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June 10, 2022

Chiquita Brooks-
LaSure Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: CMS-1771-P
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation**

Via: Regulations.gov

Dear Administrator Brooks-LaSure:

The Trauma Centers Association of America (TCAA) represents 430 hospitals with state designated and American College of Surgeons (ACS) verified trauma programs. My name is Jennifer Ward, and I am the President of TCAA, and we appreciate the opportunity to comment on key issues in the FY 2023 IPPS proposed rule. We would like to address two issues related to trauma centers in the proposed rule:

1. The first topic we wish to address concern CMS' request for "other possible ways we can incorporate meaningful indicators of clinical severity."

TCAA agrees that there other factors to consider that significantly impact clinical severity and resource utilization. As we commented for last year's IPPS proposed rule, TCAA has had longstanding concerns that the current MS-DRG grouping logic and rate setting process does not reasonably account for costs of patients having traumatic injury and who are treated by hospitals having designated and verified trauma programs. These programs exist because the rigorous standards and practices applied are proven to improve patient outcomes. The positive patient outcomes result from each program's readiness, clinical team activation response and coordinated care furnished under verified clinical criteria for patients having traumatic injuries. Trauma team activation occurs based on objective, verifiable criteria that define patients at increased risk of death and complications and who require more intensive, coordinated care than other patients. Trauma programs provide enhanced care throughout the patient's inpatient stay, not merely upon arrival in the emergency department/trauma bay, even though the trauma team activation response is the one of the most resource intensive services furnished by trauma programs. The care of these trauma patients meets the description of one the nine guiding principles you describe for use together with mathematical analyses of claims data, namely: "Typically requires higher level of care (that is intensive monitoring, greater number of caregivers, additional testing, intensive care unit care, extended length of stay)".

2. The second topic TCAA wishes to provide a comment concerns CMS's request for information on social determinants of health (SDOH) and health inequities. TCAA urges CMS to consider Z codes beyond the Z65 especially Z codes for personal history which are closely related to SDOH. For example, Z codes in the Z91 code range related to underdosing of medication may be indicative of unemployment or food insecurity. Patients may share these personal history circumstances while they may not answer more direct questions related to SDOH in the Z55-Z65 code range. We urge CMS to include all Z codes in its future policies concerning obtaining ICD-10-CM claims data associated with SDOH.

Specifically, TCAA is concerned about Z91.81 for a history of falling. TCAA has engaged CMS in discussions about this indication being the number one reason for traumatic injuries of Medicare beneficiaries. TCAA urges CMS to analyze this code as a potential CC or MCC. Z91.81 is the code used for history of falling and applies when a patient has fallen in the past and is at risk for future falls. These patients are the most likely to receive extensive fall screening when admitted to the hospital. Identifying patients at risk for falls before they sustain a serious fall requiring hospitalization and/or surgery would allow for effective injury prevention interventions and decrease both the public health burden of these injuries and the substantial costs to the Medicare system. TCAA notes that in addition to trauma programs' readiness, activation and coordinated care, designated and verified programs are required to engage in injury prevention. Since falls are the single most common mechanism of injury for trauma admission for Medicare beneficiaries at all hospitals (trauma centers and non-trauma centers), we believe it is important for CMS to engage in policies designed to prevent falls and mitigate the incidence of hip/ extremity fractures and traumatic brain injury, which are a major source of disability for beneficiaries.

As CMS has done in the past, we urge CMS to share data with hospitals. Possible approaches include making beneficiary data available for hospital admissions after falls sorted by geographic location and treating hospital and including the source of admission for these beneficiaries. With appropriate information, hospitals could direct injury prevention efforts in collaboration with community organizations, nursing facilities and senior centers to assist with proven fall prevention interventions such as installing safety equipment (e.g., grab bars and railings), introducing exercise programs and promoting safe routines for activities of daily living. Other approaches could involve providing reimbursement for prevention activities targeted at patients who present with a first or recurrent fall in an attempt to avoid a future, more severe injury that could result in a debilitating hip and/or extremity fracture.

In last year's proposed rule, CMS said it needed additional time for further analysis of the claims data to determine the causes of the hip and knee fractures and other possible contributing factors with respect to the length of stay and costs of these cases, as well as the rate of outlier payments. TCAA did not read any further analysis in this year's IPPS proposed rule. We hope that CMS is continuing its analysis and encourage CMS to include history of falling (Z91.81) and whether trauma team activations occurred (FL 14, 5) as part of this analysis.

TCAA remains interested in continuing discussions with CMS, including CMMI and other stakeholders and policy makers about all trauma-related issues, including those related to more accurate and comprehensive estimation of inpatient clinical severity and the development and implementation of methods that encourage fall prevention initiatives.

Related to the topic of obtaining additional codes on claims, TCAA notes that due to the significant number of comorbid conditions associated with hospitalized Medicare beneficiaries, increasingly hospitals do not have available fields beyond the 25 diagnosis fields on 5010 837I/UB-04 claims to report all applicable diagnosis codes such as Z codes related to personal history and social determinants of health. To help this issue, we suggest CMS ask the National Uniform Billing Committee (NUBC) if the three existing patient reasons for visit diagnosis fields used solely on outpatient claims could be used on inpatient claims to report relevant ICD-10-CM diagnosis codes for the reason for admission including social determinants of health impacting the inpatient case.

We look forward to participating in additional stakeholder discussions around fall prevention and the impact of social determinants of health and strategies to avoid and close any health inequity gaps.

We appreciate this opportunity to provide comment.

Best regards,

A handwritten signature in cursive script that reads "Jennifer Ward".

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