



Herb B. Kuhn
President and CEO
P.O. Box 60
Jefferson City, MO 65102

June 16, 2021

Shalanda Young
Acting Director, Office of Management and Budget
Executive Office of the President
1600 Pennsylvania Avenue NW
Washington, DC 20500

Re: Methods and Leading Practices for Advancing Equity and Support for Underserved
Communities Through Government

Dear Ms. Young:

On behalf of its 141 members, the Missouri Hospital Association appreciates the opportunity to submit the following comments in response to the Request for Information titled “Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government” published in the *Federal Register* on May 5, 2021.

Our comments are pertinent to Area 1: Equity Assessments and Strategies.

MHA applauds the spirit and intent of Executive Order 13985 and the thoughtful approach of the Office of Management and Budget in requesting information on how best to accomplish the vision of the order in a way that balances the resources that will be required to pragmatically fill the many gaps surrounding health equity. At its core, our submission is centered around the existing dearth of standardized, yet meaningful and widely available data on issues related to health equity, as we feel strongly that you cannot meaningfully change what you do not meaningfully measure. At the same time, and in reflection of the earlier point on pragmatism, the data generation processes required to meaningfully measure health disparities within and between finite population segments will be an expensive, yet necessary process. For example, most hospitals currently collect detailed information on patient social determinants of health, yet evidence suggests those data are rarely matriculated into administrative claims data systems in the form of ICD-10-CM Z codes for wider use in clinical research and policy setting applications.^{1,2,3} Ensuring the systematic capture of information on patient-level SDOH and other factors, in addition to the technology required to harmonize electronic medical records systems with administrative claims billing systems, will require a significant government investment to offset provider costs.

Additionally, recognizing that improving data collection through policy and incentive frameworks is the first step required in advancing health equity. This act, in isolation, will do nothing to improve the health and well-being of socially complex and historically underserved Americans. The infinitely, more complex step will require a larger government investment in the provision of social care, a model that has been tested by the Centers for Medicare & Medicaid

Services through optional supplemental benefit packages, Medicaid waivers and other programs. Furthermore, asking patients about sensitive issues such as homelessness, gender identity and food stability is a delicate process that can be made moot by having a lack of resources to do anything meaningful with the information shared between patient and clinician. Enabling health care providers with resources required to effectively intervene with patients' health-related social needs also will make the act of generating the data less frustrating for both patients and clinicians alike.

Additional considerations include:

OMB should be cognizant of the burden of data generation for any future equity measures. For example, in health-related equity settings, CMS should invite stakeholders to the table to identify both gaps and availability of relevant metrics while discussing the data abstraction format that would create the least amount of burden. In addition, OMB should consider the possibility of merging administrative data from disparate federal agencies to maximize efficiency and minimize data generation burden. For example, merging data on lifetime income and other assets from the Department of Treasury with health-related data from CMS would immediately negate the dependence on proximal data sources for SDOH such as dual eligibility for both Medicare and Medicaid which has limited interstate comparison and reliability due to variation in Medicaid eligibility and relative costs of living, although used in the assessment of penalties for excess readmissions at IPPS hospitals under the Hospital Readmission Reduction Program.⁴

In addition, OMB and CMS should adopt an "equity in all policies" approach and ensure that it is applied consistently across organizations. CMS should assess inequities across various payer and provider programs seeking means to address variation and disparities by convening and facilitating dialogues that increase awareness of health equity gaps and opportunities for improvement. Further, CMS, the U.S. Department of Health and Human Services and OMB should ensure inter- and intra-agency consistency in approaches to equity to ensure alignment. This would entail establishing policies that govern how equity is incorporated and executed to eliminate inter- and intra-agency misunderstandings and miscommunication that contribute to inefficiency and could potentially derail the process.

In addition to alignment of policies, CMS should create interagency registries of data to allow organizations to query as needed to help advance equity. This strategy ensures registries have rich data from multiple agencies and can be mapped to identify key trends that can provide a foundation for addressing equity.

To evaluate and address geo-granular disparities, CMS should incentivize the collection and adoption of technology that allows for interoperability to integrate the Race, Ethnicity, and Language (REaL) data, Z codes for SDOH, sexual identity and orientation into both EHR and administrative systems. Incentives to adopt and expand REaL and Z code data collection would enable care teams to identify and develop targeted policies and research agendas to reduce inequalities in health outcomes. It will be important that CMS incentivize the adoption of standardized data collection for REaL, sexual orientation, sexual identity, and ICD-10 Z codes

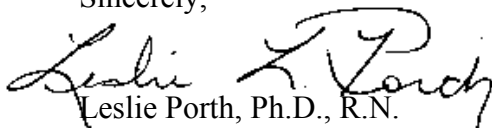
focused on SDOH. This strategy will seek to increase collection of critical data which will, in turn, provide information key to reducing health disparities.

In addition to incentives for interoperable data collection systems, CMS should support organizations working as innovation hubs for equity-centered care to encourage innovation. Investing in these organizations will help to refine information costs, returns and scalability while enabling innovation in efforts designed to build solutions aimed at moderating the deleterious effects of this complex issue. Innovation hubs would enable CMS to identify approaches to how health equity goals could be incorporated into pay-for-performance models. This strategy would help promote the adoption of equity-driven activities that seek to close current gaps.

Finally, CMS should provide the necessary infrastructure for health care workers to meet the needs of underserved communities. Advocating for a diverse workforce, cultural competence, and health literacy, among other approaches, would be formative to an equity-focused approach. Expanding the portfolio of what providers, community health workers, health educators and others on the care team can offer patients to address their unique needs within diverse communities, such as payment for community-based social and safety net services — including transportation, food, and housing — would reduce disparities created by adverse SDOH.

Thank you for the opportunity to provide our thoughts on this important issue. Any questions about our comments may be directed to Stephen Njenga at snjenga@mhanet.com.

Sincerely,



Leslie Porth, Ph.D., R.N.

Senior Vice President of Quality, Safety and Research

lp/ks

¹ Truong HP, Luke AA, Hammond G, Wadhwa RK, Reidhead M, Joynt Maddox KE. (2020) Utilization of Social Determinants of Health ICD-10 Z-Codes Among Hospitalized Patients in the United States, 2016–2017, *Medical Care*. September 11, 2020. Available at https://journals.lww.com/lww-medicalcare/Abstract/9000/Utilization_of_Social_Determinants_of_Health.98256.aspx

² Reidhead, M., Moyer, L. & Greimann, A. (2020, January). Z Codes for Social Determinants of Health: Which Hospitals are Most Likely to Use Them and for Which Patients? *HIDI HealthStats*. Missouri Hospital Association. Hospital Industry Data Institute. Available at <http://bit.ly/HIDIHealthStats0120>

³ Reidhead, M. (2018, September). Decoding Social Determinants of Health. Missouri Hospital Association. Available at: <http://bit.ly/PolicyBriefSDOH>

⁴ Joynt Maddox KE, Reidhead M, Qi AC, Nerenz DR. (2019). Association of Stratification by Dual Enrollment Status With Financial Penalties in the Hospital Readmissions Reduction Program. *JAMA Internal Medicine*. Available at <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2730354>