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November 16, 2018

Brenda Destro

Assistant Secretary for Planning and Evaluation, Room 415F

U.S. Department of Health and Human Services (HHS)

200 Independence Avenue, SW

Washington, D.C. 20201

aspeimpactstudy@hhs.gov

Re: **IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors**

Dear Ms. Destro:

On behalf of the Healthcare Association of New York State's (HANYYS) member not-for-profit and public hospitals, nursing homes, home care agencies and other healthcare provider organizations, thank you for the opportunity to submit comments in response to the following research question:

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

HANYYS appreciates that HHS is turning to the field to solicit recommendations for improving care for Medicare beneficiaries. We are pleased to participate in this national conversation about the healthcare delivery system.

General Comments

HANYYS appreciates HHS' growing recognition that social risk factors—such as income, education, race and ethnicity, employment, community resources and social support—play a major role in health, and significant gaps remain in health and life expectancy based on income, race, ethnicity and community environment.

As the healthcare system moves toward value-based or alternative payment models that tie payment to the quality and efficiency of care, we appreciate the additional focus on understanding the relationships between social risk and performance on these programs. HANYYS strongly believes that providers should not be penalized for variables outside of their control.

HANYYS members' experience validates the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) findings in its first report to Congress:

- Beneficiaries with social risk factors had worse outcomes on many quality measures, regardless of the providers they saw, and dual enrollment status is a powerful predictor of poor outcomes.ⁱ
- Providers that disproportionately served beneficiaries with social risk factors tend to have worse performance on quality measures, even after accounting for their beneficiary mix. Under all five value-based purchasing programs in which penalties are currently assessed, these providers experience somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors.ⁱⁱ

HANYS supports the study of social risk factors and their impact on patient outcomes and resource use in the Medicare program. HANYS has long advocated for refining the hospital readmission adjustment methodology to take into account socio-demographic factors. Failure to recognize the effect of socio-demographic factors on hospital readmission rates can unfairly penalize these hospitals. While hospitals should do all within their power to care for and assist patients in challenging circumstances, they should not suffer financial penalties due to gaps in the community's healthcare infrastructure.

HANYS supported enactment of the provision in the 21st Century Cures Act intended to address this problem. It directs the HHS Secretary to implement a methodology beginning in federal fiscal year 2019 that assigns hospitals to peer groups based on their proportion of full-benefit, dual-eligible individuals, and to provide separate comparisons of hospitals within groups in determining a hospital's adjustment factor.

We believe this is a reasonable first step toward providing a socio-demographic adjustment for the hospital readmissions program. However, it is vital that the methodology to implement the mandated adjustment be carefully designed to provide adequate relief for those hospitals that serve a high proportion of poor and disadvantaged patients. The necessity of socio-economic status adjustment has been confirmed by national leading organizations in healthcare outcome and measures, such as the National Academy of Sciences, Engineering, Medicineⁱⁱⁱ (National Academy of Medicine, ASPE contractor) and National Quality Forum.^{iv}

Recommendation: While the Centers for Medicare and Medicaid Services' (CMS) risk stratification by dual-eligible status is directionally correct, more study is required to ensure the methodology is expanded to more accurately reflect the differences in population (which are beyond a hospital's control) that affect outcomes. We encourage HHS, CMS and others to expand their look beyond the readmission measures, as social risk factors are a large driver of healthcare utilization and patient outcomes across the continuum of care. In addition, we encourage study of the advantages/disadvantages of adjusting for social risk factors at the patient/case level, which may provide a more accurate and meaningful adjustment, rather than at the hospital (aggregate) level.

Delivery of Services

New York State is currently engaged in a Delivery System Reform Incentive Payment (DSRIP) program, which is redesigning the way care is delivered to Medicaid beneficiaries. The statewide goal of New York's DSRIP program is to reduce avoidable hospital use by 25 percent over five

years. To achieve this significant improvement, New York's healthcare community is transforming how care is delivered, with a particular emphasis on social risk factors. While this program is focused on the Medicaid program, lessons learned can be translated to the Medicare population. DSRIP is also driving the transition from volume to value within the Medicaid program. To qualify for a Value-Based Payment (VBP) contract, contractors in New York State are required to address at least one social determinant of health.

Promising practices^v include:

- care management to address social and medical needs;
- integration of behavioral health and primary care;
- working with certified patient educators (asthma, diabetes, etc.);
- real-time connections to healthcare providers for time-sensitive issues via telehealth;
- nutrition services; and
- support to ensure housing security.

In addition, hospitals and health systems are working with a broader range of partners across their organizations and in their communities to identify and address health needs impacted by income, ethnicity, education, housing, food insecurity and other social determinants. These efforts typically focus on reducing health disparities and advancing health equity, and are collaborative, focus on specific populations, preventive and evidence-based.

In New York State, much of this work is aligned with the *Prevention Agenda*,^{vi} the state's health improvement plan. With the goal of making New York the healthiest state for people of all ages, the *Prevention Agenda* addresses social determinants of health, reducing disparities and improving health equity. Under the *Prevention Agenda*, hospitals and health systems work together with local health departments and partners in the community to identify community health needs and develop, implement and measure initiatives to address those needs. Some of the initiatives focus on social determinants of health. Examples include:

- screening inpatients and outpatients for food insecurity and housing needs, and incorporating these findings into the electronic medical record;
- providing "prescriptions" for food for the food insecure;
- providing outreach and education in barber shops, beauty salons, churches, etc., to engage populations in blood pressure management initiatives; and
- partnering with communities for safe, well-lit, walkable spaces for exercise, recreation and socialization.

Recommendation: HHS should look to programs underway within New York and other states for promising practices related to delivery of services for beneficiaries with social risk factors.

Data

HANYS supports the use of data to drive quality improvement. However, we urge HHS to proceed with caution as it considers new data collection requirements related to social risk factors.

Streamline, Align, and Focus on the Measures that Matter Most for Improving Patient Care

In our [Measures that Matter](#) report, HANYS notes that while the value of measurement is clear, measurement is also clearly out of control and in need of reform.

While providers, patients, consumer groups, payers (government and commercial), and professional societies are united in their commitment to the provision of high-quality, safe, patient-centered care, they are often divided on what to measure and report, and how. As the American Hospital Association noted, opportunities to make meaningful enhancements in quality and patient safety may be lost because there is a lack of focus and agreement on which measures can help improve patient outcomes.^{vii}

The current environment is chaotic. Hospitals and other providers must report on hundreds of measures required by government and commercial payers, accreditation agencies, professional societies and registries. Underlying the collection and reporting of each measure is a complex system of specifications, definitions, data abstraction, analysis and reporting, consuming significant time, expense and drawing from limited clinical, information system and administrative resources.

This has created an imbalance of values as provider practice has shifted to accommodate quality program reporting, undermining patient care. Despite the abundance of existing metrics, new measures are being developed to address the fundamental shifts in how care is paid for (volume to value) and delivered (integrated, preventive care at lower costs).

While many measures evaluate the same focus area or patient population, the measure specifications may be different, requiring providers to understand and implement distinct methodologies and systems. This lack of alignment and coordination, coupled with the sheer volume of quality measures and the limitations of current electronic health record (EHR) technology, has created an environment of measure madness. This madness is further complicated by the fact that EHRs were not designed with clinician input to support the existing workflow. As a result, clinicians are forced to modify current practice to meet electronic documentation requirements, which further displaces and redirects resources from meaningful quality improvement efforts.

Recommendation: We urge HHS to align with the [CMS Meaningful Measures Framework](#), which seeks to focus on the most critical quality improvement areas, while minimizing provider burden.

Transparency to Support Continuous Improvement

As part of an ongoing effort to improve quality, safety and patient outcomes, HANYS and our members are working hard to understand the impact of social risk factor adjustment. We look forward to ASPE's findings and the publication of the second report.

In general, **in advance of implementation, CMS should prioritize social risk factor adjustment methods and data sources that can be transparent.** For example, if CMS develops social factors at the patient level and uses them in the Readmission Reduction Program, those factors should be made available in the Standard Analytic File, Medicare Provider Analysis and Review (MedPAR), and other analytical files. This was not the case with the dual-eligible percent adjustment in the current program; those factors were not available until final adjusted factors were released.

We encourage ASPE to consider the following recommendations:

- **HHS should evaluate differences in the relationship between social risk factors and outcomes among types of conditions, procedures, patients, etc., rather than using a common adjustment across the board.**
- **HHS should make adjustments that can be done consistently across patient populations (i.e., payers) as well as across geographies (state vs. national data).**
- **HHS should analyze how social risk factors vary in different geographic markets (i.e., urban vs. rural access to automobile).**
- **HHS should avoid using data that are selectively reported and are not consistently available for all patients/cases (i.e., ICD 10 social risk factor codes that may not be entered, but would be valid).**

Again, the findings of this study should be made available to providers and other stakeholders to support quality improvement efforts.

Address Significant Electronic Health Record and eCQM Challenges

HANYS supports the long-term vision of using EHRs to streamline quality reporting practices while improving care. Hospitals and health systems in New York State have devoted significant resources and efforts to meet electronic clinical quality measures (eCQM) requirements, yet, challenges such as data mapping, data validation, submission of test and production files, among other issues, continue to hinder the ability of providers to use accurate clinical quality measure information to effectively impact patient care and quality.

That being said, the EHR as it currently exists may not be the most appropriate place for data collection related to social risk factors. Since the EHR is designed to handle an episode of care and social determinants involve daily life, providers need another mechanism and entry point to connect these data fields and integrate the information into the providers' data stores and workflow.

CMS should ensure that the accuracy, reliability and reporting feasibility of eCQMs are fully tested before expanding any eCQM requirements. We believe there is also opportunity for improvement related to the EHR itself, along with vendor certification.

Specific to the EHR, literature indicates that content is not captured or presented in a meaningful way and modifying the EHR to align with workflow would allow for greater efficiencies and improved clinical care. Additionally, the lack of interfacing with systems and technology, such as

monitoring equipment, affects many organizations' ability to deliver effective and efficient care, and achieve eCQM specification requirements.

The HHS Office of the National Coordinator for Health Information Technology (ONC) created vendor certification criteria to address issues such as these. However, the literature indicates that 34 percent of certified vendor reports reviewed did not meet the ONC certification requirement of stating their user-centered design (UCD) process, although certified as having met these requirements (Benda, A, Ratwai, Hettinger, & Fairbanks, 2015). This lack of adherence may be a significant contributing factor regarding poor usability.

Recommendation: HANYS strongly recommends that ONC enforce the current requirements and validate UCD testing.

Again, thank you for the opportunity to submit comments on this important issue. Please contact me if you have questions or need additional information.

Sincerely,



Loretta B. Willis, RN, CPHQ
Vice President, Quality Advocacy, Research, and Innovation

ⁱ Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 21, 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>

ⁱⁱ Ibid.

ⁱⁱⁱ National Academies of Sciences, Engineering, and Medicine. Accounting for social risk factors in Medicare payment. Washington, DC: National Academies Press, 2017.

^{iv} National Quality Forum. Risk adjustment for socioeconomic status or other sociodemographic factors. August 15, 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

^v Frescatore, D. Medicaid in New York: Fostering Collaboration to Improve Health. United Hospital Fund Conference presentation. July 18, 2018.

<https://uhfnyc.org/uploads/Files/Presentations/Donna%20Frescatore%20UHF%2007.18.2018.pdf>

^{vi} New York State Department of Health. *Prevention Agenda 2013-2018: New York's Health Improvement Plan*. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

^{vii} American Hospital Association (AHA). "Quality Measure Prioritization: An AHA Proposal." December 2014.