Submitted electronically via www.regulations.gov
June 17, 2022
The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: FY 2023 Hospital Inpatient Physician Fee Schedule (IPPS)

Dear Administrator Brooks-LaSure:

On behalf of RIP Medical Debt, I am pleased to submit the following comments regarding the FY 2023 Hospital Inpatient Physician Fee Schedule (IPPS). RIP Medical Debt is a national nonprofit service organization committed to lifting the burden of medical debt for thousands of people nationwide. Our unique debt abolishment model combines the generosity of donors with debt industry expertise to produce a high volume of debt relief return, mitigating significant financial and mental distress for millions of people. Our work also seeks to bring attention to the negative impacts caused by medical debt, to distill the causes of medical debt, and ultimately to use these findings to address its upstream causes.

We appreciate the opportunity to comment on the FY 2023 Inpatient Physician Fee Schedule. We recognize that the rule covers a broad range of issues and will focus our attention on three key areas: 1) the use of z-codes to capture social determinants of health, including medical debt, and risk adjust; 2) modifying the calculation of DSH to exclude non-insurance uncompensated care pools as Medicaid covered days; and 3) a new "Hospital Commitment to Health Equity" inpatient quality measure for consideration for 2023. Our comments are informed by our work with hospitals and provider groups as well as beneficiaries of medical debt abolishment.

1. **CMS should require the collection and reporting of Z codes to capture patient-level information regarding the social determinants of health, including medical debt**.

Given the continuing COVID-19 pandemic, Z codes – which can be used to capture information about the social and economic circumstances that impact patient health and wellbeing—are and will continue to be important in identifying additional supports for patients whose financial challenges are impacting their ability to access needed health care services or follow recommended health care protocols. However, an October 2021 report by the Centers for Medicare and Medicaid Services (CMS) on the use of Z-code claims in Medicare fee-for-service

contexts found that the current use of Z codes to report on these social and economic determinants of health (SDOH) is both underutilized and inconsistently reported.[1] **We believe that requiring reporting of these codes, including economic challenges such as medical debt, will allow for more appropriate risk adjustment. Critically, requiring reporting on Z-codes for medical debt serves a dual purpose: they can also inform tax-exempt hospitals' design of their financial assistance programs (FAP) and serve as a data point for their community health needs assessments**.

Increasingly, social science research is demonstrating that **medical debt is a social determinant of health in its own right, not simply an unfortunate externality of our current health care financing and economic systems.** When individuals carry medical debt, they are less likely to seek health care due to fears about cost and are more likely to use substances and struggle with mental health. People with medical debt delay key life decisions ranging from saving for retirement to attending school; medical debt ripples through families and communities and disproportionately affects people of color further exacerbating the racial wealth gap. For providers, capturing data to better understand individuals' economic insecurity that could result in unpaid medical bills—and, thus, noncompliance with recommended treatment or avoidance of timely care—is crucial. The use of Z codes as a tool to flag economic insecurity takes an important step in mitigating the risk of medical debt.

Furthermore, medical debt is a social and economic determinant of health that health care providers can help address through improved internal policies and practices (e.g. financial assistance, billing and collections). Reporting the data from Z codes can provide insight across the organizational silos of health systems and is one way to drive better health outcomes, economic security and address inequities. Specifically, patient-level Z code data can help tax-exempt hospitals better target their financial assistance policies—required under Section 501(r) of the Internal Revenue Code as part of the Affordable Care Act's reforms—to local patient needs, and to better incorporate financial assistance screening into the clinical workflow to mitigate harm to the patient during the billing process. As noted by CMS, a Z code can "trigger referrals to social services that meet individuals' needs." This can and should include providers' own financial assistance policies and programs. Under current federal law, charitable hospitals have flexibility to design their financial assistance policies. While they are encouraged to gather information from their communities and public health partners about community needs—including financial barriers to care—through routine community health needs assessments, they are not yet explicitly required to use this information to design financial assistance and billing policies that respond to community needs. We believe more extensive use of Z codes could aid providers to make these connections.

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[1] Among their findings, CMS reported that although Z code claims accounted for 0.1% of all claims, the most frequently used Z codes were related to homelessness (22%), disappearance and death of a family member (12%), problems related to living alone (12%), problems related to living in a residential institution (5%), and problems in relationship to spouse or partner (5%).

Finally, as CMS notes in its analysis of Z codes, additional support for screening is critical: "Further, borrowing from the Accountable Health Communities (AHC) Model framework, non-provider staff, including screeners and navigators, may also play a key role in screening for social determinants of health. Trainings might include issues around standardizing the identification of SDOH-related issues, as well as coding." We strongly encourage this approach, to reduce the administrative burden on treating clinicians, and increase the likelihood that these determinants are identified. We note, however, that fluctuations in patient incomes are common and as such, financial assistance screening must occur at multiple points in the health care delivery and billing cycle before sending patients to debt collection. While Z codes offer insight into a patient's needs, they reflect only a moment in time and should not replace additional screening for economic needs later in the billing process that can often occur over 180 days post health care service.

Requiring Z codes is an important element of any health equity strategy and are a promising tool to maximize enrollment in financial assistance programs to help people avoid medical debt. Further, the Z code data can support hospital financial health by identifying patients that require additional supports. We strongly agree that "reporting SDOH Z codes in inpatient claims data could enhance quality improvement activities, track factors that influence people's health, and provide further insight into existing health inequities." **One key Z code that we believe could be instrumental to preventing people from being saddled with medical debt includes**:

- Z59 - Problems related to housing and economic circumstances – specifically, Z59.63: "Unable to pay for medical care."

2. **Increase incentives to hospitals to relieve people of their medical debt through charity care** (also known as financial assistance). Congress has established different funding mechanisms to reimburse hospitals that serve high numbers of low-income patients and are therefore more exposed to higher levels of uncompensated care. This includes the Medicare and Medicaid Disproportionate Share Hospital (DSH) funding streams. Hospitals use the S-10 worksheet to report uncompensated care to CMS, which then uses this data to determine Medicare DSH reimbursements. On the S-10 worksheet, bad debt is defined as the "expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy." By contrast, charity care "include[s] costs of care provided to both uninsured individuals and patients with insurance who cannot pay deductibles, co-payments, or coinsurance." In both cases, the hospital has not been fully paid for care. But for the patient, having an account classified as "charity care" can be life-changing, removing the specter of medical debt.

If CMS wants to streamline supplemental payments to ensure that DSH is serving a high number of low-income uninsured and Medicaid-enrolled individuals, it should revisit how uncompensated care is defined across Medicaid DSH and Medicare DSH programs, structuring them in a way to incentivize charity care as a portion of uncompensated care. This would best protect patients from medical debt, a growing challenge as increasing numbers of insured people struggle to pay out of pocket costs associated with their insurance plan. As a non-profit organization that abolishes medical debt for individuals through hospital partnerships, we have

observed that the equal weighting of bad debt and charity care in the S-10 worksheet lessens financial incentives for hospitals to ensure that patients who are eligible for charity care receive it, rather than have their accounts classified as bad debt. We theorize that this is because the administrative work of charity care identification through financial assistance programs (FAP) is significant and requires developing costly processes and systems that screen and re-screen individuals for financial assistance throughout the health care billing life cycle. Therefore, classifying a patient account as “charity care” requires additional steps and administrative capacity relative to bad debt reporting. Even if hospitals do not proceed to collect on these patient accounts, however, we know from our beneficiaries that having medical debt takes a massive toll on their lives. **The research bears this out: medical debt also is known to have significant negative impacts on health and mental health. It is also more prevalent in communities of color and thus represents a health equity issue.** As such, we encourage CMS to consider weighting charity care more than bad debt in any uncompensated care calculation, incentivizing hospitals to maximize charity care screening.

Second, we appreciate CMS’s effort to more clearly streamline supplemental payments to ensure that hospitals that serve high numbers of low-income uninsured and Medicaid patients are made whole for the cost of the care they provide. We note that uncompensated care pools have been used by some states to pay for “patients who are underinsured as well as for patients who are uninsured,” thereby providing a pathway for hospitals to help offset patient medical debts. While we appreciate CMS wanting to clarify that DSH should be tied to comprehensive coverage and not an uncompensated care funding pool, we are concerned about the adverse effects on patient populations in Medicaid non-expansion states where hospitals rely heavily on these pools for financial support. We urge CMS to work with providers and patient advocates in any states impacted by these proposed changes to ensure that patients are screened for hospital financial assistance policies or for premium support under the Affordable Care Act.

Third, CMS also proposes to use the average of two years of uncompensated care (UC) data from worksheet S-10 of the Medicare cost report to calculate each hospital’s share of UC in the DSH calculation and proposes beginning in FY 2024, to use three years of UC data from audited cost reports to calculate UC-based DSH payments. We support this move to use multiple years of UC data to calculate DSH payments since using multiple years can account for annual disruptions in the data (economic trends, COVID surges, natural disasters, receipt of Medicaid revenues from prior years, etc.).

3. **A "Hospital Commitment to Health Equity" assessment must include a commitment to addressing patient medical debt**. We appreciate CMS' focus on a health equity strategy and support the proposed use of an evaluative approach to gauging hospitals' commitment to building a culture of health equity across five domains: 1) Equity as a strategic priority; 2) data collection; 3) data analysis; 4) quality improvement; and 5) leadership engagement. At RIP Medical Debt, we work with hospital partners and know they are committed to leading the work on health equity. An assessment tool that documents and evaluates their commitment—including how their financial assistance, billing and collection policies are tailored to improve health equity—will highlight how hospitals are pursuing various strategies to reach their goals.

A commitment to health equity must be foundational to any health system. As asserted by Secretary Becerra in his comments regarding the current administration's work to address medical debt, "Too many Americans with lower income, poorer health, and from communities of color have higher rates of medical debt." There are deep and persistent inequities in health and wealth in this country due to the legacy of systemic racism. While these policies and practices of exclusion harm all people of color and intersectional identities, the effects on Black and Indigenous people are disproportionate and devastating. This is evident in our work to abolish medical debt; as highlighted in numerous analyses including the US Census Survey of Income and Program Participation, "27.9% of households with a Black householder had medical debt compared to 17.2% of households with a White non-Hispanic householder" and medical debt is concentrated in the south where fewer pathways to affordable health coverage exist. In addition to being an issue of racial equity, medical debt is a social determinant of health affecting the care people can access to secure good health and wellbeing. The evidence is clear; when people carry medical debt, they are less likely to seek or obtain the health care they need. These hesitations or fears can lead to delays in diagnosis and treatment and/or a worsening of a condition. Unsecured or personal debts like medical debt weigh heavily on people, leading to increases in mental health issues and substance use. It is for these reasons, reinforced by our own qualitative data collection of debtors' stories and circumstances, that **we strongly urge CMS to consider medical debt across the 5 domains of consideration when asking hospitals to attest to a commitment to health equity.**

Domain 1: Equity as a Strategic Priority

Element (A) "our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals" provides an opportunity to identify financial assistance policies (FAP) as a tool to advance health equity. At RIP Medical Debt, we believe that access to financial assistance is an important part of economic stability and good health; robust financial assistance policies and processes are a way that hospitals can address equity as a strategic priority. This is optimized when hospitals:

- Provide clear communication about the financial assistance policy (including through community partnerships);
- Leverage presumptive eligibility (PE) to ensure patients seamlessly access FAP (this reduces administrative burden for both hospital staff and patients);
- Integrate FAP screening into the clinical workflow and screen before offering payment plans;
- Notify patients when they are found to be fully eligible or partially eligible for FAP; and
- Routinely screen patients for FAP prior to transferring a patient to collections.

This is a brief list of some best practices that hospitals deploy to make sure that those patients most at risk of financial insecurity are identified early and often. Ideally, integrating FAP screening into the clinical workflow is the best way to ensure patients understand the availability of financial assistance and apply. **All strategic plans to drive health equity should include financial assistance programs as one way to mitigate medical debt.**

Domain 2: Data Collection

Element (C) "Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology" is a clear opportunity to operationalize domain #1. The inclusion of a financial assistance policy (FAP) screening into EHR technology that incorporates key 'flags' or 'triggers' (such as a Z code) can quickly link to presumptive eligibility for FAP and/or screening the patient for financial need. This is critical to linking data on SDOH and financial assistance in a deliberate way to maximize FAP identification for those who are eligible.

Domain 3: Data Analysis

As an organization committed to abolishing medical debt and partnering with hospitals to analyze and abolish bad debt, we understand how challenging it can be for hospitals to connect strategies to address equity, safeguard hospital financial health, and drive high quality care. The element (A) "Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards" can provide a lens into the risk of patient accruing medical debt. Being able to stratify patient data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and ability status will assist in hospitals' development of policies and practices to protect their patients from the harm of medical debt. As part of these efforts, **CMS should require hospitals to engage in data collection methods that rely on self-reported data.** Self-reported data collection is the gold standard for disaggregated data collection; this is particularly important when collecting social determinant of health data; race, ethnicity, language, disability (REL-D) data; and sexual orientation and gender identity (SOGI) data. To mitigate patient concerns that data may be used in a discriminatory way, providers should explain that the data will be used to improve the quality of care and use evidenced-based approaches to increase reporting.

Domain 4: Quality Improvement

Medical billing is now being used in quality rankings by the Leap Frog Group to highlight the importance of medical debt as a health and safety issue for patients. Founded in 2000 by large employers and other purchasers, The Leapfrog Group is a national nonprofit organization driving the quality and safety of American health care; they do annual rankings of hospital systems. As part of the 2022 Survey, the non-profit added a section on "billing ethics." The questions are designed to capture hospital-level information on key strategies to reduce medical debt and advance health equity. The domains include financial assistance; billing accuracy; and litigation practices in addition to a series of questions regarding health equity. The CMS "quality improvement" domain strongly connects to this work. The element (A) "Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities" aligns with the quality work being spearheaded by the Leap Frog Group. The hospital rankings group highlights the importance of medical debt as both a quality and equity issue. **CMS should consider medical billing as a quality issue when evaluating a hospital's efforts to engage in improvement activities.**

Domain 5: Leadership Engagement

Leadership is an important driver of the success of strategic planning and plays a key role in accountability. We applaud the inclusion of leadership as a key domain for evaluation. The two elements play a critical role in removing silos across medical billing, the delivery of patient health services and referral to community partners: (A) “Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity; and (B) “Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.” Engaging leadership in driving institutional and cultural practices that prioritize health equity is vital to the plan’s success. For example, in our work, when leadership understands the positive effects of medical debt for their patients, they are more likely to engage in medical debt abolishment.

We applaud the inclusion of an equity measure and the realization of HHS' commitment to making health equity central to all health care programs. To fulfill IQR obligations, hospitals would have to attest to their efforts at improving health equity in the five domains; **we recommend a review of the reported elements through a medical debt lens and auditing annually. Finally, we recommend that the data be publicly available enabling research and review**.

Please direct any questions to Eva Marie Stahl, Vice President of Public Policy (eva.stahl@ripmedicaldebt.org) and thank you for the opportunity to provide comments.

Regards,

Allison Sesso
President and CEO
RIP Medical Debt