

June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS-1771-P, Medicare Program: Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements, etc.

Dear Administrator Brooks-LaSure:

The National Association of County and City Health Officials (NACCHO) appreciates the opportunity to comment on the proposed rule CMS-1771-P, Medicare Program: Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements, etc. NACCHO represents the nation's nearly 3,000 local health departments and would like to provide feedback on two aspects of CMS-1771-P: 1) Request for Information on Social Determinants of Health Diagnosis Codes, and 2) multiple sections related to ensuring data from reporting requirements can inform community-level public health efforts.

Request for Information on Social Determinants of Health Diagnosis Codes

NACCHO's local health department members work in their counties and cities each day to build partnerships to address the social determinants of health and structural barriers that contribute to health inequities. These efforts—often a core mission of local public health—cannot be done in silos and require a community-wide approach that links public health, healthcare and hospitals, and other critical sectors.

Therefore, NACCHO is pleased that CMS recognizes that hospitals can and should build health equity into their core functions to address healthcare disparities in hospital inpatient care and beyond. Expanding access to quality, affordable healthcare and screening patients for social needs and then linking them to community services are indeed important efforts towards addressing health disparities and improving health outcomes.

It is also important that CMS recognize the role of critical partners to the hospital system, including local health departments, whose expertise, data, and essential services address the community-level contextual factors that have an even greater impact on health than individual-level clinical care.¹ These factors include examples cited by CMS in the proposed rule, including housing, transportation, and access to nutritious foods. Local health departments have long played an integral role working with

¹ <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>



community partners, including hospital systems and health centers, to address the social determinants of health (SDOH).

NACCHO strongly encourages CMS to make the distinction between individual-level social needs and community-level SDOH, as defined by the WHO² and framed by Healthy People 2030³, when articulating and implementing future rulemaking to avoid confusion between individual and community-level interventions and, by extension, best characterize the distinct yet collaborative roles that healthcare, including hospitals, and governmental public health play.

As articulated by John Auerbach, Director of Intergovernmental and Strategic Affairs at the Centers for Disease Control and Prevention (CDC), and Brian Castrucci, president and CEO of the de Beaumont Foundation, efforts to address individual social needs are necessary, but not sufficient without addressing broader underlying social conditions within patients' communities.⁴ To this end, NACCHO recommends that this rule serve as an opportunity to more clearly and directly connect hospital health equity efforts, including conducting social needs screenings, with partners in local public health systems, including health departments, to improve and better coordinate SDOH efforts. This would further recognize the leadership roles that both hospital systems and health departments play in improving health in complementary, yet distinct ways.

One way CMS could better distinguish and support the roles of hospitals and health departments is through data collection and sharing requirements. Both local health departments and nonprofit hospital systems conduct community health (needs) assessments (CH[N]A) to inform community health improvement planning (CHIP), with increased collaboration engaging in community health improvement (CHI) activities, particularly since the passage of the Affordable Care Act. As addressed in NACCHO's Community Health Needs Assessment Policy Statement, sharing relevant local quantitative and qualitative health data is instrumental for identifying health disparities and addressing both individual-level health needs and the broader social determinants that directly impact health⁵. To this end, proposing the three health equity-focused measures for adoption in the Hospital Inpatient Quality Reporting (IQR) Program is a laudable step towards enhancing data collections that could benefit both health care and public health service delivery. NACCHO recommends that these measures be tied directly to nonprofit hospital community benefit requirements and efforts, ensuring that this data be included in hospital CHNA/CHIP processes, conducted in collaboration with local health departments, and that community benefit investments be driven by those results.

To best inform strategies to meet individual social needs and address SDOH, **NACCHO recommends that CMS not only require hospitals to report levels of social needs screenings conducted, but what specific social needs are being identified and the results, including which patients were referred to community services to support those needs and the level to which those supports or services were available at the time of referral.** Abiding by the public health maxim of 'No referrals without resources,' this richer level of data would be instrumental to identify where resources are needed to best meet individual

² <https://www.who.int/teams/social-determinants-of-health/equity-and-health/commission-on-social-determinants-of-health>

³ Healthy People 2030. Social determinants of health. <https://health.gov/healthypeople/objectives-and-data/social-determinantshealth>.

⁴ <https://www.healthaffairs.org/doi/10.1377/forefront.20190115.234942/full/>

⁵ <https://www.naccho.org/uploads/downloadable-resources/12-05-Community-Health-Needs-Assessment.pdf>

social needs and to more meaningfully address the contextual factors that result in poorer health outcomes.

It is also critical that collected data be leveraged to improve the communities' health. Therefore, **we also request that these data be shared with local health departments and other service providers so that they can be used to help identify community need, locate gaps in coverage, and help guide efficient use of resources towards strengthening resources available to community members in need.** This would also be important for internal planning for existing services, as many local health departments may see increased referrals for service from hospitals if the rule were finalized as proposed, including for nutrition programs like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as from individuals who need adequate housing, as highlighted by CMS as a particular SDOH area of interest. By leveraging data in this way, the rule would support a more integrated systems-approach to population health and patient care.

Ensuring data from reporting requirements can inform community-level public health efforts

Local health departments work to keep their communities safe and healthy, including through preventing and controlling healthcare-acquired conditions (HACs), engaging in antimicrobial resistance efforts, and responding to emerging infectious diseases. However, local health department capacity to respond efficiently and effectively is often limited by a lack of access to relevant data from clinical care settings, including from hospitals.

NACCHO recognizes the CDC's leadership in establishing National Healthcare Safety Network (NHSN) data collection and reporting in healthcare facility settings and supports this proposed rule's goal of promoting and standardizing data reporting in areas such as COVID-19, HACs, and antimicrobial use and resistance. These threats require coordinated and data-informed action and response. While NACCHO supports the proposed efforts to ensure these data are reported via the NHSN, **NACCHO urges CMS to ensure reported data is accessible to all health partners, including local health departments, which do not universally have access to NHSN.** Continued leveraging of NHSN must complement, not replace, data collection efforts that inform health department awareness and practice.

Local data collection systems vary across the country and NACCHO recommends that CMS consider how proposed reporting requirements might be implemented at the local level. Local health departments are increasingly called to facilitate coordination between healthcare facilities; provide leadership; respond to outbreaks of HACs and antimicrobial resistant organisms; and develop and support programs relating to antibiotic stewardship. Local health departments can leverage their jurisdictional data to inform outbreak detection and response, support coordinated efforts among healthcare facilities, establish trends for their jurisdiction, and target stewardship and infection prevention and control (IPC) initiatives.

NACCHO is concerned that person-level data from hospitals would not be reported to both NHSN and any local surveillance systems given the resource burden that would place on healthcare providers, and therefore recommends that reporting to both entities be a priority for this proposed rule. Even for local health departments with access to NHSN, becoming solely reliant on NHSN data would present several barriers to local public health efforts. The proposed rule indicates that person-level data would not contain significant identifiers used by local health departments to conduct IPC initiatives including name, date of birth, and patient's address. These deficits would limit local health departments' ability to link case data, utilize exposure data, and identify clusters that would normally be recognized through

addresses provided. Person-level data would also be missing important indications of severity of disease like intensive care unit and intubation data. Additionally, without clearly defined diagnostic terminology and parameters, comorbidity data could be inconsistent or incomplete.

Should continuing to promote NHSN as a sole source of data be a priority or byproduct of this proposed rule or future proposed rules, **NACCHO recommends that further investment be made to provide local health departments access to NHSN data to preserve the critical role that local health departments serve to control spread of infectious disease in their communities and beyond.** Increased federal funding, expanded technical assistance, staffing, and resources would be required for local health departments to access and use NHSN data. Continued proactive facilitation by CDC to provide and maintain a clear process for local health departments to access NHSN datasets and ability to seek continued data access through Data Use Agreements would be a critical step in ensuring that local health departments are able to carry out their role in IPC. These changes would need to be implemented before a future public health emergency is declared to ensure that local health departments are not delayed in their response.

However, even when local health departments have access to NHSN data, they must manually extract the data to process and analyze it, rather than working with an automated system that directs data directly from hospitals to health departments like in some jurisdictions. **New regulations for reporting should avoid creating more difficult systems for local health departments by promoting broader interoperability or retaining flexibility for local health departments to access needed data via the most streamlined options available.** Local entities are accustomed to acting on data faster than CMS is sometimes able to report back those data and delays in this bi-directional flow of information could cause delays in local responses, particularly during public health emergencies.

Thank you for the consideration of these comments. For additional information, please contact Adriane Casalotti, Chief of Government and Public Affairs, at acasalotti@naccho.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Tremmel Freeman". The signature is fluid and cursive, with a long horizontal flourish at the end.

Lori Tremmel Freeman, MBA
CEO