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June 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: 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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment (CMS–1752–P; 86 Fed. Reg. 25070, May 10, 2021)

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). Our detailed comments are below.

In summary:

- The AMA continues to be encouraged by CMS' efforts in the proposed rule to reduce physicians' administrative burden. While we believe some proposals need to be refined, we support CMS' efforts to focus the program on interoperability and improved patient access to health information.
- The AMA supports CMS' efforts to reduce physicians' and hospitals' reporting burden by removing and de-duplicating many quality measures within the hospital quality reporting programs, and we include comments on how these proposals could be further improved.
- The AMA supports with modification three provisions contained in the Consolidated Appropriations Act, 2021 (CAA) affecting Medicare direct Graduate Medical Education (GME) and Indirect Medical Education (IME) payments to teaching hospitals.
- The AMA supports advancements in data availability and integration for quality improvement and measurement through efforts such as data aggregation, but they must result in data that are easily accessible at the point of care and provide actionable information that can inform shared decision-making while also easing reporting burden.
- The AMA strongly urges CMS not to move forward with the proposed transplant-related proposals prior to completion of a comprehensive study of the potential impact of the transplant-

related proposals on patient access to transplantation and to work closely with stakeholders in conducting this evaluation.

- The AMA urges CMS to finalize with modification the proposal to allow ACOs to elect to remain in their current level of the BASIC glide path in PY 2022 and should not automatically advance ACOs to the level they would have been in without this policy and should allow ACOs that elect to remain in their current level to continue to the next level of the glide path.

Please see our detailed comments below on the following topics:

I. Promoting Interoperability Program;
II. Hospital Inpatient Quality-Reporting Program;
III. Closing Gaps in Health Equity in GME and other related provisions;
IV. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—Request for Information (RFI);
V. Future of Digital Quality Measurement—Advancing Digital Measurement RFI;
VI. Organ Acquisition Payment Policies; and
VII. Medicare Shared Savings Program—Proposed Policy Changes.

I. Promoting Interoperability Program

The AMA continues to support CMS' goals of focusing the Promoting Interoperability (PI) program on interoperability and improved patient access to health information as opposed to burdensome, prescriptive data capture and measurement policies. **We urge CMS to continue to limit regulatory requirements in the PI program as long as physicians can share data among themselves and with their patients.** The AMA welcomes the opportunity to provide feedback on the evolution of the PI program.

Proposals the AMA Supports

- *Maintain the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional, while increasing its available bonus from five points to 10 points for the EHR reporting period in FY 2022.*

The AMA supports CMS' proposal to maintain the PDMP Query measure as optional as many physicians and health systems remain incapable of interconnecting their health information technology (Health IT) with PDMP systems. We also support increasing the available bonus from five points to 10 points as this provides positive incentives to connect electronic medical records (EHR) to PDMPs without unduly burdening physicians who have little control over their EHR vendors' interoperability decisions.

- *Add a new Health Information Exchange (HIE) Bi-Directional Exchange measure as a yes/no attestation to the HIE objective as an optional alternative to the two existing measures beginning with the EHR reporting period in FY 2022.*

The AMA also strongly supports CMS' inclusion of a new HIE Bi-Directional Exchange measure as a yes/no attestation to the HIE objective. The AMA appreciates CMS taking steps to reduce PI reporting burden for physicians by making new measures "yes/no" attestation and believes this is a positive direction for the PI Program. We encourage CMS to continue to move away from legacy numerator/denominator measurement for all PI measures as this will significantly reduce physicians'

EHR burden, while simultaneously informing CMS about how certified EHR technology is utilized and what functionalities are useful to patients and clinicians.

- *Remove attestation statements 2 and 3 from the Promoting Interoperability Program's prevention of information blocking requirement.*

The AMA strongly supports CMS removing statements 2 and 3 from the PI Program's information blocking attestation requirement. The AMA urges CMS to include this same provision within its upcoming Quality Payment Program proposed rule.

Additional Recommendations from the AMA

- *Modify the Provide Patients Electronic Access to Their Health Information measure to establish a data availability requirement beginning with encounters with a date of service on or after January 1, 2016, beginning with the EHR reporting period in FY 2022.*

The AMA appreciates CMS' objective to expand the timeframe for electronic health information availability to patients. We recognize CMS' intent of aligning its information access policies between providers and payers and to reduce the friction patients face when accessing their medical information. While more can be done, the AMA is concerned there could be unintended consequences with requiring patient health information with encounter start date of January 1, 2016, be made immediately available starting with the CY 2022 EHR reporting period. Many physicians and health systems have digitized old medical records using digital imaging or PDF-style formats. These formats make it challenging to search for or protect specific information in EHRs that, by state or federal law, must be withheld upon request or when sending information to other individuals or entities. For instance, California state law requires physicians to withhold information about child abuse from being released. This information is often intermixed with other medical information inside various "notes" electronically contained within an EHR.

CMS' policy to make all information available would require physicians and health systems to manually review and redact certain information prior to the release of these notes. Due to the limitations of imaging or PDF-style formats used to document many of these notes, this process can be extremally time-consuming and costly. We are aware of a health system in California that has estimated it would take 60,000 work-hours to manually go through EHR charts and to label or mark notes to prevent this information from being released. The AMA urges CMS to consider the limitations of EHR technology to support physicians and health systems' compliance with its policies. **We recommend CMS create flexibility that allows physicians to provide most of the information requested but still allows leeway for health information management personnel or a physician's professional judgment to determine when it is impractical for certain information to be made available. For instance, CMS should provide no less than a 48-hour window for physicians and health systems to review the request for information if they believe the release will require manual redaction or extraordinary technical effort to accommodate state or federal law.**

- *Continue the 90-day reporting period for FY 2023 but require a 180-day reporting period for FY 2024.*

The AMA appreciates CMS' intent to retain the 90-day reporting period for FY 2023 and urges CMS to maintain consistency in its reporting period requirements beyond FY 2023. The AMA continues to advocate for less EHR reporting burden and CMS' own stated policy goals support that desire. EHRs are

nearly universally used by providers. The most recent data from ONC shows that as of 2016, over 96 percent of hospitals use certified EHRs.[1] We expect that number to have increased over the last five years. While adoption is high, research shows that EHR use directly contributes to physician burden and burnout.[2] EHR use also contributes to "non-clinical" physician work. For example, studies have documented lower patient satisfaction when physicians spend more time looking at the computer and performing clerical tasks.[3] Doubling the reporting period burden on physicians and health systems is likely to contribute to burnout and non-clinical work. Additionally, providers do not simply turn on their EHRs for 90 days and turn them off for the remainder of the year. There really is no policy reason to increase the PI reporting period because the 90-day period is a snapshot of how clinicians use their EHRs all year long. Finally, because of the multitude of upgrades to certified EHR technology that will occur in the coming months and years, we caution that many health systems will need to update their technology over the next 18-24 months. Increasing the EHR reporting period during this time will only add to the burden and stresses of a workforce straining to recover from or keep up with changes to federal health IT requirements, cyber-attacks, and the public health emergency (PHE). **The AMA strongly urges CMS to consider the administrative burdens caused by unnecessarily expanding the reporting period from 90 to 180 days and recommends that CMS maintain the 90-day reporting period beyond 2023.**

II. Hospital Inpatient Quality-Reporting Program

We appreciate the opportunity to comment on future measure proposals in the Inpatient Quality Reporting (IQR) program. The AMA offers the following measure specific comments CMS proposes to add, remove, or consider for future rulemaking for the Inpatient Quality Reporting (IQR) Program:

- *Maternal Morbidity Structural Measure*

The AMA remains committed to addressing inequity and decreasing maternal morbidity and mortality. We appreciate that the measure requirements are aligned with the Centers for Disease Control and Prevention (CDC) Alliance for Innovation on Maternal Health (AIM) bundles, since they are well vetted, in use, and have buy-in from multiple stakeholders. We are concerned with the shortened initial reporting period of 10/1/21–12/31/21 given hospitals were given no advance notice on the measure and not all states have implemented perinatal quality collaborative (PQC) or (AIM) bundles. At a minimum, we recommend CMS delay the start of the measure until 2023 reporting period, which will allow localities to launch or join PQC or AIM bundles.

- *COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure*

The AMA supports the inclusion of this measure. We encourage the CDC to revise and/or update the measure as new evidence comes forward and based on feedback received from the field.

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[1] https://dashboard.healthit.gov/evaluations/data-briefs/non-federal-acute-care-hospital-ehr-adoption-2008-2015.php.
[2] Sinsky C et al., Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties, Annals of Internal Medicine 2016.
[3] 1 Street RL et al., Provider Interaction with the Electronic Health Record: The Effects on Patient-Centered Communication in Medical Encounters. Patient Educ. Couns., 2014; Kazmi Z, Effects of Exam Room EHR Use on Doctor-Patient Communication: A Systematic Literature Review. Inform Prim Care, 2013; Farber NJ et al., EHR Use and Patient Satisfaction: What We Learned. J Fam Pract 2015.

- *Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (Hybrid HWM) measure*

While the AMA agrees that the health care system and providers must track important patient outcomes such as mortality, measures must be evidence based, attributed to the appropriate levels where the greatest influence can occur, and proven to produce valid and meaningful results. While the AMA agrees that it is useful to understand the rate of mortality in the 30 days following hospital discharge, particularly for quality improvement and to ensure that cost reductions do not have unintended consequences, we do not believe there is sufficient evidence to support the outcome at the hospital or facility level. Specifically, we are not aware of any evidence demonstrating that hospitals can directly or indirectly impact mortality within 30 days in general or of any hospital-driven structures or processes that can lead to improved mortality rates for these patients.

We question whether CMS has demonstrated that the resulting measure score is valid since the testing submitted and reviewed by the National Quality Forum (NQF) did not include a robust face validity assessment or a correlation analysis with the other key outcome of interest—the Hospital-wide, Risk-Standardized Readmissions measure. In addition, CMS continues to test social risk factors after assessment of clinical and demographic risk factors for potential inclusion in the risk adjustment model. On review of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report,[4] it is clear that the approaches to testing these data should be revised to strategies such as multi-level models or testing of social factors prior to clinical factors and that as access to new data becomes available, it may elucidate more differences that are unrelated to factors within a hospital's control. Additional testing that evaluates clinical and social risk factors at the same time or social prior to clinical variables rather than the current approach with clinical factors prioritized should be completed prior to implementation in this program.

Lastly, the measure does not distinguish meaningful differences in performance and therefore is not useful for accountability or informing patients of the quality of care provided by hospitals. The technical report released during the public comment period in January 2018 outlined that only six hospitals were identified as statistically worse than the national average and over 90 percent of all hospitals were no different than the national average.

As a result, the AMA does not believe that this measure should be implemented in the Hospital IQR program.

- *Hospital Harm—Severe Hypoglycemia eCQM*

The AMA continues to have concerns regarding the limited testing and variation in performance and need to harmonize this measure with the proposed Hospital Harm—Severe Hyperglycemia eCQM. Testing was only completed using two EHR vendor systems, which does not truly enable us to have a broad understanding of the feasibility and validity of the data elements beyond those two systems. Additional testing in other EHR vendor systems is needed prior to finalization. We also question whether the information provided as a result of this measure is truly useful for accountability and informing patients of the quality of care provided by hospitals. Specifically, our concern relates to the relatively limited amount of variation discovered during testing of the measure with variation across the six hospitals ranging from 1.05 percent to 3.56 percent. We do not believe measures that currently only identify such small differences in performance allow users to distinguish meaningful differences in performance.

[4] National Quality Forum. Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors. Final report. July 18, 2017. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=85635. Last accessed December 18, 2018.

Lastly, while we appreciate that the proposed Hospital Harm—Severe Hyperglycemia eCQM meets the request to have a balancing measure, this measure reports the number of severe hypoglycemia events that occur during one admission, while the other assesses the number of days with a severe hyperglycemic event across all qualifying days in one admission. These measures must be harmonized prior to implementation in the Hospital IQR program.

- *Hospital Harm—Severe Hyperglycemia eCQM*

The AMA is also concerned with the limited testing and variation in performance and need to harmonize this measure with the proposed Hospital Harm—Severe Hypoglycemia eCQM. Again, testing was only completed using two EHR vendor systems, which does not truly enable us to have a broad understanding of the feasibility and validity of the data elements beyond those two systems. Additional testing in other EHR vendor systems is needed prior to finalization. We also question whether the information provided as a result of this measure is truly useful for accountability and informing patients of the quality of care provided by hospitals. Specifically, our concern relates to the relatively limited amount of variation discovered during testing of the measure with variation across the six hospitals ranging from 2.52 percent to 2.96 percent. We do not believe measures that currently only identify such small differences in performance allow users to distinguish meaningful differences in performance. Lastly, while we appreciate that the proposed Hospital Harm—Severe Hypoglycemia eCQM meets the request to have a balancing measure, this measure reports the number of days with a severe hyperglycemic event across all qualifying days in one admission, while the other assesses the number of severe hypoglycemia events that occur during one admission. These measures must be harmonized prior to implementation in the Hospital IQR program.

<u>Measures Proposed for Removal</u>

The AMA supports CMS' proposal to remove the following measures:

- The Death Among Surgical Inpatients with Serious Treatable Complications measure (NQF #0351) beginning with the FY 2023 payment determination.
- The Admit Decision Time to Emergency Department (ED) Departure Time for Admitted Patients (NQF #0497) measure beginning with the CY 2024 reporting period/FY 2026 payment determination.
- Anticoagulation Therapy for Atrial Fibrillation/Flutter eCQM (STK-03) (NQF #0436) and Discharged on Statin Medication eCQM (STK-06) (NQF #0439) beginning with the CY 2024 reporting period/FY 2026 payment determination.

<u>Potential Future Expansion of IQR to Include the Following Measures:</u>

- *Mortality measure for patients admitted with COVID-19*

The AMA believes that it is extremely premature to consider whether a measure examining the mortality rate for patients admitted with COVID-19 is needed. Therapies remain in development, evidence continues to be collected, and no clinical guideline yet exists to provide guidance on evidence-based treatment protocols. In addition, the incidence and prevalence of this virus continues to be unpredictable with regions and hospitals experiencing varying admission rates and acuity levels. We are also concerned such a measure may contribute to increased disparities. Systems serving more historically marginalized

people might look worse on COVID-19 mortality as a measure, even after adjusting for race and ethnicity.[5] Any measure on this virus should not be pursued until this PHE is resolved and ensure a measure does not penalized hospitals that treat a larger portion of patients with social risk factors.

Alternatively, we encourage CMS to consider balancing measures around access (not only reporting of stratified data for existing/updated clinical outcomes, but also ensuring access to care/services across demographics) to avoid cherry-picking of patients/communities by hospital system.

- *Patient-reported outcomes measure following elective total hip and/or total knee arthroplasty (THA/TKA)*

The AMA supports the assessment of patient-reported outcomes but believes that the burden of data collection both to the hospital and the patient required by this measure must be adequately addressed. The current feasibility information provided during the NQF endorsement review does not adequately assess the potential data collection burden both to the hospital and patient. Specifically, the responses to the questions on feasibility do not discuss how the testing sites coordinated data collection across settings or whether the responsibility of the multiple data elements from additional patient-reported surveys used in the risk adjustment approach was placed on the hospital. This question is particularly important since the specifications require hospitals to collect data for one measure from 90 days pre-operatively to up to one-year post-operative. More importantly, we would have liked to see an assessment from the patient's perspective on whether the timing and number of items solicited throughout this process were appropriate and does not result in survey fatigue. For example, if these data were collected on the morning of the surgery, could stress and anxiety have impacted responses or would the number of surveys throughout the pre-, intra-, and post-operative timeframes lead them to be less likely to complete other surveys such as HCAHPS? We believe that it is critical to understand the potential impact and burden that could be experienced. While it may seem reasonable for one measure, if this measure is an example of how future measures could be specified, what is the potential long-term impact on patients and hospitals as more and more patient-reported outcome performance measures are implemented?

- *The potential future expansion of measure data stratification for the Hospital-Wide All-Cause Unplanned Readmissions measure*

The AMA believes that continued stratification of quality data by dual eligibility and race and ethnicity remains insufficient and while the expansion to disability provides useful information, CMS must make significant efforts to advance the data that are used to identify health care inequities. For example, quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. Collection of additional information is an essential early step towards identifying where racism and bias may exist in clinical decision-making tools and how they should be addressed to ensure clinical care and health of historically marginalized communities are not negatively impacted by their application. Continued reliance on existing data that have known deficiencies is not acceptable and we must advance to more accurate and relevant data.

The usage of race and ethnicity as variables, and how both are defined, varies among the clinical algorithms in use today. This is attributable in part to changes in protocols over time, as some of the clinical data registries from which algorithms are derived are more than several decades old. There is also

[5] Asch DA, Islam MN, Sheils NE, et al. Patient and Hospital Factors Associated With Differences in Mortality Rates Among Black and White US Medicare Beneficiaries Hospitalized With COVID-19 Infection. JAMA Netw Open. 2021;4(6):e2112842. doi:10.1001/jamanetworkopen.2021.12842.

variation among multiple health data systems in how the data is collected (are race and ethnicity patient or investigator/clinician reported?) and the number of choices provided to the reporter. Furthermore, because race is a social construct, there is significant variability in how "races" are defined by society, lawmakers, and others—including individuals themselves. These definitions have changed and evolved in usage and application over time and do not always correspond with biology and genetic ancestry. Accordingly, their inclusion as variables creates challenges in developing meaningful consensus definitions, especially as our society diversifies over time, further clouding how we define these variables. Given that the approaches in design and implementation, as well as underlying data provenance, vary, it is important to seek further input from organizations that have expertise and direct experience with development and use of specific data algorithms and coordination of data standardization.

The AMA House of Delegates in November 2020 passed historic new policy directing our organization "to collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors."[6] The AMA is currently undertaking an effort to convene a variety of organizations to gather more information about the use of clinical algorithms and create an action plan for how to address these problems.
We believe that, in addition to efforts like our own, the Agency for Healthcare Research and Quality (AHRQ) is ideally situation to conduct and fund additional research into the use of race and ethnicity data in clinical settings and algorithms, their potential contribution to medical racism and/or bias in clinical decision-making, and the methods needed to eliminate such racism.

A new report finds that bias in algorithms is making health care delivery more biased along racial and economic lines, opposed to making health care delivery more objective and precise.[7] Perhaps the most well-known example of an algorithm that contributed to inequitable care is the Optum algorithm which used health care cost as a proxy for health, resulting in lower risk scores being assigned to Black patients who were equally sick as White patients.[8] While assigning higher risk scores to patients who have higher health care costs may have seemed reasonable to the developers because higher health costs are often associated with greater needs, doing so failed to account for the systemic and long-standing inequities in care that have resulted in fewer expenditures on Black patients. This resulted in further inequitable care, including excluding Black patients from care management programs that dedicate additional resources to coordinate care for higher risk programs.

Therefore, we continue to believe relying on algorithms that incorrectly use race and ethnicity as proxies for biologic or genetic ancestry is not an appropriate solution. If proxies for race and ethnicity data are going to be used to help identify and address inequities in care delivery and health outcomes, it must be based on self-reported data. A study by Jarrin, et al. explores the accuracy of Medicare's administrative data variables for race and ethnicity data compared with the gold-standard of self-reported data and found inaccuracies, especially related to classification of American Indians/Alaskan Natives and Asian/Pacific Islanders.[9] We also question the accuracy of the algorithms and appropriateness outside of the hospital

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[6] AMA policy "Racial Essentialism in Medicine" D-350.981.
[7] Ziad, Obermeyer et al, "Algorithmic Bias Playbook," Center for Applied AI at Chicago Booth. June 2021. https://www.chicagobooth.edu/-/media/project/chicago-booth/centers/caai/docs/algorithmic-bias-playbook-june-2021.pdf
[8] Obermeyer et al, "Dissecting racial bias in an algorithm used to manage the health of populations," Science (Oct 25, 2019), https://science.sciencemag.org/content/366/6464/447.
[9] Jarrín OF, Nyandege AN, Grafova IB, Dong X, Lin H. Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared With Gold-standard Self-reported Race Collected During Routine Home Health Care Visits. Med Care. 2020 Jan;58(1):e1-e8. doi: 10.1097/MLR.0000000000001216. PMID: 31688554; PMCID: PMC6904433. https://pubmed.ncbi.nlm.nih.gov/31688554/.

setting due to concerns of sufficient sample to make such estimations. As we highlighted, it is unclear how well such algorithms capture varied patient populations.

- *The possible future adoption of a structural measure to assess the degree of hospital leadership engagement in health equity performance data.*

While the AMA supports the integration of health equity strategies and initiatives throughout a hospital's leadership and the entity's overall structure and practices, we do not believe that the development of a structural measure, particularly one that primarily looks for the presence of equity-focused documents, in the absence of any demonstrated linkage to improvement in patient outcomes should be pursued. This approach could increase administrative burden to report a measure that does not drive the improvements we all desire and would be one that will top out quickly. We encourage CMS to shift focus from developing this type of measure and target those measures, initiatives, and activities that prioritize the collection and reporting of additional relevant disparities data and promote interventions that address them.

We strongly believe that initiatives or programs that are considered to address inequities are best addressed through small pilots and tests and rolled out through a scaled approach and not within national accountability programs. As a part of the AMA's efforts to reduce health care inequities, we are currently in the process of developing a collaborative with health systems across the country that will leverage data-driven approaches to confront and overcome health disparities. A program is being designed to drive equity in health care by leveraging the foundational concepts of quality and safety improvement practices and making equity improvement an integral part of health care practice. The key objectives cross domains from patient care to operations to quality initiatives to culture and education. The framework to guide the AMA's work is based on five key drivers:

- Driver 1: Integrate Equity into all Quality, Safety and Risk Analyses
- Driver 2: Use Equity-Informed High-Reliability Education
- Driver 3: Use Data to Support Equity Improvement
- Driver 4: Leadership Awareness and Engagement
- Driver 5: Organizational Accountability to Stakeholders

As we continue to collaborate with health systems to test this framework and determine any unintended consequences, the AMA continues to support efforts to pilot test innovative strategies to improve health equity and reduce disparities.

III. Closing Gaps in Health Equity in Graduate Medical Education and other related provisions

Three provisions contained in the Consolidated Appropriations Act, 2021 (CAA) affect Medicare direct GME and IME payments to teaching hospitals.

A. Section 126 of the CAA makes available 1,000 new Medicare-funded GME positions (but not more than 200 new positions for a fiscal year), to be distributed beginning in fiscal year 2023, with priority given to hospitals in four statutorily specified categories.

B. Section 127 of the CAA makes statutory changes relating to the determination of both an urban and rural hospital's full-time equivalent (FTE) resident limit for direct GME and IME payment purposes with regard to residents training in an accredited rural training

track (RTT), and the 3-year rolling average set out at section 1886(h)(4)(G)(i) of the Act used to calculate payments for these hospitals.

C. Section 131 of the CAA makes statutory changes to the determination of direct GME PRAs and direct GME and IME FTE resident limits of hospitals that hosted a small number of residents for a short duration.

The AMA appreciates the opportunity to provide comprehensive comments on the implementation of the provisions contained in these sections of the CAA.

A. Distribution of Additional Residency Positions Under the Provisions of Section 126 of the CAA

As the United States population grows and ages, the demand for physicians continues to outpace the supply. In the latest study, the projected shortage of physicians is between 37,800 and 124,000 by 2034.[10] The shortage of primary care physicians is projected to be between 17,800 and 48,000 and the physician shortage for non-primary care specialties is projected to be between 21,000 and 77,100 physicians. While new medical schools are opening and existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains subject to a stagnated federal cap that falls dramatically short of the needs of the U.S. population.

Last year, in the first increase since 1996, Congress provided 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act, 2021 (CAA). However, no more than 200 slots may be made available each fiscal year (FY) and no hospital can receive more than 25 additional FTE residency positions in total. Moreover, CMS chose to narrowly limit the increase to 1.0 FTE per year—significantly less than the limit established by statute. The increase applies to both direct graduate medical education (DGME) and the IME adjustment. The legislation also calls for no less than 10 percent of the slots to go to each of the following four categories of hospitals:

- Located in rural areas or treated as being in a rural area;
- Training residents over their Medicare GME cap;
- Located in states with new medical schools or branch campuses on or after January 1, 2000; and
- That serve areas designated as health professional shortage areas (HPSAs).

CMS proposed requirements for the four categories of "qualifying hospitals," and suggested two alternative methods to assign priority when awarding slots. Under the first method, CMS proposes to rank applicant hospitals by HPSA score; those with the highest scores would be awarded the maximum 1.0 FTE. Remaining slots would go to applicant hospitals with the next highest HPSA score until all 200 slots for that fiscal year are awarded. In the case of a tie, hospitals with the same HPSA score would receive a prorated slot (i.e., less than 1.0 FTE) when an insufficient number of slots remain.

Under the alternative methodology CMS proposed for FY 2023 only, teaching hospitals would be ranked based on the number of statutorily specified categories they meet, with hospitals meeting all four categories receiving slots first, then those meeting three, two, and one receiving slots if any remain. Again, CMS proposes that no hospital would receive more than 1.0 FTE per year, and ties would result in hospitals receiving a prorated FTE amount.

[10] The Complexities of Physician Supply and Demand: Projections from 2019 to 2034, https://www.aamc.org/media/54681/download.

The AMA supports a distribution system for FY 2023 only to "allow [CMS] additional time to work with stakeholders to develop a more refined approach for future years." Finalizing a methodology for only one year will also provide an opportunity to evaluate how the process operates and provide real-time feedback on the success of the procedures. We also believe that CMS' FY 2023 alternative proposal should be finalized with significant modifications. Regardless of the methodology finalized, the AMA strongly opposes the limitation of 1.0 FTE per hospital per year. The 1.0 FTE limitation does not allow for meaningful program expansion, is not sufficient to start a new program, and may disincentivize hospitals from participating at all. We also suggest revisions to other parts of the proposal for the section 126 slot distributions.

- *The 1.0 FTE Limitation Should Not Be Finalized*

The limitation of awarding no more than 1.0 FTE per hospital per year should not be finalized. A 1.0 FTE increase is not adequate to start a new program and is unlikely to meet the needs of established programs that want to expand or fill a full complement of positions already approved by the Accreditation Council for Graduate Medical Education (ACGME). When considering obtaining at most a 1.0 FTE, some teaching hospitals have said they would be discouraged from applying given the administrative burdens of the application process. Other hospitals have stated that 1.0 FTE is not sufficient to allow them to participate in strategic program growth.

As such, the AMA urges CMS to allow hospitals to apply for up to 15 residency slots to allow programs, depending on specialty, a reasonable expansion over five years. For example, this would allow a five-year general surgery program to recruit three residents for each of the five years. With the assurance of funding for up to 15 slots, hospitals could meaningfully expand one or more training programs. However, if CMS decides that slots should be distributed to as many teaching hospitals as possible, then at a minimum each hospital would receive three to five slots. Depending on specialty length, this will allow for an increase of one resident for each year of training, although this is likely insufficient to provide an opportunity to start a new program.

Even by increasing the maximum number of slots that may be awarded to a hospital, CMS may encounter hospitals that are tied by the ranking system that CMS selects. For FY 2023, the AMA suggests that in the case of a tie CMS give preference to hospitals that are at least 10 FTEs over their cap, and further, that hospitals that are the highest number over their cap given preference. The AMA believes it would be desirable to have additional tiebreakers rather than prorating slots at less than 1.0 FTE so that full funding can be provided for any additional resident slots. Following the FY2023 slot distribution, CMS can evaluate how well this preference system has worked and adjust accordingly.

Additional CMS Proposals for Slot Distribution

- *Demonstrated Likelihood of Filling the Position*

CMS proposes separate criteria that hospitals must meet to show that they have a demonstrated likelihood of filling the residency positions within the first five years of training. CMS proposes criteria depending on whether the hospital is applying for a new residency program or an expansion of an existing residency program. The AMA suggests that CMS update the criteria to use language that is consistent with the terminology currently used by ACGME and the American Board of Medical Specialties (ABMS). For example, the proposed rule refers to hospitals applying to ACGME for "approval" of slots for a new program, but ACGME uses the term "accreditation" rather than approval. CMS also talks about the need for hospitals to meet an ACGME deadline when a program wants to expand or when a hospital seeks accreditation for a new program. According to ACGME each Residency Review Committee sets its own deadlines and may have multiple deadlines throughout the year.

The CMS proposal does not account for the possibility that a hospital may be at or over its cap and may have previously received ACGME accreditation for one or more programs for slots that have remained unfilled. In this case, the hospital should be able to meet the "demonstrated likelihood" requirement by showing that the number of filled slots is less than the complement of residents accredited by ACGME.

- *Definitions of the Four Hospital Categories*

CMS is proposing to define each of the four categories of hospitals in the proposed rule. The AMA supports the proposed definitions of: Category 1: hospitals in rural areas or that are treated as being in rural areas; Category 2: hospitals over their cap; and Category 3: hospitals in states with new medical schools or branch campuses. However, changes should be made to the definition of Category 4: hospitals that serve areas designated as HPSAs. The suggested changes include eliminating the requirements that the hospital or provider-based department be located in the HPSA and that at least 50 percent of the resident's training must occur in a facility located in the HPSA.

CMS Should Revise the Definition of Hospitals That Serve Areas Designated as HPSAs (Category 4). The CAA does not give preferential treatment to the HPSA category, but rather provides that at least 10 percent of the slots should go to hospitals that serve areas designated as HPSAs. Further, CMS notes that "the CAA does not explicitly address the question of how HPSAs for different medical specialties should factor into determining which hospitals serve areas designated as HPSAs." The AMA believes that the plain reading of the legislation dictates that no differentiation exists based on medical specialty, especially considering physician shortages which occur in many specialties.

CMS proposes to use primary care geographic HPSAs and mental health geographic HPSAs to determine if a hospital or its provider-based department is located in the HPSA. CMS further plans to prioritize applications from "hospitals that serve specific designated underserved population[s] of a population HPSA". Conversely, the legislation does not distinguish among HPSAs but focuses on serving areas designated as HPSAs, a much broader category. If CMS finalizes this proposal, we ask that the agency clarify whether there is any difference in prioritization between a primary care or mental health geographic HPSA and a population HPSA. Further, we ask CMS to clarify that for the FY2023 alternative distribution methodology a population HPSA qualifies along with, geographic, primary care, and mental health HPSAs.

Moreover, the AMA recognizes the shortage of psychiatrists and all mental health professionals and does not support limiting hospitals in mental health HPSAs to applying only for psychiatric residency slots. The AMA suggests that CMS give preference to hospitals in mental health geographic HPSAs that apply for psychiatry but not limit hospitals to psychiatry residencies. Given shortages in many other non-primary care specialties, expansion in any specialty will benefit the population that is served by that hospital and should be allowed.

Furthermore, the AMA strongly opposes the proposed requirement that the hospital or provider-based department be physically located in a HPSA. The AMA also opposes CMS' proposal to require that at least 50 percent of the resident's training time occur at facilities located in a HPSA.

To bolster its argument that a hospital should be physically located in a HPSA, CMS posited the extreme example of a hospital that qualifies for this category although it treats only one patient from a HPSA. This is not the reality for teaching hospitals that may be outside a HPSA but are the primary point of care for a HPSA population. Patients who live in HPSAs may choose to go to a nearby teaching hospital that is adjacent to, but not located in a HPSA, often because it is the closest facility to their home, or it provides specialized services that are needed and are unavailable elsewhere. According to the Association of American Medical Colleges' (AAMC) analysis of the FY 2019 American Hospital Association Annual

Database, AAMC member teaching hospitals represent five percent of all inpatient, short-term, non-Federal, non-specialty hospitals yet they provide 26 percent of all Medicaid inpatient days and incur 32 percent of all charity costs.

Teaching hospitals are best positioned to determine the locations in which to train residents to meet patient needs and accreditation standards. Accreditation standards ensure that residents train in locations with a large enough population to provide them with the necessary mix of patients and conditions for their specialty. Of equal consideration is where adequate teaching physician supervision is available. To mandate that these new residency slots meet the "at least 50 percent" requirement means that hospitals must design residency rotations differently for these residents to ensure that the "at least 50 percent requirement is met." This is untenable for teaching hospitals and residency programs and should not be finalized.

Since resident positions are aggregated, and not individualized, within a training program, individual section 126 slots would not be identifiable. If it were possible to track the section 126 slots at an individual resident level, the "at least 50 percent requirement" would place an extraordinary burden on teaching hospitals which would have to document for each rotation whether the location of the "Section 126 slot resident" was in a HPSA. Essentially, hospitals would have to set up dual reporting systems—one for section 126 slots and one for all others. Resident schedules also can change quickly which further increases the potential burden and could lead to inadvertent errors. The proposed requirements do not align with the way in which rotation schedules are recorded by institutions or are entered into the Intern and Resident Reporting System (IRIS).

The AMA strongly urges CMS to revise its definition of the HPSA category. The definition of the HPSA category should be expanded so that a hospital will qualify if (1) it is located within a certain distance, for example 10 miles of a HPSA or (2) is in a geographic, primary care, mental health, or population HPSA. CMS also should not finalize the proposal that requires at least 50 percent of the residents' training to occur in a HPSA. Teaching hospitals must have the flexibility to decide the locations in which residents need to train based on a variety of factors. They also should not be burdened by the extraordinary recordkeeping requirements that this proposal would entail.

- *CMS Should Not Finalize the Proposal to Award Slots Based Solely on HPSA Score*

The CAA recognized the need to include consideration of underserved populations in the slot distribution when it added the category of "hospitals that serve areas designated as health professional shortage areas" to the list of hospitals that are to receive no less than 10 percent of the slots. However, the HPSA category is not prioritized over the other three categories of hospitals that are named in the law. The AMA strongly opposes the use of HPSA scores to determine priority for awards of residency slots, with hospitals with the highest score receiving up to 1.0 FTE. The AMA also strongly opposes a prorated FTE being awarded in cases where there is a tie and an insufficient number of residency positions. HPSA scores speak to the need for more practitioners in a given state but do not speak to the ability of the hospitals in those states to train more residents or to provide care for patients who live in HPSAs.

In proposing reliance on the HPSA score to award slots, CMS says that "there is a strong likelihood that…the result will be that 10 percent or more of the additional residency positions will be distributed to hospitals in each of the four categories." If only HPSA scores are used, the AMA does not agree that there is a strong likelihood that each of the four categories of hospitals will receive at least 10 percent of the slots. The best way to meet the "at least 10 percent" requirement is to adopt the proposed alternative distribution methodology for FY 2023 with modifications, and then refine the distribution methodology in future rulemaking.

CMS' proposed alternative slot distribution methodology is that, for FY 2023, hospitals that qualify under all four statutorily specified categories would receive top priority for slot distribution, followed by those that qualify under any three, then two and lastly one category. Hospitals would be awarded 1.0 FTE or a prorated amount if insufficient slots are available. This approach would allow CMS more time to work with stakeholders to develop a refined approach for the remaining four years of distribution.

The AMA supports the proposed approach for FY 2023, which is to use the four categories of hospitals to determine the slot distribution priority, but strongly urges CMS to modify the methodology as follows:

1. A hospital should be able to apply for and be awarded at least the minimum number of slots to allow for the training of one additional resident per year for the duration of the specialty, in other words, at least three to five FTEs. To provide for more program expansion, or the possibility of starting a new program CMS should award up to 15 residency slots, depending on specialty.
2. A hospital will qualify for the HPSA category if it is within a certain distance of a HPSA or is located in a primary care, mental health, or population HPSA.
3. A hospital located in a mental health only geographic HPSA can apply for slots for any residency program, but preference will be given to hospitals in mental health only geographic HPSAs that apply for psychiatry residency slots.
4. If hospitals scores are tied and an insufficient number of slots remain, CMS will award slots to those hospitals that are 10 FTEs or more above their caps, with those most above their cap receiving slots first.
5. Additionally, CMS should stipulate in its regulations that residency slots are not assets that belong to the teaching institution but rather acknowledge that residency slots that are paid for by Medicare are owned by Medicare and upon potential closure of a hospital are meant to be redistributed into the medical community to ensure the continued education of residents.

The AMA notes that if CMS finalizes the revisions proposed above the application form will need to be revised to be consistent with these changes.

- *Hospital Attestation to the National Class Standards*

CMS proposes that all applicant hospitals will have to attest that they meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) "to ensure that the residents are educated and trained in culturally and linguistically appropriate policies and practices."

National CLAS Standards overlap with requirements that hospitals already meet, such as the Internal Revenue Service requirements that 501(c)(3) hospitals must complete a Community Health Needs Assessment and Implementation Plan every three years; The Joint Commission Standards related to language access and interpreter services; the ACGME requirements that residents must show competence in "communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds." (Common Program Requirements, IV.B.1.e).(1).(a)); and the AAMC quality improvement and patient safety competencies in health equity. As such, myriad requirements and strong institutional values that exist outside of—but are consistent with the National CLAS Standards—ensure that residents receive training in health care environments that are culturally and linguistically appropriate and meet the local needs of the institution and the communities they serve.

Though the AMA appreciates the goals of the National CLAS Standards, we believe that the concept of a national standardized or mandated curriculum is inappropriate. Medical schools and teaching hospitals, within accreditation standards and requirements, have local missions and community health needs that necessitate that the faculty have the freedom and ultimate responsibility to design, implement, and evaluate the educational program.

- *Application and Announcement of Slot Awards*

CMS proposes that awarded residency position slots would be effective July 1 of each year, and an application must be submitted by January 31 of the prior fiscal year. Slot awards will be announced by January 31 of the federal fiscal year (FY) in which they are effective. For example, for the initial 200 slots which are effective July 1, 2023 (FY 2023) the completed application would be submitted by January 31, 2022 (FY 2022). The slot award announcement would be made January 31, 2023.

The AMA requests that CMS revise the date by which the slots must be announced to October 1 of the federal FY in which the slots are effective. The timing proposed by CMS does not fit with the residency recruitment cycle. Most residents obtain their residency positions through the National Residency Matching Program (NRMP). The typical recruitment cycle for residents involves hospitals interviewing potential candidates in the calendar year prior to the year in which the resident will start the residency. Hospitals submit their rank order list by the first week of March, but program quota changes are due by January 31. If hospitals do not know whether they will be awarded slots, or how many, until January 31 of the year in which the slots are effective, it will be almost impossible to recruit the appropriate number of residents and show a "demonstrated likelihood" that the slots will be filled within five years.

B. Proposal for Implementation of Section 127 of the CAA, "Promoting Rural Hospital GME Funding Opportunity"

Section 127 of the CAA expanded the opportunities for urban and rural hospitals to engage in Rural Training Track (RTT) programs. The changes proposed by CMS will encourage more training in rural areas which may result in more physicians deciding to practice in those areas upon completion of their residencies. **The AMA Supports CMS' Proposal for Implementation of Section 127 of the Consolidated Appropriations Act, "Promoting Rural Hospital GME Funding Opportunity" with Modifications.**

The AMA supports the majority of the proposals in this section including the proposal to implement this section of the CAA by allowing rural hospitals participating in RTTs to adjust their caps for programs that do not qualify as "new" and allowing urban hospitals that have RTTs to receive further cap adjustments if the urban hospital creates RTTs in more specialties. The AMA also supports the additional eligibility for RTT cap adjustments, for cost reporting periods on or after October 1, 2022, for hospitals not located in a rural area that establish a medical residency training program or an accredited program (or rural tracks) in a rural area. Additionally, the AMA supports the proposal to prospectively allow IME and DGME cap increases of both the urban and rural hospitals that expand a qualifying RTT. Moreover, the AMA supports CMS' proposal to allow a five-year cap building window for new RTT programs.

However, the AMA would suggest some modifications to this section. CMS has proposed to "limit the provision of an increase to the urban and rural hospitals' RTT FTE limitations only to the instance where additional residents are recruited to add a new rural RTT 'spoke' to the existing urban 'hub' and not allow increases . . . to the RTT FTE limitation in instances where the urban and rural hospital add additional FTE residents to an existing rural RTT 'spoke.'" The AMA appreciates CMS' concern that allowing the expansion of existing programs might render RTT cap limitations meaningless. **However, we urge CMS to create an exceptions process that would allow for the expansion of existing RTTs if hospitals can**

demonstrate that the only way they can only train more residents at a rural hospital is to expand a current RTT.

C. Proposal for Implementation of Section 131 of the CAA, Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

Consistent with section 131 of the CAA, CMS proposes to allow certain hospitals to reset their low FTE, IME, or DGME resident caps and allow certain hospital with a low per resident amount (PRA) to receive a replacement PRA. To qualify to reset the FTE resident cap, CMS proposes that a hospital must have either a cap based on less than 1.0 FTE before October 1, 1997 (termed Category A hospitals) or a cap based on no more than 3.0 FTEs for cost reporting periods beginning on or after October 1, 1997 and before December 27, 2020 (termed Category B hospitals). **The AMA Supports the CMS Proposed Rule Implementation of section 131 of the CAA, Addressing Adjustment of Low Per Resident Amounts and Low FTE Resident Caps for Certain Hospitals**

The AMA supports the CMS proposal to reset a qualifying hospital's PRA with the requisite number of residents training on a given cost report, on or after December 27, 2020. The AMA also supports establishing, as the base period, the first period after enactment in which a Category A hospital trains at least 1.0 FTE and a Category B Hospital trains more than 3.0 FTEs. The PRA recalculation is consistent with establishing a PRA at a new training hospital, and the AMA supports the CMS proposal to treat the PRA setting in the same way.

- *Use of the Predicate Facts Rule*

The AMA is concerned with the CMS suggestion that Medicare Audit Contractors (MACs) could use "predicate facts" to establish a new FTE resident amount, using whatever "contemporaneous documentation we would need to establish a PRA" or "contemporaneous documentation we would need to establish the FTE resident caps." Predicate facts may cause some hospitals to decide not to engage in training residents due to the possibility that they could be incorrectly categorized if a MAC discovered information that would leave them with an extremely low PRA or FTE cap.

Section 131 of the CAA addresses a persistent problem for hospitals that inadvertently set low PRA and FTE counts. The hospitals that benefit from this legislation would like to train residents but are reluctant to do so because there is little or no support from Medicare. As we have established elsewhere in this comment letter, there exists a very real and problematic national shortage of physicians. The AMA requests that CMS provide assurance that MACs would not be expected or encouraged to search for "predicate facts."

- *The Intern and Resident Information System*

The AMA is pleased that CMS will be replacing the IRIS diskette with an Extensible Markup Language (XML)-based IRIS file for cost reporting periods beginning on or after October 1, 2021. **However, the AMA strongly objects to the CMS proposal that a hospital's cost report would be rejected for lack of supporting documentation unless IRIS data contains the same total counts, of direct GME FTE residents (weighted and unweighted) and of IME FTE residents, as the total counts on the cost report and ask that CMS not finalize it.** IRIS will continue to catch inadvertent errors and those errors will continue to be fixed.

IRIS was developed to allow MACs to determine when hospitals inadvertently "double-counted" residents. In other words, the creation of IRIS acknowledges that errors occur and provides a way in which to detect and correct those errors. Typically, hospitals receive reports with double-counted

residents and then the hospitals work to resolve those issues. This process ensures accurate counts for Medicare support and is an important role of the IRIS system.

Hospitals should not be penalized for inadvertent errors that commonly arise due to the complications of recording resident rotations and that ultimately are corrected to ensure proper Medicare payment. CMS acknowledges the way in which IRIS is used when it states in part that "if duplicates are identified, the contractors will make the hospitals that claimed the same time aware of this situation and will correct the duplicate reporting on the respective hospitals' cost reports for direct GME and IME payment purposes.". We also ask that CMS recognize that the adoption of a new software program may present technical issues for hospitals that must transition to an application they have not used before.

IV. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—Request for Information (RFI)

In recognition of persistent health disparities and the importance of closing the health equity gap, CMS requests information on revising several CMS programs to make reporting of health disparities based on social risk factors, race, and ethnicity more comprehensive and actionable for providers.

Specifically, CMS is seeking comment on the following:

- *The potential future application of an algorithm to indirectly estimate race and ethnicity to permit stratification of measures (in addition to dual-eligibility) for hospital-level disparity reporting, until more accurate forms of self-identified demographic information are available.*

The AMA believes gathering additional information on clinical algorithms in use today and the impact of including race and ethnicity into their calculations is of utmost importance. Collection of additional information on these specific algorithms is an essential early step towards identifying where racism and bias may exist in clinical decision-making tools and how they should be addressed to ensure clinical care and health of historically marginalized communities are not negatively impacted by their application. Given that the approaches in design and implementation, as well as underlying data provenance, vary, it will be important to seek further input from organizations that have expertise in equity and direct experience with development and use of specific algorithms.

As mentioned earlier in our comments, the usage of race and ethnicity as variables, and how both are defined, varies among the clinical algorithms in use today. This is attributable in part to changes in protocols over time, as some of the clinical data registries from which algorithms are derived are more than several decades old. There is also variation among multiple health data systems in how the data is collected and the number of choices provided to the reporter. Furthermore, because race is a social construct, there is significant variability in how "races" are defined by society, lawmakers, and others—including individuals themselves. These definitions have changed and evolved in usage and application over time and do not always correspond with biology and genetic ancestry. Accordingly, their inclusion as variables creates challenges in developing meaningful consensus definitions, especially as our society diversifies over time, further clouding how we define these variables.

The AMA House of Delegates in November 2020 passed historic new policy directing our organization "to collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors."[11] The AMA

[11] AMA policy "Racial Essentialism in Medicine" D-350.981.

is currently undertaking an effort to convene a variety of organizations to gather more information about the use of clinical algorithms and create an action plan for how to address these problems.

We believe that, in addition to efforts like our own, the AHRQ is ideally situated to conduct and fund additional research into the use of race and ethnicity data in clinical settings and algorithms, their potential contribution to medical racism and/or bias in clinical decision-making, and the methods needed to eliminate such racism.

A new report finds that bias in algorithms is making health care delivery more biased along racial and economic lines, opposed to making health care delivery more objective and precise.[12] Perhaps the most well-known example of an algorithm that contributed to inequitable care is the Optum algorithm which used health care cost as a proxy for health, resulting in lower risk scores being assigned to Black patients who were equally sick to similarly White patients.[13] While assigning higher risk scores to patients who have higher health care costs may have seemed reasonable to the developers because higher health costs are often associated with greater needs, doing so failed to account for the systemic and long-standing inequities in care that have resulted in fewer expenditures on Black patients. This resulted in further inequitable care, including excluding Black patients from care management programs that dedicate additional resources to coordinate care for higher risk programs.

Therefore, we continue to believe relying on algorithms for indirectly estimating race and ethnicity is not an appropriate solution. If going to use proxies for race and ethnicity data to help identify and address inequities in care delivery and health outcomes, it must be based on self-reported data. A study by Jarrin, et al explores the accuracy of Medicare's administrative data variables for race and ethnicity data compared with the gold-standard of self-reported data and found inaccuracies, especially related to classification of American Indians/Alaskan Natives and Asian/Pacific Islanders.[14] We also question the accuracy of the algorithms and appropriateness outside of the hospital setting due to concerns of sufficient sample to make such estimations. As we highlighted, it is unclear how well such algorithms capture varied patient populations.

- *Recommendations for other types of quality measures or measurement domains, in addition to readmission measures, to prioritize for stratified reporting by dual eligibility, race and ethnicity and disability.*

The AMA believes that continued stratification of quality data by dual eligibility and race and ethnicity remains insufficient and while the expansion to disability provides useful information, CMS must make significant efforts to advance the data that are used to identify health care inequities. For example, quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. Continued reliance on existing data that have known deficiencies is not acceptable and we must advance to more accurate and relevant data.

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[12] Ziad, Obermeyer et al, "Algorithmic Bias Playbook," Center for Applied AI at Chicago Booth. June 2021. https://www.chicagobooth.edu/-/media/project/chicago-booth/centers/caai/docs/algorithmic-bias-playbook-june-2021.pdf.

[13] Obermeyer et al, "Dissecting racial bias in an algorithm used to manage the health of populations," Science (Oct 25, 2019), https://science.sciencemag.org/content/366/6464/447.

[14] Jarrín OF, Nyandege AN, Grafova IB, Dong X, Lin H. Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared With Gold-standard Self-reported Race Collected During Routine Home Health Care Visits. Med Care. 2020 Jan;58(1):e1-e8. doi: 10.1097/MLR.0000000000001216. PMID: 31688554; PMCID: PMC6904433. https://pubmed.ncbi.nlm.nih.gov/31688554/.

We discourage CMS from strictly relying on dual-eligibility (DE) status when stratifying readmission measures. While the 2016 Assistant Secretary for Planning and Evaluation (ASPE) report to Congress on social risk factors and their impact on measures in CMS value-based purchasing programs[15] may have identified dual eligibility as a strong predictor for disparities, a recent study found that due to the differences in the DE population stratifying by DE-only within the confidential hospital Disparities Report is misleading and further exacerbates inequities, which is counter to the goals of quality and its related incentives to close or minimize health care inequities.[16] The potential addition of race and ethnicity data using the indirect estimation approach, while potentially informative for quality improvement purposes, should not be used for any other purpose.

We urge CMS to focus on longer-term strategies that will truly drive improvements as opposed to spending time on resources to implement "quick fixes" and utilize proxies. The methodologies chosen to stratify and present data for purposes of improvement are multifaceted and it is a complex topic. Therefore, it requires more research to develop an evidence-based approach to account for social risk-factors and reduce inequities.

In addition, **we recommend that CMS consider exploring the following concepts through an open and transparent measure development process that involves extensive opportunity to provide input:**

- Stratify by race, ethnicity, language, disability, age, gender, and other demographic factors and determinants of health (e.g., insurance type) for root cause analysis;
- Reduction of inequities through positive incentives;
- Access to interpreters;
- How well are social and structural determinants of health data collected and addressed; and
- Access to care or patient experiences during health care interactions.

The development of new quality measures that more effectively address health equity should be prioritized.

- *Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risk Factors*

The AMA discourages CMS from developing a Hospital Equity Score until such time as: 1) the data that accurately capture social risk factors and drivers of disparities are available; and 2) CMS can determine which quality measures are most effective at discriminating meaningful differences in performance due to inequities in care delivery.

As CMS begins to consider addressing health inequities and the potential development of a Hospital Equity Score, CMS must consider the potential unintended consequences and provide supportive education to ensure that this score does not exacerbate inequities and that institutions are appropriately educated on best practices for data collection and/or program implementation. As noted above, perhaps the most well-known example of an algorithm that contributed to inequitable care is the Optum algorithm,

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[15] U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. Washington, DC: 2016.

[16] Alberti, Philip., Baker, Matt., Dual Eligible Patients Are Not The Same- How social risk may impact quality measurement's ability to reduce inequities.

which used health care cost as a proxy for health, resulting in lower risk scores being assigned to Black patients who were equally sick to similarly situated White patients.[17] While assigning higher risk scores to patients who have higher health care costs may have seemed reasonable to the algorithm developers because higher health costs are often associated with greater needs, doing so failed to account for the systemic and long-standing inequities in care that have resulted in fewer expenditures on Black patients. This resulted in further inequitable care, including excluding Black patients from care management programs that dedicate additional resources to coordinate care for higher risk patients.

Not only is it important to ensure that the risk factors by which a measure or summary score is stratified or calculated accurately represent the characteristics of patient populations as discussed above, CMS must also be thoughtful on the set of measures on which these comparisons are made. It should not be assumed that a score derived from all of the outcome measures in a quality program, for example, can be used to identify meaningful differences in performance that are due to health care inequities. CMS should determine what quality metrics would be most informative and not just from those measures that exist but also consider whether additional measures must be developed and implemented. If measure gaps are identified, they must be filled prior to the development of any Hospital Equity Score.

In addition, any consideration of such a measure must also be accompanied by significant resources and education. Well-intended measures or tools often create new problems and only health care facilities and physician practices that are well-financed and capitalized have the necessary resources to invest in quality improvement. For instance, the Hospital Wide Readmission program has substantially increased penalties for hospitals that serve a disproportionate number of low-income patients.[18] **CMS must provide adequate resources to help providers achieve better health outcomes for high-risk patient populations.** All patients with Medicare coverage do not have equal opportunities to achieve good health outcomes, so one-size-fits-all measures or programs are more likely to increase than reduce disparities.

We strongly believe that inequities are best addressed through pilots and thoughtfully scaled initiatives and not within national accountability programs. As a part of the AMA's efforts to reduce health care inequities, we are currently in the process of developing a collaborative with health systems across the country that will leverage data-driven approaches to confront and overcome health disparities. The program, For Impact on Racial Justice and Equity (FIRE), is designed to drive racial justice and equity in the health care arena by leveraging the foundational concepts of quality and safety improvement practices and making equity improvement an integral part of health care practice. The key objectives cross domains from patient care to operations to quality initiatives to culture and education. The framework for FIRE to guide the AMA's work is based on five key drivers:

- Driver 1: Integrate Equity into all Quality, Safety and Risk Analyses
- Driver 2: Use Equity-Informed High-Reliability Education
- Driver 3: Use Data to Support Equity Improvement
- Driver 4: Leadership Awareness and Engagement
- Driver 5: Organizational Accountability to Stakeholders

[17] Obermeyer et al, "Dissecting racial bias in an algorithm used to manage the health of populations," Science (Oct 25, 2019), https://science.sciencemag.org/content/366/6464/447.

[18] Zuckerman, R. et al., Effect of a Hospital-wide Measure on the Readmissions Reduction Program. *N Engl J Med 2017;* Oct. 19, 2017. 377:1551-1558 DOI: 10.1056/NEJMsa1701791.

As we continue to collaborate with health systems and implement FIRE to determine any unintended consequences, the AMA continues to support efforts to pilot test innovative strategies to improve health equity and reduce disparities.

V. Future of Digital Quality Measurement—Advancing Digital Measurement RFI

Data Aggregation

The AMA supports advancements in data availability and integration for quality improvement and measurement through efforts such as data aggregation, but they must result in data that are easily accessible at the point of care and provide actionable information that can inform shared decision-making while also easing reporting burden. Many third-party aggregators such as clinical registries and health information exchanges (HIEs) have demonstrated the great potential that can be experienced through data sharing, such as increasing transparency on patient interactions across the health system to promoting initiatives that inform public health, but we strongly recommend that CMS consider the following issues if they move forward with this effort.

Hospitals, practices, third-party aggregators, and others must have sufficient time and guidance to implement dQMs prior to any required reporting of the data and/or measure scores. The recent experience encountered by accountable care organizations (ACOs) with the Medicare Shared Savings Program (MSSP) changes as outlined in the letter to Secretary Becerra dated May 4, 2021, from multiple health care organizations including the AMA serves as an example on how reporting requirements that are not adequately researched or delineated can create confusion and expend unnecessary and costly resources. Specifically, as ACOs attempt to be responsive to the shift to reporting of electronic clinical quality measures (eCQMs) or the Merit-based Incentive Payment System clinical quality measures (MIPS CQMs) using all payer data, each are encountering multiple challenges, including:

- The significant number of vendor systems from which the data are collected and across multiple practices;
- The extent to which the ACO may or may not have permissions to access and report data on patients beyond their assigned beneficiaries;
- How to best complete patient matching across all participating practices; and
- How to best clean and validate these data, including the extent to which the ACO can assume responsibly for that reporting and validation and likely includes thousands of patients for a single measure.

Perhaps more importantly, many must build the necessary internal infrastructure or identify and pay an external vendor to assist in the data aggregation and reporting and many are spending hundreds of thousands to over a million dollars to enable this transition. These unexpected costs, particularly with little advance warning, will likely require ACOs to shift resources that would traditionally have been used to improve patient care and should not be replicated again.

We also do not believe that it is realistic to assume that any one hospital or physician practice will be asked to coordinate and share data with only one entity unless CMS served as the sole third-party aggregator. Rather, it is not unreasonable to expect that one provider will need to interact and establish data sharing with multiple third-party aggregators and it will further add to the costs and challenges of data sharing. We urge CMS to explore the potential impact that these requirements may have and develop solutions that will minimize costs, address user resistance, and ensure that the reporting burden and

expenses do not increase for those entities at the point of care. This analysis should be broad and include those groups that will serve important roles both in providing important data and driving improvements in individuals' health such as public health agencies. In addition, creating some governance and defining a minimum set of standards and capabilities for these data aggregators could minimize the reporting burden experienced by hospitals, practices, and others, particularly if they must interact with more than one group. This information will also ensure that third-party aggregators are able to demonstrate and offer the services that will be required for quality measure reporting such as robust processes around patient matching, ensure adequate privacy and security of the data, and demonstrate data accuracy and validation. Hospitals, practices, and others must be able to ensure that those aggregators with whom they partner will meet CMS expectations/requirements.

In addition, the broader implications to quality measurement if data aggregation is supported must be considered. While the expansion to the broader population could provide a snapshot of care within a community, it is likely not representative of the care provided by the hospital or other providers. It is important to note that the IQR or MIPS is a Medicare program so organizations naturally focus their efforts on Medicare patients, causing them to target services and interventions for their assigned Medicare patient population. The issue with payer mix will become more complicated as CMS moves to measure providers on more outcome and intermediate outcome measures. The AMA performed a query of 2016 National Ambulatory Medical Care Survey (NAMCS) data, looking at blood pressure control rates and on a national level the rates are different by insurance types demonstrating that payer mix and associated patient populations will affect scoring. As a result, performance on quality measures could be skewed based on inequities and differences in patient mix. This misrepresentation does not serve to drive change in a meaningful and useful way and potentially penalizes providers treating more vulnerable populations.

- *CMS is seeking feedback on developing a common portfolio of measures for potential alignment across CMS regulated programs, federal programs and agencies, and the private sector.*

We support the two-pronged approach of alignment of the individual measures and specifications separate from the necessary data elements. This division is useful, as it would allow a staged approach to implementation of aligned measures based on the degree to which data elements are standardized and demonstrated to be available within a specific setting or for a specific CMS quality program. We encourage CMS to be thoughtful on when a dQM might be proposed for inclusion in a quality program and perhaps create thresholds by which these determinations would be made. For example, once a data element that captures a patient-reported outcome result relevant to inpatient care is created, it must first be incorporated into the USCDI and relevant implementation guides and have a certain percentage of all electronic health record vendors in the inpatient setting in collaboration with hospitals and others demonstrate that the data element is feasible to collect. At that point, any dQM that seeks to include this data element would be pilot tested in the inpatient setting and provide information on whether the required data elements and resulting measure score are reliable and valid. The dQM could then be considered for CMS inpatient quality programs and others.

We also encourage CMS to continue to advance a dQM that provides more clinically meaningful data within one setting or program even if the measure cannot be aligned across programs initially. Rather, the goal should be to work with the other relevant settings and programs to enable them to also leverage the advanced data as quickly as possible while not holding up the implementation of dQMs that may ease reporting burden and inform patient care.

While we also support the concept of a broad dQM portfolio that can be used by multiple end users, we encourage CMS to identify what has limited our ability to create that portfolio to date and actively

address those challenges and barriers. One approach may be to identify one or two dQMs that are ready to be implemented across multiple programs, agencies, and settings and determine what actions or efforts are needed to ensure widespread adoption and success.

- *CMS is seeking feedback on changes needed to advance to digital quality measures by 2025*.

We appreciate CMS' acknowledgement that it will work with stakeholders to achieve interoperable data exchange and that to transition to full digital measurement requires its programs, where possible, to ensure alignment of: (1) measure concepts and specifications including narrative statements, measures logic and value sets, and (2) the individual data elements used to build these measures specifications and calculate the measures. Further, the required data elements would be limited to standardized, interoperable elements to the fullest extent possible; hence, part of the alignment strategy will be the consideration and advancement of data standards and implementation guides for key data elements. However, the AMA believes to realize the full extent of digital quality measurement requires rethinking EHR certification.

While health IT certification was initially designed to evaluate a product's ability to meet Meaningful Use (MU) requirements, the usability and interoperability of EHRs going forward must be improved, which in part will require the Office of the National Coordinator for Health Information Technology's certification program to be refocused. Many demands by clinicians, hospitals, and other providers to improve EHRs (e.g., better usability, easier access to meaningful information, less time spent documenting or redocumenting data) can be addressed by examining key aspects of eCQMs or dQMs. A more robust approach to certification should focus on the quality, exchange and usability of data and aligned with measure reporting requirements. Generally, this includes:

- Capturing information relative to the clinical needs and goals of patients while leveraging alternative sources of data, instead of direct human documentation, as frequently as possible;
- Using data models that retain the intended meaning of information, including attributes about the data (e.g., provenance);
- Reporting and exchanging information in a structured format using standard terminology where possible; and
- Demonstrating the usability by focusing on integration of the data into their products and the degree of clinical workflow changes that may or may not be needed at the point of care.

Said another way, EHRs that improve the capture, management, and communication of clinical information will better accommodate the actual needs of providers and their patients, ensure the accuracy of quality measurement, and support a broader array of measures. We regularly hear that vendor certification timelines do not always match with CMS quality reporting requirements, such as the Merit-based Incentive Payment System (MIPS) reporting requirements. In addition, vendors are not required to complete robust testing of measure and updates every year and as a result the test cases are insufficient to truly ensure that the measure can be "easily" and "accurately" reported. Currently, all of this is placed on measure developers and participating practices when it should really be a vendor's responsibility. **Therefore, prioritizing testing and certification that validates strict conformance to the principal aspects of dQMs will improve overall EHR user experience and reduce vendor development burden.**

A key component of the quality data infrastructure requires that payers utilize a single source for code and terminology mappings to ensure greater consistency with measure calculations and comparisons of

performance (data mapping). Currently, vendors, practices, health systems, and consultants perform their own mapping, which leads to data inconsistencies and is a reason why no two EHRs can reliably calculate comparable results.

Work is needed to ameliorate data mapping issues by building upon the strengths of existing terminologies. For example, linking a terminology based on a comprehensive ontological model (e.g., SNOMED-CT) and an administrative/billing terminology (e.g., Current Procedural Terminology® (CPT®)) would allow for the seamless collection of information from the clinician at the bedside, the ability to capture and automate coding for fees and billing, extend the capabilities of clinical decision support systems (CDS), save countless hours of manual coding, and reduce errors in the process. Both terminologies provide unique advantages to end users and together optimize data for clinical care, research, and administrative uses. Data maps, both new and existing, should be leveraged to resolve issues around efficiency and consistency of measures across EHRs and providers. The AMA has already initiated a close collaboration between SNOMED-CT and CPT terminologies.

Importantly, not only should a complete record be accessible, but also the data contained therein must be consistent, understandable, and usable (data consistency). For this to occur, data must be in a recognizable electronic package (data structure or syntax) and maintain a consistent meaning (data semantics). Just as the English language is built from words and grammar, the translation from data to knowledge can only occur if the meaning of data is consistent. However, levels of semantic interoperability vary greatly in the health care system. Most providers agree that the current level of interoperability is inadequate to support the necessary changes, reforms, and innovations desired in health care. As a practical matter, the more data exchanged that lacks both semantic and syntactic interoperability, the less useful it is to providers and patients.

In order to improve electronic capture, calculation and reporting of quality measures, CMS should incent the use of standardized semantic content from recognized developers. In the development and specification of a quality measure intended for use in CMS programs, the clinical concepts used in the measure could be derived from recognized clinical content models. For example, if a measure is looking at blood pressure, and using the concepts as defined in one of these models, CMS-recognized data aggregators and registries could be given incentives to use those concepts and avoid variation in data management. Incorporation of data requires the development, maintenance, and refinement of administrative codes such as ICD and CPT and clinical vocabulary standards such as SNOMED CT, LOINC, and RxNorm. CMS should promote collaborative efforts across these different coding systems and ensure consistency when data are exchanged.

- *CMS is seeking feedback on leveraging advances in technology (e.g., Fast Health Interoperable Resources Application Programing Interfaces or FHIR APIs) to access and electronically transmit interoperable data for dQMs and other reinforcing activities to support quality measurement and improvement.*

Quality measurement can be labor-intensive, fragmented, and inconsistent. It is also largely retrospective. Eliminating unnecessary or duplicative work and expenditures related to quality measurement can result in cost savings and free up invaluable time for patient care. Physicians need more automated, unified, accurate, prospective, and timely quality measurement and reporting. Moreover, CMS bases many of its performance incentives on insufficiently validated data processed through systems that are prone to error. This undermines CMS' goal of rewarding high quality care and support for value-based arrangements. Furthermore, electronic clinical data requires the validation of clinical data sources—increasingly outside the "four walls" of the medical office—prior to use in quality and incentive programs.

Yet, due to the variability in technology and health care technical standard implementation, we are not yet at a point of achieving standardization nor sufficiently able to leverage advanced technology to accommodate dQMs. The best chance to accelerate adoption of dQMs across parties is to incent technology developers to develop a uniform set of tools in a common, secure environment to facilitate better data flow. Digital quality systems can enable rapid feedback and integrated content development across clinical guidelines and decision support, quality measures, and data specifications—each informing the other. However, **the AMA believes there are fundamental overarching goals that CMS should consider as it looks toward a dQM future. These include:**

- **Timeliness of the data and the reporting—moving from batch transactions measured in months to near real-time;**
- **Facilitating the reuse of data already captured in the EHR, reducing physician and administrative burden; and**
- **Supporting the opportunity for all stakeholders to interoperate at scale.**

Several entities are using or considering FHIR as an approach to develop clinically relevant measures that reduce burden, enhance accuracy, and drive quality improvement. The use of FHIR-based APIs may also allow data verification at hubs such as health information exchanges (HIEs) to a degree not practical for physician offices. HL7's efforts to incorporate clinical quality language (CQL) used to specify dQMs is more precise, provides new options for measure logic, and reduces the opportunity for interpretation errors. Moreover, dQMs allow for preprogrammed packages ready for execution within a digital-ready data environment. dQMs are quicker to disseminate than measures with narrative specification which must be interpreted, programmed, and tested before use.

The AMA has identified several benefits in leveraging FHIR and CQL for digital quality measures. These benefits include:

- Defining quality measures as computable artifacts;
- Automating data collection and quality measure reporting;
- Easing the burden of identifying quality measures applicable to specific patients;
- Facilitating the exchange of gaps in care and quality measures;
- Closing clinical and information gaps prospectively versus retrospectively; and
- Minimizing the burden of manual data abstraction for measure reporting.

However, we stress that CMS must address several fundamental issues prior to moving physicians and other providers to dQM reporting and tying payment and/or quality rating systems to dQM performance. Including that:

- Challenges persist related to level of maturity of FHIR implementation overall. Not all resources are normative/mature; for others, significant work is needed to support dQM use cases;
- Adoption of US CORE profile capabilities by EHR vendors is not yet widespread enough to attempt full migration to FHIR. This is not expected to occur until 2023. CMS should promote alignment between QI CORE and US CORE;
- Digital clinical data are frequently in disparate, non-standard formats. As previously discussed, CMS should incent the use of standardized content;
- Generating the necessary data to support dQM implementation is not practical for most medical practices at this time and readiness is highly variable; and

- Smaller health systems and those serving underserved populations will need resources and technical support. CMS should make supporting these health care facilities a priority.

VI. Organ Acquisition Payment Policies

The AMA requests that CMS complete a thorough analysis of the potential impact of these proposals on patient access to transplantation before determining whether these proposals should be finalized.

The AMA is concerned that these proposals have been put forward at a time when CMS has clearly acknowledged that transplantation is generally the best and most cost-effective treatment option for those with ESRD and is undertaking numerous initiatives focused on increasing the availability of kidney transplantation. While we understand that CMS' stated intention is to reimburse only for organs procured for Medicare patients, this proposal appears to have been put forward without consideration of its potential impact not only on the availability of deceased donor kidneys but on the availability of all other deceased donor organs as well.

CMS estimates that these changes would result in substantial Medicare payment reductions for organ acquisition costs. The most significant proposed change would eliminate a longstanding feature of the payment system under which organs that are procured at a Transplant Center hospital and transplanted at another Transplant Center are "counted" as Medicare organs for the purpose of determining Medicare's portion of organ acquisition costs. This feature of the cost accounting system functions as a strong incentive for Transplant Center hospitals to establish effective programs for the identification of potential deceased organ donors and engage in other organ acquisition-related activities. The incentive has worked: Transplant Centers constitute only four percent of Medicare certified hospitals but retrieve 36 percent of deceased donor organs, and organ donation has been increasing over the last few years.

The precipitous elimination of this feature of the payment system, scheduled to begin as early as October 2021 for some Centers, has the potential to significantly reduce the deceased donor organs available for transplantation, reduce access to transplantation, and increase the number of patients who die while waiting for a transplant. In addition, the proposed policies appear to impose an unreasonable burden on Donor Transplant Centers, which would be required to obtain from Recipient Transplant Centers information regarding the Recipient Centers' non-Medicare third party payer contracts (to confirm Medicare as Secondary Payer liability) and to track recipients' Medicare eligibility determinations, many of which are made retroactively. Some portion of these increased administrative costs may be passed on to the Medicare Program.

CMS does not consider the potential impact on Medicare costs of the potential reduction in access to kidney transplantation and the concomitant increase in Medicare spending for dialysis. Other provisions of the Proposed Rule that bear further scrutiny would preclude Medicare payment for organs transplanted under a research protocol, eliminate Medicare payment for living donor follow up visits, and preclude Medicare payment for transportation of donor organs.

The AMA strongly urges CMS not to move forward with the proposed transplant-related proposals prior to completion of a comprehensive study of the potential impact of the transplant-related proposals on patient access to transplantation and to work closely with stakeholders in conducting this evaluation.

VII. Medicare Shared Savings Program—Proposed Policy Changes

The AMA commends CMS for its proposal to permit a "freeze" for ACOs participating in the BASIC track's glide path, thus allowing them to opt out of the automatic level advancement for 2022. As ACOs continue to grapple with the COVID-19 PHE, expenditures and utilization continue to be difficult to predict and manage, making it more challenging to shift to risk. In light of this uncertainty, the AMA supports the goal of this proposal to allow flexibility for ACOs currently participating in the BASIC track. This is a continuation of the policy finalized by CMS as part of the May 2020 interim final rule with comment period (IFC), allowing ACOs to elect to freeze their participation level for 2021, citing the COVID-19 PHE.

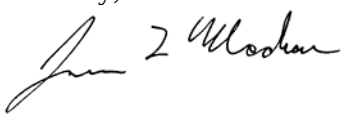
However, while we are supportive of this proposal, we are also concerned that, once 2022 concludes, those ACOs who elect this "freeze" will be placed back on the glide path as if the freeze had not occurred. In other words, this policy creates a cliff for ACOs by requiring those who take a "freeze" to have a dramatic jump in risk the following year. This is contrary to CMS' goal of a gradual increase in risk, which was the intent behind developing the glidepath. Given the highly unusual and challenging circumstances brought on by the COVID-19 pandemic, it would be fair and appropriate to maintain the gradual glidepath for all ACOs, even those that elect the freeze. **Therefore, we urge CMS to augment this proposal to permit those ACOs who elect the "freeze" for 2022 to continue to the next step in the glide path in 2023, rather than fast forwarding to the stage where they would have been had COVID-19 not occurred.**

Additionally, **the AMA is concerned that CMS did not establish a clear timeframe within which ACOs would have to decide whether to freeze or continue their advancement on the glide path.** CMS acknowledged that the annual MSSP change cycle would begin before the proposed rule is finalized, and there will be "limited opportunity to submit a repayment mechanism, resolve any deficiencies, and have it approved in time for the start of the performance year." This is concerning as ACOs will have insufficient time and information to evaluate a decision and notify CMS and **the AMA urges CMS to provide increased time and flexibility for ACOs throughout the application process to enable informed decision-making.**

Conclusion

We greatly appreciate this opportunity to share the views of the AMA regarding the proposals, issues, and questions that CMS has raised in the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Proposed Rule. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



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