June 25, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: 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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment [CMS–1752–P] (hereafter referred to as “2022 IPPS”)

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, we appreciate the opportunity to provide comments on the proposed 2022 IPPS and requests for information. OCHIN is a national, nonprofit community-based innovation and research network, as well as a national leader in promoting high-quality health care in historically underserved communities across the country. **OCHIN urges the Centers for Medicare & Medicaid Services (CMS) to adopt our recommendations, which would accelerate digital health information standardization and interoperability to strengthen quality measurement and increase health equity, while also reducing administrative burdens and complexity.**

Implementing national digital health data standards and policies promoting adoption are essential to modernizing the nation’s health care infrastructure to drive equity, reduce administrative burden and complexity, improve the reliability and accuracy of patient health information, transition to alternative delivery and payment models, engage patients, and enhance and maintain public health capabilities. As a result, OCHIN strongly supports provisions in the proposed 2022 IPPS and offers responses to the requests for information that would:

- Prioritize standardization of clinical quality measures.
- Advance the use of digital quality measure reporting and standardized electronic exchanges that are integrated into provider workflow, including the certified electronic health record.
- Improve national standardized demographic and social determinant of health data collection.
- Increase transparency and accountability through reporting of quality measures that are stratified by race and ethnicity, sexual orientation and sexual identity, tribal affiliation, language preferences, rurality, and social determinants of health.
- Support the development of an evidence-based approach to an equity score for hospitals (and all other providers across the continuum of care) that synthesizes results across multiple social determinants of health risk factors.
OCHIN members have done over 700,000 social determinant of health screenings in OCHIN Epic for nearly 430,000 patients. OCHIN has also undertaken research among community-based providers (serving patients facing significant structural inequality) on social complexity and quality measurement, as well as quality measure digital exchange. The OCHIN-supported research findings point to the importance of having performance metrics that account not only for medical complexity, but also account for the social complexity of a provider’s patient population, particularly in an era of value-based payment. OCHIN also strongly urges CMS to adopt OCHIN’s recommendations across Medicare and Medicaid payment systems while working, to the greatest extent possible, with commercial health insurers to harmonize policies that improve standardization in quality measures and reduce variation to the greatest extent possible given significant persistent structural challenges. For example, several OCHIN member clinicians participated in a randomized controlled trial testing whether quality reporting could be a by-product of clinical care. The initial descriptive study of the capacity for, and quality of exchange of standardized quality measures from health systems in a secure transfer of physician-level quality measures from four health systems with mature measure processes proved difficult. It was reported that there were errors that required human intervention to repair, thereby precluding full automation. This study reconfirmed an important problem, namely, that, despite widespread health information technology adoption and federal meaningful use policies, even advanced systems remain far from goals to make clinical quality reporting a reliable by-product of care. Furthermore, community-based providers have limited resources and are not able to implement multiple data standards, payment models, and quality reporting programs because the administrative complexity diverts resources while increasing compliance challenges and risks. Finally, the lack of updated and widely accepted national data standards for unique patient identification, as well as demographic and social determinant of health information, negatively impacts minoritized and underserved patients and their providers in communities that perennially face resource constraints because it obscures the extent, severity, and underlying causes of inequity. The complexity of varied “unique” patient identification policies and demographic and social determinant of health data capture, reporting, and exchange continues to grow as states and various federal agencies continue to impose conflicting requirements. For example, in 2020, the State of Oregon’s Legislature passed a law that prescribes how the state’s health care providers must collect information on race, ethnicity, language, and disability (referred to as REALD), while in California, legislation introduced this year proposed development of a methodology for unique patient identification. At the same time, federal agencies are guided by the White House’s Office of Management and Budget standards that have not been updated in key areas. OCHIN strongly urges the Biden Administration to convene an advisory stakeholder group on demographic and social determinant of health data as part of the Equitable Data Working Group established by President Biden’s Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. As noted by CMS in the proposed rule, OCHIN agrees that federal, as well as state datasets, are not disaggregated by race, ethnicity, gender, and other key demographic variables, such as social determinants of health, and that “[t]his lack of data has cascading effects and impedes efforts to measure and advance equity.”

OCHIN applauds provisions of the 2022 IPPS proposed rule and requests for information that would advance interoperability, public health capacity building, and equity in health care delivery through

increased health-related digital data standardization, transparency, incentives, and accountability. **OCHIN has enclosed detailed comments in response to provisions of the 2022 IPPS proposed rule, as well as responses to several requests for information.** We welcome the opportunity to work closely with CMS as the agency develops proposals after consideration of comments in response to the RFIs. OCHIN is able to provide rapid, data-driven feedback that would support the agency’s assessment of how policy proposals would impact community-based providers despite significant structural inequality and resource limitations. Please contact me at **stollJ@ochin.org**.

Sincerely,

Jennifer Stoll  
Executive Vice President  
Government Relations & Public Affairs
APPENDIX

CLOSING THE HEALTH EQUITY GAP IN CMS HOSPITAL QUALITY PROGRAMS – REQUEST FOR INFORMATION

Stratification of Quality Measure Results by Race and Ethnicity & Improving Demographic Data Collection. The Centers for Medicare & Medicaid Services (CMS) is seeking comment on expanding the agency’s method of measuring hospital equity (currently based on dual-eligibility) to include race and ethnicity. However, CMS proposes to use an imputation algorithm for race and ethnicity until CMS determines that self-reported information is sufficiently available. CMS notes that there are shortcomings in existing government administrative race and ethnicity data. OCHIN strongly supports CMS’s interest in moving forward to apply additional stratification of quality measures based on race and ethnicity and other demographic categories and social determinants of health (SDH). However, OCHIN strongly urges CMS, along with all other U.S. Department of Health & Human Services (HHS) agencies, to ask the White House Office of Management and Budget to convene an advisory body comprised of stakeholders with experience collecting SDH and demographic data to inform and accelerate a unified approach across agencies and programs, as well as states. For instance, each year, the Health Resources & Services Administration (HRSA) health center grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS), which include race and ethnicity for two of the quality measures. Further, the scope of this effort should be expanded to include sexual orientation and gender identity, functional status, tribal affiliation, rurality, and language preferences. Currently, OCHIN members utilizing the OCHIN Epic Model System collect this demographic and SDH data, which supports improved clinical practice, research, and data-driven policy recommendations that embed equity considerations. Specific attention and priority should be given to the work by the Office of the National Coordinator for Health Information Technology (ONC) to drive national standard development, testing, and finalization of the USCDI version 2, particularly regarding SDH. Related to the foregoing, OCHIN strongly supports existing efforts of a broad cross-section of stakeholders through the Gravity Project to accelerate national standard development in these areas and urges CMS to direct resources and support to these initiatives that improve the quality and accuracy of data.

We also urge CMS to encourage widespread adoption of designated national standards through incentives, including quality performance points, training, and technical assistance of this data collection and appropriate payment for the associated counseling and evaluation that this data collection informs. CMS is able to work with stakeholders to identify policies that ensure consistent and accurate capture of demographic and SDH information. While working with stakeholders like OCHIN to evaluate the appropriate modalities and strategies to collect this wide-ranging information (with varied levels of potential sensitivity), there are steps that CMS is able to take immediately to increase accurate collection of SDH and demographic data. For example, CMS could measure the rate at which a minimum set of demographic information is collected by providers as part of the Promoting Interoperability program to incentivize consistent collection of data of interest. CMS would be able to expand the range of standard demographic data elements that are collected with clear guidance for patients and providers. It is essential that these incentives are available across the continuum of care, as it is likely that primary care would conduct most of the data collection and resulting assessments, evaluation, and counseling.

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3 An algorithm that imputes demographic information raises concerns given the suitability and quality of the data relied upon. Further, releasing patient specific data using this methodology to providers could introduce erroneous information into the patient records while withholding this information would hinder the ability to validate the accuracy of the algorithm.

4 The UDS is a standardized reporting system that provides consistent information about health centers and look-alikes.
Hospital Equity Score. CMS suggests expanding the current Hospital Equity Score beyond dual eligibility to eventually represent the calculation of results across multiple social risk factors and disparity measures, including race/ethnicity. OCHIN strongly supports CMS efforts to evaluate the potential benefits and challenges of designing, developing, validating, and implementing an expanded Hospital Equity Score. OCHIN would welcome working with CMS to test and evaluate the methodology and urges development for use across Medicare and Medicaid payment programs, as well as provider type. There will be significant challenges in developing a methodology that produces a fair and accurate Hospital Equity Score. Development and testing of the methodology across providers, particularly those who offer services to patients who face significant structural inequality, is critical to ensure that Equity Scores do not simply reflect the relatively fewer resources allocated to providers and their patients in underserved communities.

PROMOTING INTEROPERABILITY PROGRAM FOR ELIGIBLE HOSPITALS AND PROVIDERS

Prescription Drug Monitoring Program. CMS proposes to maintain the Electronic Prescribing Objective’s Query of Prescription Drug Monitoring Program (PDMP) measure as optional while increasing its available bonus from five points to 10 points for the reporting period in CY 2022. OCHIN strongly supports retaining this as an optional measure as there is significant variability in the manner that state and local jurisdictions have implemented their PDMPs. Some state PDMPs cannot be integrated into a provider’s electronic health record (EHR) system as part of standard workflow. Further, state programs also vary on data use policies, as well as which personnel are permitted to access the PDMP. To increase uptake and use of the PDMP, an important tool that clinicians can utilize in the face of the deepening substance use disorder epidemic, OCHIN strongly urges CMS to convene a national workgroup with states to develop technical and other programmatic standards to improve access and use of state PDMPs.

CMS also seeks information on the use of the applicable Fast Healthcare Interoperability Resources (FHIR) exchange standard by PDMPs. First, OCHIN applauds CMS efforts to advance nationals standards. The NCPDP SCRIPT 2017071 standard is already widely adopted by providers using certified health information technology for e-prescribing. OCHIN supports promoting the use of the NCPDP SCRIPT 2017071 standard for exchanging data with PDMPs, while continuing to use the SMART on FHIR specification to support single sign-on as an option, where appropriate.

Health Information Exchange (HIE) Objective. CMS proposes to add a new, optional HIE Bi-Directional Exchange measure for the 2022 reporting period as a yes/no attestation. Hospitals could attest to this measure in place of reporting the two existing measures: 1) Support Electronic Referral Loops by Sending Health Information and 2) Support Electronic Referral Loops by Receiving and Incorporating Health Information. OCHIN supports this proposal. However, given the complexity and range of items that could be subject to the attestation, CMS should provide additional as well as examples of the documentation needed, to support the attestations to ensure that providers and their vendors are able to automate and/or retain needed documentation for audits.

Patient Electronic Access to Patient Health Information (PHI) Measure. CMS proposes to modify the “provide patients electronic access to their health information” measure to specify that hospitals must ensure that PHI from encounters on or after January 1, 2016, is accessible indefinitely, including via APIs, in the hospital’s certified electronic health record technology (CEHRT). OCHIN strongly urges CMS to give providers advance notice and opportunity to implement needed changes on a prospective basis because
retrospective application of technology requirements, in this case the required use and availability of the application programming interface (API) option, disproportionately and negatively affect providers in underserved communities, as such policies often require substantial resources to engineer. API technology has only increased in use over the last couple of years and it would be resource intensive to apply this requirement retrospectively with a relatively new standard specification on legacy systems. OCHIN supports patient electronic access to their health information and, consistent with the foregoing, urges CMS: (1) to allow for access based on existing document management system options and, (2) to apply the API requirement prospectively to records generated beginning with the next cost year, January 1, 2022. Further, indefinite availability of PHI is impracticable and costly for thinly resourced providers in underserved communities and, therefore, should not be required. This is further complicated by potential conflicts with state medical records laws and regulations and specific retention state records policies, and with regard to Health Insurance Portability and Accountability Act of 1996 (HIPAA), the existence of a standards-based API does not guarantee the feasibility of providing information that is “readily producible” electronically.

Public Health and Clinical Data Exchange Objective. CMS proposes to amend the “public health and clinical data exchange” objective to require four public health measures, including electronic case reporting (eCR), syndromic surveillance, immunization registry reporting, and electronic laboratory reporting. OCHIN strongly supports this effort to promote the increased capture and exchange of digital health information needed to address public health emergencies through the alignment of incentives, including through clinical quality measures. OCHIN has committed significant resources to support the development, of the eCR along with key stakeholders. Since April 2020, OCHIN members have triggered 1,009,805 COVID-19 related eCRs to the Association of Public Health Laboratories Informatics Messaging Services (AIMS) platform. At a patient level, OCHIN members have delivered reports to all states. OCHIN urges CMS to mandate the eCR measure for 2022 and offer bonus points in the Promoting Interoperability program for reporting on the other three measures for the 2022 reporting year before making them required in 2023, which will provide more time for implementation.

Furthermore, OCHIN also supports the bonus optional measure to promote expansion in other areas of public health reporting. Currently, the proposed rule specifically calls out transmission to public health agencies of antimicrobial use and resistance reporting and health care surveys, but many more programs that are implementing interoperability standards could benefit from becoming options in future rulemaking. The public health reporting page of ONC’s Interoperability Standards Advisory includes additional standards that should be considered in optional measures, including vital records reporting, newborn screening, birth defect reporting, and cancer reporting.

FHIR and HIE Exchange Objective Measures. CMS seeks information on provider use of FHIR APIs to exchange information in order to meet the measures under the HIE objective in Promoting Interoperability. OCHIN strongly supports national standards, like FHIR API, however, most nationwide networks and exchanges have not delineated how FHIR API should be incorporated into their frameworks. As a result, CMS should continue to engage stakeholders to obtain feedback on the relative maturity of adoption efforts before including FHIR in a performance-based metric for health information exchange.

FHIR API and Public Health Agencies. CMS seeks feedback on whether FHIR APIs should be used for quality reporting. Many agencies use existing standards-based interfaces (for example, the HL7 v2) that health IT developers incorporated into their products to meet ONC’s certification criteria for public health
data exchange. OCHIN recommends that CMS support continued use of existing standards while identifying other supplemental improvements.

**Patient Access Outcome Measures.** CMS is seeking information on creating patient access measures that reflect the frequency with which patients view or interact with their health information in patient portals and via third-party applications. OCHIN supports measures that incentivize patient engagement. However, rural hospitals and other providers and their patients continue to face a digital divide. We are versed in this structural inequality as OCHIN provides broadband network services to our members, including through a subsidiary, the California Telehealth Network. **Given continued lack of access to broadband in many areas of the nation, quality measures, if not adjusted to reflect structural inequality, would place providers for underserved communities at a relative disadvantage even where patients have access to patient portals, as well as the ability to share information with third-party applications, but lack broadband and cellular connectivity.** While some investments have been made in broadband by Congress and state legislatures due to COVID-19, it is too early to know if this funding will be optimized to ensure that all providers have medical grade connectivity, that there is reliable and affordable last mile connectivity, and that patients have access to digital devices or sufficient cellular coverage. OCHIN urges CMS to first test measures to assess whether the measure reflects structural inequality.

**ADVANCING TO DIGITAL QUALITY MEASUREMENT AND THE USE OF FHIR IN HOSPITAL QUALITY PROGRAMS – REQUEST FOR INFORMATION**

**Alignment of Measures Across Reporting Programs, Federal and State Agencies, and the Private Sector.** CMS seeks feedback on opportunities to collaborate with other federal agencies, states, and the private sector to adopt standards and technology-driven solutions to address our quality measurement priorities across sectors. OCHIN applauds and strongly supports CMS leading such an effort and urges the agency to consider the impact of these coordinated, aligned, and/or harmonized efforts on underserved communities and patients. OCHIN would welcome the opportunity to collaborate with CMS.

**Harmonizing Quality Measurement and Interoperability Requirements.** CMS seeks comment on aligning data needed for quality measurement with interoperability data requirements. OCHIN strongly supports harmonization to the greatest extent possible. For example, to reduce complexity and improve data quality, data elements relevant to quality measures should be conformed to the data elements and classes in the United States Common Data Initiative (USCDI) where possible. The expansion of USCDI data elements and classes is a resource intensive process from the standards development stage to widespread provider adoption and use. As a result, **when suggesting expansions to USCDI, CMS should focus on adopting quality measures with specifications using discrete data that is already captured during clinical care, as this would be most aligned with USCDI.** Further, CMS should ensure that stakeholders have a clear roadmap to increase broader buy into this approach by other government health care programs and commercial health insurers.

**Approaches to Improve Functionality of Quality Measure Tools.** CMS requests information on several proposals that could improve the functionality of quality measure tools by leveraging standards and technological advances.

- **Standardize the quality measurement data model.** OCHIN strongly supports CMS efforts to standardize the quality measurement data model to ensure the curation of an established dataset. This allows CMS to implement policies that promote the accuracy and suitability of the data for the intended purpose.
• **New methodologies and systems - challenges.** OCHIN agrees that, as CMS suggests, advances in natural language processing, big data analytics and artificial intelligence can be applied to validating observed patterns in data and inferences or conclusions drawn from associations, as one approach to data quality validation. However, it is critical that the deployment of such systems is appropriately validated, and that data selection does not reinforce existing structural inequality through bias, but instead is suitable and accurate for intended use. Further, as part of ideation, design, development, validation, and deployment of these systems, bias should be evaluated and there should be sufficient transparency so that all stakeholders understand how these systems function and may alter performance measurement. For example, validation and assessment are critical where providers and patients communicate in a language other than English and where documentation may include a language mix, as well as differential abbreviations and shorthand. Once implemented, significant validation and assessment of these systems are needed to assess bias and any negative disparate impact in networks where data is readily available for evaluation and modification.

• **Existing infrastructure and capacity - challenges.** Even in health systems with mature, established clinical quality measurement and tracking systems, automating direct transmission of clinical measures remains a challenge, particularly when making clinical quality reporting a reliable by-product of care. Four such systems participating in the Trial of Aggregate Data Exchange for Maintenance of Certification and Raising Quality had common errors including, measure miscalculations, data delivery errors, data reporting interrupted, and third-party errors. It is essential that CMS invest significant resources to test new systems and methods before scaling.

**Patient Generated Health Data (PGHD).** CMS seeks comment on the relative importance of data standardization compared to the inclusion of PGHD and other currently non-standardized data. OCHIN supports standardization in capture and transmission of PGHD. OCHIN strongly urges CMS to collaborate with ONC to prioritize the development of data standards that developers must use for PGHD to improve the quality and suitability of data for clinical use, research, and quality reporting. In the interim, remote patient monitoring and management with the associated PGHD continues to drive improved clinical outcomes. As a result, PGHD should be included in quality measurement. For example, home blood pressure values should be used in hypertension measures but should be recorded as different than in-clinic values and may well require different thresholds.

**Use of FHIR for Reporting eCQM Data.** CMS requests information on the use of FHIR to report quality measure data. OCHIN supports adoption of new methods, systems, and technologies that reduce clinician burden, improve actionability of quality measure reporting (for example, providing performance standing in near real time), and remedy structural inequality. Currently, the adoption of the available FHIR-based quality reporting is not widespread and involves significant changes to current standards and processes. CMS should continue to intensively engage stakeholders to ensure the adoption of a FHIR framework that moves beyond iteration in quality measure reporting to transformation that warrants the investment in time and resources this change would require. Further, **CMS should provide adequate time to stress test this change, particularly in underserved communities.**

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DUAL ELIGIBLES PROVIDER POLICY

CMS is proposing that state Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers if the provider or supplier otherwise meets all federal Medicaid enrollment requirements, even if a provider or supplier is of a type not recognized as eligible to enroll in the state Medicaid program. OCHIN strongly supports this proposed change in order to ensure access to underserved patients given the significant difficulties beneficiaries face navigating the complexity of the Medicare and Medicaid programs. This also ensures continuity of care and strengthens patient choice and engagement in their health care.

UNIQUE PATIENT IDENTIFICATION

Although not proposed in the 2022 IPPS proposed rule or contained in the requests for information, OCHIN strongly urges CMS to prioritize the development of methods to uniquely identify patients. Efforts to standardize data and implement a national digital data health framework will continue to be costly and complex to the extent there are not nationally adopted standards to accurately identify patients. The varied patient identifiers and methods currently in use impede electronic exchange, increase administrative complexity and cost, and negatively impact patient safety, public health, and clinical research. Currently, during the 2021 state legislative session, at least one state considered a bill that would mandate a state “solution” to uniquely identify patients. 6 Multiple “unique” identifiers for patients who move among states, providers, health plans, and public health jurisdictions undermine efforts to improve interoperability as well as privacy, security, patient safety, and equity. For example, in the OCHIN network, mismatching and duplication disproportionately affects communities of color, thus undermining health equity and contributing to structural inequality:

- Hispanic/Latinx patients make up 21% of the populations that our members serve, yet they make up 35% of the duplications.
- Black patients represent 13.6% of patients, yet 22% of the duplicates.

Many state leaders understand the importance of data collection and are developing state solutions. Though well-intentioned, these efforts undermine efforts at standard data exchange across neighboring states, regions, and the country, as well as federal interoperability and privacy modernization efforts. More resources are needed to ensure that states are engaged actively in the national efforts.

This lack of standardization is costly and confusing for providers (particularly providers in underserved communities who often have more reporting requirements and fewer resources). It also creates safety risks, undermines the ability to compare outcomes and trends at the regional and national level, and will continue to hinder public health sentinel and response capabilities even after infrastructure is modernized because the systems will not speak the same language when transferring and sharing data.

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6 Although the U.S. Department of Health and Human Services (HHS) is prohibited from spending any federal dollars to promulgate or adopt a national unique health identifier standard, the Agency should implement policies that improve unique identification and imputation. Further, CMS should work with Congress to address statutory limitations that undermine patient safety and equity in health care while also hindering innovation, interoperability, privacy and security.