patient to include "structural factors," the well-being of the patient is no longer the primary focus. This is a dangerous precedent for CMS to set. Individual health should always be the main priority in the healthcare system.

Furthermore, CMS acknowledges that once reporting of healthcare disparities is complete, the presentation of results will not be objective. CMS offers four ways for stratified results to be presented: Statistical Differences; Rank Ordering and Percentiles; Threshold Approach; and Benchmarking. For example, when using the *Threshold Approach*, healthcare providers could be grouped based on their performance using defined metrics, such as fixed intervals of results of disparity measures, indicating different levels of performance.[9] However, this method does not convey the degree of disparity between healthcare providers or the potential for improvement based on the performance of other healthcare providers. It also requires a determination of what is deemed "acceptable disparity" when developing categories. CMS could potentially create a healthcare provider ranking system based on the results of the nonmedical, social risk factors included in the stratification method—another unacceptable and inappropriate use of the healthcare system's resources.

Taken together, CMS's efforts at stratification come down to the creation of a confidential database of patient information that will distract healthcare providers from treating patients highest and most individualized level.

## The Hospital Readmissions Reduction Program

CMS seeks comment on (1) The benefit and potential risks, unintended consequences, and costs of incorporating hospital performance for beneficiaries with social risk factors in the Hospital Readmissions Reduction Program; (2) the approach of linking performance in caring for socially at-risk populations and payment reductions by calculating the reductions based on readmission outcomes for socially at-risk beneficiaries compared to other hospitals or compared to performance for other beneficiaries within the hospital; and (3) measures or indices of social risk, in addition to dual eligibility, that should be used to measure hospitals' performance in achieving equity in the Hospital Readmissions Reduction Program.[10] Once again, the proposed rulemaking threatens healthcare providers' ability to treat and improve the health of individual patients.

9. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
10. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

The Hospital Readmissions Reduction Program is a Medicare value-based purchasing program that encourages hospitals to improve communication with patients and caregivers in discharge plans and thereby reduce readmissions.[11] This program is designed to improve the quality of hospital care for all Americans. CMS now wants to use it to improve "health equity" and reduce healthcare disparities, despite there being no statutory authority for changing the program's purpose and goals.[12]

By pursuing this rulemaking, CMS will change the medical community's focus from medical diagnosis and treatment to social issues like income, education, employment, and housing quality.[13] However, these indicators remain unconnected from and unnecessary for treating the patient's individual health needs. CMS should not be distracting healthcare providers from focusing on patients' specific health concerns and treatment plans.

# DATA COLLECTIONS

CMS seeks public comment on how the reporting of diagnosis codes in categories Z55–Z65 may improve CMS's ability to recognize severity of illness, complexity of illness, and/or utilization of resources in an effort to advance health equity for all. CMS wants to expand its data collection by requiring medical facilities to report to CMS additional diagnosis codes in the Social Determinants of Health (SDOH). CMS uses SDOH as an assessment for coverage decisions and for designing programs, benefits, and services, yet making decisions based on these factors has no proven correlation with improving patient health and may in fact undermine it.

Specifically, Codes Z55-Z65 include the following data: (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; and (Z65) Problems related to other psychosocial circumstances.

11. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
12. CMS-1771-P, Proposed Rule: Medicare Program; page 28480 (May 10, 2022) https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
13. https://www.neighborhoodatlas.medicine.wisc.edu/

The information in Z Codes is self-reported by the patient. According to CMS, "patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider."[14] Documentation of social information from social workers, community health workers, case managers, or nurses could be utilized if the documentation is included in the patient's official medical record.

By expanding data collection to include such characteristics as housing and social environment, CMS could decide to increase Medicare coverage for individuals that fall into these categories. Additionally, CMS could rank and assess healthcare facilities based on their interactions with patients from certain demographic groups. This means CMS is attempting to identify certain demographics in its data collection efforts for non-healthcare purposes. By requiring medical facilities to report this data, CMS is once again diverting resources and time from patient care. CMS should not be spending money on an initiative that is meant to collect data on non-medical information.

# CONCLUSION

CMS' proposed rulemaking threatens medical excellence and the quality of care provided to patients. It injects controversial, politicized, and non-medical factors into federal healthcare decision-making, which will limit providers' ability to serve patients' unique needs and develop individualized treatment plans. CMS should focus on improving health outcomes for everyone, which this proposed rulemaking fails to do.

14. ICD-10-CM Official Guidelines for Coding and Reporting (April 1, 2022) https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf.