

NEW CMS QUALITY METRICS FOR HEALTH EQUITY

Key Takeaways

- The Centers for Medicare & Medicaid Services (CMS) has recently committed to improving health equity across all its programs and activities.
- As part of this work, CMS adopted new reporting requirements for hospitals under the Inpatient Quality Reporting (IQR) Program regarding commitment to health equity and screening for health-related social needs.
- The measures are intended to produce greater data necessary to better address inequities in care delivery and outcomes and promote greater commitment to achieving health equity.

Background

In 2022, CMS adopted the following definition of “health equity” as the first pillar of the agency’s Strategic Plan:

“Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.”

Since December 2005, CMS has publicly reported hospital performance on quality measures required under its portfolio of quality reporting and performance programs for hospitals. Those programs include the IQR Program (2004), the Outpatient Quality Reporting Program (2008), the Hospital Readmissions Reduction Program (2012), the Hospital Value-Based Purchasing Program (2012), and the Hospital-Acquired Condition Reduction Program (2014). The Agency has targeted the use of these quality measure programs to address health equity through new measures, beginning with the hospital IQR Program.

New Measures

In the FY2023 Inpatient Prospective Payment System rule, CMS finalized the adoption of the following three new required *pay-for-reporting* quality measures for hospitals under the IQR. Performance on these measures will be reported publicly on the CMS *Care Compare* website.

Hospital Commitment to Equity (required beginning CY2023 reporting period, due in Spring 2024)

This measure requires hospitals to attest to activities across five domains to demonstrate commitment to health equity. The five domains are: Equity is a Strategic Priority, Data Collection, Data Analysis, Quality Improvement, and Leadership Engagement. Hospitals will only receive credit for a domain if

they attest “yes” to each activity or element within that domain. For example, Domain 1 is “Equity is a Strategic Priority,” and there are four elements within the domain tied to the hospital’s strategic plan. Those four elements are: identification of priority populations who currently experience health disparities, identification of healthcare equity goals and discrete action steps to achieving those goals, outline of specific resources dedicated to achieving equity goals, and description of the approach for engaging key stakeholders. Full details of the measure domains and elements are available in the measure specifications linked below. CMS intends to publish hospital performance as 0 – 5, representing the number of complete domains a hospital attests positively to.

Social Drivers of Health – Screening Rate (required beginning CY2024 reporting period)

This measure assesses the rate a hospital screens adult inpatients during the inpatient stay for all five of the following health-related social needs (HRSN): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure excludes patients who opt-out of screening and those patients unable to complete the screening without a legal guardian or caregiver able to do so on the patient’s behalf. If a patient (or their representative) opts out of screening for a specific HRSN, they should be excluded from the measure reporting altogether. The measure does not require a specific screening tool, only that each of the five required HRSNs are screened for. Additionally, if patient has multiple inpatient stays during the annual reporting period, the measure requires the hospital to *screen* for each stay, though subsequent screening could be tailored to confirm the status of any previously reported HRSNs and re-screen for any HRSNs not previously reported. However, the hospital should only *report* unique patients in any one annual reporting period – i.e., the hospital should not report each admission for a patient with multiple admissions in the calendar year. Additionally, hospitals should use the discharge date to determine the applicable reporting period. For example, a patient admitted in December 2023 and discharged in January 2024 should be reported for the CY2024 reporting period.

Social Drivers of Health – Screen Positive Rate (required beginning with CY2024 reporting period)

This measure pairs with the Screening Rate measure and requires the hospital to report the percentage of patients who screened positive for each of the five HRSNs of the total number of inpatients screened during the reporting period. This measure will be calculated and reported as five distinct rates. When reporting for a patient with multiple admissions during the reporting period, hospitals should report the most recent result. For example, if a patient is admitted and screened in both May and December of the reporting period, only the results of the screening during the December admission should be used for the reporting.

In addition to hospital reporting, in the CY2023 Physician Fee Schedule and Quality Payment Program rule, CMS adopted a separate version of a screening rate measure that eligible clinicians and clinician groups may *opt* to report under the Quality category of the Merit-based Incentive Payment System, effective with CY2024 performance. CMS did not propose the adoption of a clinician-specified version of the screen positive rate metric.

Impacts of New Quality Metrics for Health Equity and Looking to the Future

Hospitals must be able to report on these measures in order to receive full payment updates from Medicare, and understand that performance will be publicly reported on the CMS *Care Compare* website. Currently performance will not be used in scoring for the pay-for-performance programs,

though this could change in the future. It is unclear at this stage whether these measures will be used in the CMS Overall Quality Hospital Star Ratings Program.

CMS has made it clear that these measures are the start of the agency's efforts to use quality measurement to address inequities in health care processes and outcomes. We anticipate seeing additional measures developed and proposed for CMS quality reporting programs in the future, including metrics regarding hospital efforts to address health-related social needs identified through screening.

AAMC Perspective

The AAMC and its members are committed to promoting health care equity and addressing health inequities. We believe that building the evidence base for health equity requires improving data collection to guide the decisions that help communities thrive. The AAMC recommends that academic health systems evaluate their current activities to incorporate equity into care delivery, including evaluating whether such practices currently fulfill the actions measured under the "Hospital Commitment to Health Equity" measure and whether current social needs screening practices can be easily measured for success under the screening measures. Additionally, academic health systems should engage clinicians, patients, and community stakeholders to build trust and confidence in the system-wide health equity work, especially regarding patient-level screening and data collection to inform efforts to address social needs and inequities within their communities.

Resources

CMS Press Release, [New CMS Rule Increases Payments for Acute Care Hospitals and Advances Health Equity, Maternal Health](#) (August 1, 2022).

CMS [FY2023 Inpatient Prospective Payment System Final Rule](#) (August 10, 2022), with measures discussed beginning p. 49191 of the Federal Register.

CMS Strategic Plan - [Health Equity Fact Sheet](#)

CMS Measure Specifications and FAQs – [IQR Measures: Web-Based Data Collection](#)

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