AMA
AMERICAN MEDICAL ASSOCIATION

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June 9, 2023

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: File Code CMS–1785–P. Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

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 2024 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS) published in the *Federal Register* on May 1, 2023 (88 Fed. Reg. 26658).

Executive Summary

- The AMA opposes increasing the length of the electronic health record (EHR) reporting period for eligible hospitals and Critical Access Hospitals (CAHs) and urges CMS to utilize the proposed EHR Insights Condition and Maintenance of Certification Reporting Program by the Office of the National Coordinator for Health Information Technology (ONC) to monitor interoperability and health information exchange.
- The AMA recommends collaboration between CMS and ONC to update the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides), engage stakeholders, and undertake an education campaign to disseminate information tailored to providers of all sizes.
- The AMA opposes the proposed restrictions on physician-owned hospitals (POHs) and urges CMS to reconsider these proposals and instead support the vital role of POHs in enhancing health care delivery, fostering innovation, and ensuring equitable access to high-quality care for all patients.
- The AMA acknowledges the importance of safety net hospitals (SNHs) in preserving and expanding access to care for vulnerable patient populations. The AMA supports policies that ensure adequate reimbursement levels, address the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, and that DSH and uncompensated care (UCC) payments should be based on actual data.

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- The AMA recommends a multi-faceted definition of SNHs that considers payer composition, the hospital's role within the community, and neighborhood context.
- The AMA supports the proposed changes to Graduate Medical Education (GME) payments for Rural Emergency Hospitals (REHs) and urges CMS to address the ongoing challenges associated with funding for non-physician training to preserve adequate physician training opportunities and further urges CMS to implement safeguards to ensure accurate updates to GME funding in the future.
- The AMA supports the inclusion of patients with a primary psychiatric diagnosis in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and emphasizes the need for robust testing to capture their perspectives effectively. The AMA also has concerns about the exclusion of psychiatric patients and the experience of patients in the emergency department (ED) and suggests the inclusion of these populations to obtain a comprehensive understanding of patient satisfaction.
- The AMA supports the concept of adding a Health Equity Adjustment (HEA) to the Hospital Value-Based Purchasing (HVBP) Program scoring methodology but recommends improvements to the methodology considering the size of the hospital's budget relative to uncompensated care, creating separate calculations for distinct types of safety net hospitals, and incorporating socioeconomic indices and racial segregation in the formula.
- The AMA urges CMS to assess patient-level data beyond the designated focus population, considering linear scoring functions or actual scoring for underserved multipliers, and exploring alternative approaches to address health care disparities and advance health equity.
- The AMA recommends enhancements to the weighting and scoring methods of the Hospital-Acquired Conditions (HAC) Reduction Program to better assess hospital performance and ensure equity in payment assessments. The AMA urges CMS to promote routine disaggregation of data to track disparities and progress in addressing them and recommend adopting system responses that directly address variations in quality of care received by different groups.
- The AMA recommends focusing on meaningful HAC and harm measures in the Inpatient Quality Reporting (IQR) program that truly distinguish hospital performance and are useful for a payment program.
- The AMA urges CMS to re-evaluate the CMS PSI 90 measure (CBE 0531), which assesses potentially preventable complications and adverse events.
- The AMA has concerns about the usefulness of certain measures of the IQR Program and supports the removal of measures that are duplicative.
- The AMA supports the inclusion of the Geriatrics measures to enhance care for older patients.

Please see our detailed comments below on the following topics:

I. Promoting Interoperability Program
II. Physician Self-Referral and Physician-Owned Hospitals
III. Safety Net Hospitals (SNH) - Request for Information
IV. Proposed Payments for Indirect and Direct Graduate Medical Education (GME) Costs: Training in New Rural Emergency Hospital (REH) Facility Type
V. Hospital Value-Based Purchasing (HVBP) Program: Updates
VI. Proposed Updates to the HCAHPS Survey Measure (CBE #0166)
VII. Hospital-Acquired Conditions (HAC) Reduction Program - Request for Comment: Advancing Patient Safety
VIII. Hospital Inpatient Quality Reporting (IQR) Program

I. Promoting Interoperability Program

Length of EHR Reporting Period

The AMA supports broader interoperability and health information exchange efforts. However, the AMA believes that the benefits of increasing the length of the Promoting Interoperability Program (PIP) EHR reporting period in future rulemaking would be negligible and only serve to increase the burden on eligible hospitals and CAHs. Such a change from CMS would not result in more robust information collection, and as such, **the AMA would not support CMS increasing the length of the PIP reporting program.**

As the Agency discusses in the Proposed Regulation, data from the Office of the National Coordinator for Health Information Technology (ONC) indicates that 96 percent of non-federal acute care hospitals (most of which are eligible hospitals or CAHs) have adopted certified EHR technology (CEHRT)—demonstrating that a longer reporting period would only serve to increase reporting burden. CEHRT is fully integrated in nearly all clinical workflows and processes at eligible hospitals and CAHs and is undergoing near constant use. The PIP was established to incentivize the adoption, implementation, and demonstration of meaningful use of CEHRT and has clearly met its goals, so increasing the length of the EHR reporting period would provide little benefit to acute care hospitals, CAHs, or CMS.

If CMS' desire is to extend the EHR reporting period to better identify areas that may require investigation and corrective action for the continued improvement of interoperability and health information exchange, then CMS should consider leveraging ONC's proposed—and likely to be finalized—EHR Insights Condition and Maintenance of Certification Reporting Program. ONC intends to require and capture information use, integration, and exchange metrics from all certified EHRs and establish benchmarks to show progress, gaps, and opportunities for health IT improvement. Rather than needlessly extending the PIP reporting period and burdening eligible hospitals, CAHs, and their physicians, CMS should consider leveraging EHR vendor reporting as a gauge to monitor actual EHR-EHR system interoperability.

Annual SAFER Guides Self-Assessment

The AMA sees little benefit in CMS modifying the requirements around the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) beginning in CY 2024 to require eligible hospitals and CAHs to attest "yes" to having conducted an annual self-assessment using all nine Guides. While the AMA agrees that implementing safety practices for planned or unplanned EHR downtime is important, the SAFER Guides have not gone through a comprehensive review and update process since 2016—calling into question whether their content remains relevant. Additionally, requiring this type of annual assessment of all nine guides would place significant burden on acute care hospitals and CAHs, particularly those with limited resources—all while they are simultaneously trying to comply with other technology upgrade requirements.

The AMA does not support CMS' proposal to require a "yes" attestation to having completed an annual assessment of the nine SAFER Guides. Instead**,** CMS should work with ONC to engage in an update of the guides, informed by stakeholder input, and undertake an education and awareness campaign to disseminate information to the field, including information specifically tailored to all kinds of providers, including small and medium-sized providers that may not have adequate resources to address EHR safety.

II. Physician Self-Referral and Physician-Owned Hospitals

The AMA appreciates the opportunity to provide comments on physician-owned hospitals (POHs). CMS proposes to reinstate restrictions on POHs that qualify as high Medicaid facilities and wishes to seek exceptions to the prohibition on expanding facility capacity. In addition, the Agency proposes to expand its authority regarding approval of exceptions to the prohibition on expanding facility capacity and to increase the type of relevant community input, as well as to double the length of the community input period. **In short, the AMA strongly opposes the proposals to revoke the flexibilities for POHs serving greater numbers of Medicaid patients, to increase the Agency's regulatory authority to grant or deny exceptions to expansion, and to expand the scope of community input. The AMA believes these proposals limit the capacity of POHs to increase competition and choice in communities throughout the country, and, more significantly, limit patients' access to high-quality care.**

The AMA believes that POHs provide high quality care to patients and provide needed competition in hospital markets. The AMA supports competition between health care providers and facilities as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access. Given CMS provides a one-sided rationale to support its proposals restricting POHs, the AMA believes it is essential to begin our comments by highlighting the many benefits of POHs—their high performance on quality and efficiency, value to the community, promising role in new delivery and payment models, and increased competition.

Benefits of Physician-Owned Hospitals

The High Performance of POHs

CMS studied physician-owned specialty hospitals and found a number of factors account for their high performance.[1] They include specialization (POHs are typically single specialty organizations), improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership.[2] For example, POH staff have the ability to focus on a limited number of procedures and diseases. Nurses do not have to be pulled to different types of inpatient wards to care for patients with a broad range of clinical problems. Clayton M. Christensen, a noted Harvard scholar on disruption in industry, has observed that the hospital industry is the only industry worldwide where the factory (a hospital) is not specialized. He projects that specialty hospitals could reduce costs for hospitalizations by 15 to 20 percent and is the disruptive solution for health care.[3]

Perhaps the most essential POH efficiency identified by CMS is created by physician ownership itself:

> In our site visits, staff at specialty hospitals described the physician owners as being very involved in every aspect of patient care. The physicians monitored patient satisfaction data, established a culture that focused on patient satisfaction and were viewed by the staff as being very approachable and amenable to suggestions that would improve care processes.[4]

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[1] *See e.g.,* Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (2005) (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.

[2] *Id.*

[3] *See The Innovators Prescription: A Disruptive Solution for Healthcare*, Christiansen et al. McGraw-Hill (2008).

[4] *See* CMS report, *supra* note 1, at 50.

These CMS observations are consistent with the field of organizational economics that has long recognized that the performance of an organization may critically depend on who owns it. As explained in *Economics of Strategy*, ownership can affect critical incentives to invest in the future of the organization.[5]

In sum, physician ownership represents an important alternative that provides a different, potentially superior, opportunity to create efficiencies in the provision of health care.

Vertical Integration and Promising Role for POH in Alternative Delivery and Payment Models

Lifting the ban on POHs could also allow physicians to acquire hospitals and better enable them to implement alternative delivery and payment models in an effort to control hospital costs and supervise the overall health care product. The existing hospital systems have responded to the call for accountable care organizations (ACOs), bundled payments, and other forms of value purchasing by vertically integrating with physician practices.[6] Why not allow the flip-side—an alternative to the existing hospital-dominated integration by permitting physicians to acquire hospitals and to compete as vertically integrated systems delivering an overall health care product? Such vertical integration has the capacity to create efficiencies that benefit competition and consumers. Benefits of vertical integration between physicians and hospitals include clinical information sharing, less duplication of services and better coordination of care. Kaiser Permanente and Mayo Clinic are examples of vertically integrated systems that provide high quality and efficient care. Even assuming for the sake of argument and contrary to the evidence,[7] the unfounded concerns of alleged harms such as self-referral that is not good for patients, would need to be weighed against the benefits. This is the manner in which antitrust agencies and the courts assess announced vertical mergers; they would apply the same approach to a physician acquisition of a hospital, were it not for the ban. Antitrust agencies and courts also consider the potential benefits. A ban on POHs is the wrong policy prescription to address such concerns, for such a blanket approach eliminates entirely the benefits that may be realized.

Expanded POHs Would Increase Competition in Hospital Markets

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[8] This is partly the result of significant consolidation occurring in hospital markets around the country.[9] Many markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[10] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care "megaproviders."[11] They found that in markets "where megaproviders dominate…, health care spending is higher, often much

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[5] Besanko, D. et al., 2013 *Economics of Strategy, 6th Edition. Chapter 4. New York: Wiley.*
[6] Synthesis Project, *infra* note 19, at 6.
[7] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong., at page 6 (May 19, 2021) (Martin Gaynor, *Antitrust Applied*).
[8] *Id.,* at page 2.
[9] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/. (Accessed March 16, 2023), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).
[10] Martin Gaynor, *Antitrust Applied*, at 2.
[11] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021).

higher, and health care quality is no better, and sometimes lower."[12] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[13] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[14] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[15]

Increased levels of hospital market concentration are shown to lead to increased health care costs. One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[16] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[17] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[18] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[19] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[20] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[21] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[22]

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets has a role to play in reducing the growth of disparities in health care access. For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[23] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[24] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

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[12] Dranove, *supra,* at 178.

[13] Martin Gaynor, *Antitrust Applied*, at 5.

[14] Dranove, *supra,* at 178.

[15] Dranove, *supra,* at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.

[16] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.

[17] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages,* RAND Corporation, 3 (2020).

[18] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[19] Martin Gaynor, *Antitrust Applied*, at 4.

[20] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 International Journal of the Economics of Business 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems,* 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.

[21] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed May 13, 2023), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/.

[22] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service,* 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

[23] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?,* 115 Q J Econ. 2, 577 (2000).

[24] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. In their new book, Professors David Dranove and Lawton R. Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[25] The antitrust response has been inadequate notwithstanding the significant resources dedicated to restoring competition in health care markets. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[26] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot even enforce against anticompetitive conduct by not-for-profits; this presents a significant problem, considering how many hospitals are run as not-for-profits.[27] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the U.S. requires new remedies. While Congress must act to repeal the ban on POHs, CMS must refrain from finalizing its proposals and erecting anti-competitive barriers to expansion of existing POHs.

High Medicaid Facilities

Sections 6001 and 10601 of the Patient Protection and Affordable Care Act (ACA) and section 1106 of the Health Care and Education Reconciliation Act of 2010 (HCERA) prohibit the establishment of new physician owned hospitals and restrict the ability of those existing as of March 23, 2010, to expand. Specifically, Congress modified the "whole hospital exception" of the Stark Law in three ways, adding (a) limits on the growth of POHs in the medical marketplace, (b) requirements to disclose investment terms and investor identities, and (c) requirements to provide emergency services.[28] Although the law does allow community POHs limited expansion if they are in an underserved area, approved by CMS, and qualify as a "high Medicaid facility"[29] or an Applicable Hospital,[30] it is our understanding that only seven hospitals nationwide have been granted one of the two exceptions to-date.[31] The resulting impact of these provisions we believe has been limiting competition, job growth, and patient choice.

Recognizing the need to increase access to health care for Medicaid beneficiaries, Congress in drafting the ACA, chose not to impose certain additional restrictions on "high Medicaid facilities" that it did apply to hospitals qualifying as an "Applicable Hospital." Despite Congress intentionally exempting high Medicaid facilities from these additional restrictions, CMS had imposed, through rulemaking, these additional restrictions on high Medicaid facilities causing unnecessary regulatory burden. In the 2021 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule, CMS fixed this error and removed these restrictions from physician-owned high Medicaid facilities. The AMA strongly supported lifting these restrictions on POHs to widen access to care.

Now, CMS proposes to reverse itself and to reinstate restrictions regarding the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity for hospitals that meet the criteria for a high Medicaid facility. **The AMA strongly opposes these proposals that will restrict POHs and shrink access to care, especially for Medicaid patients.**

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[25] Dranove, supra, at 178.
[26] Martin Gaynor, *Antitrust Applied*, at 17.
[27] Martin Gaynor, *Antitrust Applied*, at 18.
[28] 42 United States Code (U.S.C.) §1395nn(d)(3)(c).
[29] 42 U.S.C. §1395nn(i)(3)(F).
[30] 42 U.S.C. §1395nn(i)(3)(E).
[31] https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals

In the 2021 OPPS/ASC final rule, in addition to citing its Patients Over Paperwork initiative to reduce unnecessary regulatory burden, CMS appropriately cited the plain language of the statute in support of its decision to reverse the restrictions on the expansion of high Medicaid facilities. We agree that Congress intentionally exempted high Medicaid facilities from these additional restrictions as qualifying POHs serve an important role in ensuring Medicaid beneficiaries have access to high-quality care. The Administration has pledged to strengthen the Medicaid program and has recently announced a plan to expand Medicaid and Affordable Care Act coverage to Deferred Action for Childhood Arrivals (DACA) recipients.[32] POHs stand ready to assist this Administration in meeting its objectives of strengthening Medicaid by providing access to care for its beneficiaries. However, should CMS finalize its proposal to reinstate the restrictions on high Medicaid facilities, POHs will be even more thwarted in their ability to serve Medicaid patients and assist the Administration in achieving its goals.

In this proposed rule, CMS' rationale for reversing its decision in the 2021 OPPS/ASC final rule and contravening the plain language of the statute is that it is concerned about program integrity and wants to treat all POHs the same when reviewing exception requests. We wish to debunk the "cherry-picking" and "self-referral" fallacies cited as CMS' program integrity concerns.

Opponents of POHs point out that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" conduct that they ascribe to the physician owners. CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[33] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[34]

CMS found that while patients treated in general hospitals are more severely ill than those treated in specialty hospitals, this was true both for patients admitted by physicians with ownership in specialty hospitals and by other physicians without such ownership. That is, CMS' analysis found no difference in referral patterns to general hospitals between physician owners and non-owners. CMS concluded that the lower severity levels seen in specialty hospitals "may be an indicator of quality in the sense that it shows that the hospital has focused on a particular type of patient. A hospital that accepts patients that it cannot properly treat may not exhibit good quality healthcare."[35]

If in 2005, when CMS conducted its comprehensive POH study there was no evidence of physician abusive referral practices for financial gain, there should be even less likelihood of abusive referrals today when reimbursement practices are transitioning from fee-for-service to value-based methods. Physicians operating POHs and competing with established general hospitals are constrained from over utilizing by the new value-based payment programs. In fact, new economic research also finds strong evidence *against* cherry-picking.[36]

Clearly, the advantages of POHs should not be lost to the unsubstantiated fears of "cherry picking" or self-referral. This is especially true presently when new entry into many hospital markets is critical to their competitiveness and when alternative delivery and payment models requiring physicians to control hospital costs are the order of the day.

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[32] https://www.whitehouse.gov/briefing-room/statements-releases/2023/04/13/fact-sheet-fact-sheet-president-biden-announces-plan-to-expand-health-coverage-to-daca-recipients.

[33] CMS Report, *supra* note 1, at 26.

[34] *Id.*

[35] *Id.* at 61.

[36] Ashley Swanson. *Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care.* 80 J Health Econ. (2021).

CMS' second rationale is also flawed as Congress recognized these two types of POH—applicable hospitals and high Medicaid facilities—as distinct. Further, CMS cites a desire to treat all POHs consistently in its review process. To our knowledge, there have been only seven POHs that have sought an expansion request since 2010. This poses the question of whether such a problem—inconsistency in reviewing exception requests—could possibly exist. The AMA believes that the potential benefit of expanding high Medicaid facilities to provide care to the growing Medicaid population, coupled with the fact that fewer than 10 exception requests have been submitted to CMS, far outweighs any concern about inconsistency in the review process.

Process for Requesting an Exception from the Prohibition on Expansion of Facility Capacity

CMS proposes to drastically expand its authority to deny facility expansion requests even if they meet the statutory requirements for an applicable hospital or high Medicaid facility. The Agency believes that meeting the statutory criteria is a minimum requirement—necessary but not sufficient. In deciding whether to approve or deny an expansion exception request, CMS would consider data and information provided by the hospital, community input, and other factors, including:

1. the specialty (for example, maternity, psychiatric, or substance use disorder care) of the hospital or the services furnished by or to be furnished by the hospital if CMS approves the request;
2. program integrity or quality of care concerns related to the hospital;
3. whether the hospital has a need for additional operating rooms, procedure rooms, or beds; and
4. whether there is a need for additional operating rooms, procedure rooms, or beds in the county in which the main campus of the hospital is located, any county in which the hospital provides inpatient or outpatient hospital services as of the date the hospital submits the expansion exception request, or any county in which the hospital plans to provide inpatient or outpatient hospital services if CMS approves the request.

As discussed above, POHs offer numerous benefits to patients and their communities, which stem from physician entrepreneurship and governance of the clinical encounter, responsiveness to the needs to their communities, and competition with incumbent hospitals. Despite these advantages, only seven POHs have been able to expand under the stringent criteria laid out by Congress for applicable hospitals and high Medicaid facilities. It is unclear why CMS feels it is necessary to create additional bureaucratic obstacles to expansion of qualifying facilities, other than to stifle competition and further obscure POHs.

A 2018 report released by HHS in partnership with the Departments of the Treasury and Labor, the Federal Trade Commission, and the White House, titled *Reforming America's Healthcare System Through Choice and Competition*, noted that the costly statutory restrictions on POHs were enacted at the behest of general hospital interests to address alleged potential financial conflicts of interest with physicians referring patients to their own hospitals (so-called "self-referral") and concerns that physicians may be referring the healthiest patients to their own hospitals (so-called "cherry picking").[37] While we more fully addressed those erroneous concerns above, we note here that the HHS Report concludes that "those concerns may have been overstated, considering that many studies suggest physician-owned hospitals provide higher quality care and that patients benefit when traditional hospitals have greater competition."[38]

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[37] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf. (See PDF page 73-74)
[38] *Id.*

The HHS Report goes on to state that, "[A]ccording to a study published by the *Journal of the American College of Surgeons*, physician-owned surgical hospitals outperform other hospitals in the Medicare value-based purchasing program. More than 40 percent of physician-owned hospitals received the top 5-star rating in a 2015 release by the CMS, compared to only five percent of general hospitals. Further, patients are 3-to-5 times less likely to experience complications at a physician-owned specialty hospital than at a general hospital."[39] These recent quality studies confirm older studies, including an exhaustive one performed by CMS, finding that physician owned hospitals achieve higher quality of care, greater patient satisfaction, reduced costs, and improved infection rates.[40]

The AMA does not believe that additional regulatory restrictions on POHs serve the Medicare or Medicaid programs because they limit patient choice and patient access to high-quality, efficient care. **Therefore, we oppose CMS' proposals to expand its regulatory authority to deny expansion exception requests despite meeting the statutory criteria.**

Community Input

CMS proposes substantial expansions to the community input opportunity. First, CMS proposes to request individuals and entities in the community to provide input regarding not only whether the hospital is eligible to request an expansion exception but also whether CMS should approve or deny the expansion exception request. Second, CMS proposes to require the requesting hospital provide actual notification that it is requesting an expansion exception directly to hospitals in the community. Third, CMS also proposes to double the length of the period for community input from 30 to 60 days. Finally, the Agency seeks comment regarding whether to extend the current 30-day period for the requesting hospital to submit a rebuttal statement.

Section 1877(i)(3)(A)(ii) of the Social Security Act (the Act) requires CMS to provide an opportunity for community input when an applicable hospital applies for an exception to the prohibition on expansion of facility capacity. However, the statute does not expressly require CMS to furnish an opportunity for community input when a high Medicaid facility has applied for such an exception. Despite the AMA's support for eliminating the community input opportunity for requests by high Medicaid facilities, CMS maintained this requirement as previously established by regulation. The AMA wishes to reiterate our opposition to the community input opportunity for high Medicaid facilities and our concerns about the Agency's proposals to drastically broaden the community input opportunity for all POH expansion applications.

Obtaining independent confirmation of the data furnished by applicable hospitals and high Medicaid facilities delays, hinders, and unnecessarily complicates the review process. As discussed above, studies show that POHs provide their communities with significant benefits, including higher quality care at a lower cost. In addition, a CMS study comparing the community benefits of physician-owned specialty hospitals with community general hospitals found that the total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care. Accordingly, the study concluded that the physician-owned specialty hospitals exhibited higher levels of net community benefits.[41]

Further, we strongly oppose expansion of the community input opportunity to allow competitors in the market to comment regarding whether an application for expansion should be approved or denied. As

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[39] *Id.*
[40] *See* CMS Report, *supra* note 1.
[41] CMS Report, *supra* note 1, at 63.

discussed above, we do not believe that CMS has the authority to deny eligible expansion requests. In addition, we believe that this proposal would create substantial obstacles to expansion that Congress did not intend and would establish a requirement akin to a federal certificate of need (CON). There is little evidence to suggest that state CON laws are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, AMA policy opposes CON laws and the extension of CON laws to physician-owned hospitals, ASCs, or private physician practices. Instead, CON laws serve to stifle competition by erecting barriers to entry.

Therefore, the AMA urges CMS to eliminate the community input opportunity for requests by high Medicaid facilities and not to finalize its proposals to expand the community input opportunity for requests by applicable hospitals. At a minimum, CMS must expand the period for the requesting hospital to submit a rebuttal statement from the current 30 days to 60 days.

III. Safety Net Hospitals (SNH) - Request for Information

The AMA appreciates CMS issuing this request for information (RFI) on this important topic. Our AMA believes health care is a human right and believes that as professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. Accordingly, we strongly support policies that preserve and expand access to care, particularly among vulnerable patient populations.

We support payment changes to achieve adequate payment levels that more accurately reflect the total cost of care that would eliminate the need for cross-subsidization across payers. More specifically, the AMA supports addressing the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients and supports an approach to DSH and uncompensated care (UCC) payments that is based on actual uncompensated care data.

Like CMS, the AMA believes that supporting safety net hospitals (SNHs) is also a critical component of advancing health equity, which the AMA remains committed to advancing by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

The AMA offers the following detailed responses to specific questions posed in the RFI below and looks forward to continuing to collaborate with CMS on this important topic as policies evolve.

What challenges face safety net hospitals (SNHs)?

SNHs face myriad challenges that force them to experience greater financial instability. SNHs treat higher proportions of Medicaid, CHIP, Medicare, and other publicly insured patients, which all typically reimburse at lower rates than commercial insurance. In addition, SNHs shoulder a greater burden of uncompensated care for uninsured populations.

In addition to being paid at lower levels (or not at all), these patient populations tend to have more complex health needs, as well as social factors that can negatively impact their overall health and make them more costly to treat. For example, lower income patients disproportionately experience housing and food insecurity issues or may lack access to reliable transportation, inhibiting their ability to pick up prescribed medications or attend follow-up visits, contributing to worse health outcomes.

Tighter margins can make it difficult for SNHs to compete with more lucrative hospitals for care staff amid consistent and growing workforce challenges, leading to staff shortages that can compromise the quality of care delivered. Unfortunately, the problem is only expected to get worse. One analysis estimates an expected shortage of 3.2 million health care workers by 2026.[42] The increased pressure to recruit and retain staff has also increased labor expenses for hospitals nation-wide,[43,44] making already thin margins even tighter for SNHs.

Due to the combined weight of these increased financial pressures, SNHs face a greater risk of closure, which means already vulnerable patient populations must travel even further for their care and puts increased pressure on neighboring health care facilities.

What are particular challenges facing rural safety-net hospitals?

Many of the aforementioned challenges are particularly acute in rural areas. To start, rural hospitals are at particular risk of closure, which can further exacerbate existing workforce and access issues. According to the U.S. Government Accountability Office (GAO), 101 rural hospitals closed in the U.S. between 2013 and 2020. When rural hospitals closed, people living in areas who received health care from them had to travel farther to get the same health care services—about 20 miles farther for common services like inpatient care. This problem was even more acute for specialized, but equally critical services like substance use disorder treatment and obstetric services. The percent of rural counties in the U.S. without hospital obstetric services increased from 46 percent in 2004 to 55 percent in 2014.[45] These access issues can be further exacerbated by broadband access challenges which can inhibit rural patients' ability to utilize telehealth services.

In addition to being more susceptible to physician shortages and longer travel times to medical care, these same rural communities also face higher rates of extreme poverty and a lack of physical and cultural amenities that can make it more difficult to maintain a healthy lifestyle as compared to more urban populations.[46] Rural populations can also be more susceptible to increased environmental exposures such as runoff from factory farms or mining operations. Importantly, more than 15 percent of rural residents are members of racial/ethnic minoritized groups, and this percentage is growing.[47]

Our AMA recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities and is committed to advancing policies that work to preserve access to community hospitals and rural primary care hospitals while maintaining high quality patient care**.**

What are the patient demographics of safety-net hospitals?

It is now well established that patient populations of SNHs disproportionately experience a number of

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[42] https://www.mercer.us/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf.
[43] https://www.kaufmanhall.com/sites/default/files/2021-09/national-hospital-flash-report_sept.-2021_final.pdf.
[44] https://www.aha.org/fact-sheets/2021-11-01-data-brief-health-care-workforce-challenges-threaten-hospitals-ability-care.
[45] http://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf.
[46] www.grahamcenter.org/rgc/publications-reports/publications/one-pagers/workforce-rural-2005.html.
[47] https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/n21_cme_03_annotated.pdf.

social determinants that can negatively impact their health.[48,49,50] Among other factors, these populations tend to have lower incomes, lack access to nutritious food and physical fitness options, and are more likely to experience housing instability. They also often lack access to reliable transportation, internet, and work physically demanding jobs with long hours and/or have unpaid caretaking responsibilities, all of which can make it difficult to make medical appointments (including telehealth visits) or pick up medications. SNH populations also tend to have a high prevalence of comorbidities including chronic disease, mobility issues, physical and mental health comorbidities, as well as substance use disorder, as well as suffer from repeated trauma as well as exposure to racism, discrimination, and violence. They suffer from disproportionate exposure to air and water pollutants and other environmentally hazardous conditions. These populations are also often historically minoritized communities facing additional language and/or health literacy barriers as well as a lack of family or community support and engagement.

What challenges do patients of SNHs face before and after receiving care at the hospital?

Lack of access to transportation can impact patients' abilities to seek medical care leading up to hospital visits, as well as follow-up care or picking up prescribed medications. Copays for visits and medications can also be a substantial barrier to receiving necessary follow-up care. Lack of caregiver support, as well as linguistic, cultural, accessibility, or health literacy-related barriers can prevent patients from fully understanding or executing on their prescribed treatment plan. Improved care coordination and patient-specific education before discharge specifically with known barriers in mind, including connecting patients and caregivers with any relevant support services, can vastly improve adherence to recommended follow-up care and improve care outcomes during care transitions, preventing future hospitalizations. These types of proven, low-cost interventions have real potential to meaningfully improve patient outcomes, improve access, and address equity.[51] However, this additional time required from physicians and care team members needs to be appropriately compensated. Safety net hospitals cannot continue to be expected to do more with less.

How should safety-net hospitals be identified or defined?

The AMA believes that adopting a multi-faceted definition that recognizes not only payer composition, but also the hospital's unique role within a community, as well as the neighborhood or community context itself, all play an important role in defining what it means to be a safety net hospital.[52] The AMA appreciates that the proportion of uninsured, Medicaid, dually eligible Medicaid-Medicare beneficiaries, LIS beneficiaries, and Medicare patients can play an important role in identifying which hospitals are under unique financial burden or otherwise bear a disproportionate burden of caring for indigent patient populations. In addition to these and other payer mix elements, we believe it is important that CMS take into consideration important neighborhood and community-level access-related factors such as rural status, whether the hospital is located within a medically underserved area, Indian Health Service or tribal status, number of patients served by that hospital, proximity to neighboring hospitals, as well as whether the hospital is a sole provider of certain core services including (but not limited to) burn or trauma units, neonatal care units, inpatient psychiatric and substance use disorder treatment services, and whether a hospital is a teaching hospital or academic medical center. Equally important, we urge CMS to consider important social, cultural, and

[48] https://health.gov/healthypeople/priority-areas/social-determinants-health.
[49] https://health.gov/healthypeople/priority-areas/social-determinants-health.
[50] https://www.cdc.gov/about/sdoh/index.html.
[51] https://www.ncbi.nlm.nih.gov/books/NBK555516/.
[52] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9081065/.

environmental factors of the local community such as income, employment, housing, and neighborhood history of violence or trauma. Ideally, this information should be evaluated at the zip code or even neighborhood level.

Should SNHs' reporting burden and compensation be different than other hospitals?

The AMA believes it is important to properly account for social risk factors so that quality reporting programs do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities. However, the AMA also recognizes that complying with existing quality reporting programs along with other administrative tasks already absorbs an exorbitant amount of clinical and administrative staff hours per week and is a significant contributor to the high cost of health care in this country.[53] Every dollar directed towards administrative tasks such as complying with quality reporting programs is a dollar pulled from direct patient care and support, which is even more critical to SNHs that operate on tighter margins.

Accordingly, the AMA recommends CMS positively incentivize the collection of social determinants of health and other demographic data through direct financial compensation. Importantly, this would incentivize the collection of this important demographic information that could be used to further advance health equity and improve care for vulnerable patient populations while injecting much-needed resources directly to safety net institutions. It is very important that physicians not be financially penalized for not reporting this data without additional compensation. Finalizing such a policy would force safety net hospitals to perform even more administrative tasks without compensation, pulling even more resources from direct patient care and causing them to fall even further behind. CMS should also look for ways to automate social and demographic data whenever possible. As CMS looks to potentially reform data collection for SNHs, we urge the Agency to consider the set of principles to use data to support health equity that was developed by the Health IT End Users Alliance, in which the AMA participates.

Are there ways to reform payments for SNHs that would also support hospital patients that need financial assistance?

Streamlining financial and quality reporting requirements on SNHs would significantly lower their administrative costs, which could translate into lower costs for patients and allow SNHs to invest in other important areas including shoring up staffing capacity, investing in new technologies, or investing in targeted care interventions or patient support staff. CMS could also consider providing direct funding support to SNHs for high-value patient support staff such as care coordinators or financial navigators so vulnerable patient populations would have access to these services without SNHs having to pull from other areas to pay for them.

What challenges do safety-net hospitals face around investments in information technology infrastructure? How can HHS advance more robust investments in infrastructure for SNHs?

EHR and other practice management technology solutions can have important benefits for treating individual patients, as well as improving health of general or more targeted patient populations. For example, EHRs can help health systems monitor quality, cost and outcome metrics and identify trends for possible intervention and improvement. Physicians can also leverage technology to enhance their treatment plans by quickly cross-referencing the most updated medical literature available based on

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[53] https://www.healthaffairs.org/do/10.1377/hpb20220909.830296/#:~:text=Administrative%20spending%20accounts%20for%2015,of%20administrative%20spending%20is%20wasteful.

specific biological factors or comorbidities of a particular patient.

Unfortunately, thinner operating margins mean SNHs have to carefully prioritize where to spend limited funds, and when fixed costs like staffing increase, this directly eats into budgets for other important but more flexible spending categories, such as investing in new technologies, which often come at substantial up-front costs. Over the long term, this means that SNHs and other hospitals are competing to deliver the same care standards with fewer resources, despite serving patient populations with some of the largest challenges that would arguably stand to benefit the most from targeted interventions.

CMS could help to address this by assisting safety net practices with the upfront costs of approved technologies or providing additional grants or other opportunities toward the use of innovative technology projects. CMS could also serve as a conduit for helping safety net institutions secure cost-effective products at reasonable contract rates.

IV. Proposed Payments for Indirect and Direct Graduate Medical Education (GME) Costs: Training in New Rural Emergency Hospital (REH) Facility Type

CMS is proposing to allow an REH to be considered a non-provider site so that a hospital can include full-time equivalent (FTE) residents training at the REH towards direct GME and indirect medical education (IME) FTE counts for Medicare payment purposes. Alternatively, the REH may decide to be paid based on a reasonable cost basis for the GME training that they provide.

Currently, REHs are considered a “provider of services.” However, they are not considered a “hospital” as defined by section 1861(e) of the Act. Nevertheless, hospitals may count residents training in “non-provider” sites for purposes of direct graduate medical education (DGME) and IME payment if the resident is engaged in patient care activities and the hospital incurs the costs of the resident salaries and benefits while the resident is training in the non-provider site. As such, CMS is now proposing to allow hospitals to count training time at REHs if the hospitals meet the non-provider site requirements. In the alternative, CMS is proposing to allow REHs to incur the costs of the resident training upfront and be reimbursed for 100 percent of the reasonable training costs that were incurred.

The AMA applauds this proposal. It is important to allow residents to have as many experiences as possible while they are training. Moreover, it is critically important that REHs are adequately staffed considering the important role that they play in rural communities. As long as the rotations at REHs meet the requirements set out by the Accreditation Council for Graduate Medical Education (ACGME), thereby ensuring that residents are still receiving the high-quality education they deserve, the AMA supports the expansion of considering REHs as non-provider sites for purposes of GME training and payment.

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Per the reasonable cost payment methodology, a hospital is paid Medicare’s share of its reasonable costs for GME related expenses including Medicare Advantage (MA) utilization for nursing and allied health education payments. These MA utilization payments for nursing and allied health professionals are funded through a reduction in payments made to teaching hospitals for DGME and are supposed to be capped at $60 million per year.

CMS is supposed to recalculate each hospital’s share of nursing and allied health professional GME costs as a proportion of total GME costs annually using cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year. Unfortunately, instead of adhering to the yearly required payment

calculation update, CMS relied on a change request and did not update the nursing and allied health education MA payments for more than 17 years. As a result, MACs continued to make payments based on data from 2003. This inexcusably long 17-year delay in updating the data resulted in systematic overpayments to nursing and allied health education and underpayments to MA DGME. During this 17-year period MA DGME payments were being offset by over 14 percent.

In this proposed rule, CMS looks to correct for this massive and systematic error by instructing the Medicare Administrative Contractors (MACs) to recalculate the hospital MA payment total for nursing and allied health education for 2010 through 2019 and reconcile them with any prior amounts already paid or recouped from the hospital. Amounts previously recouped will be returned to hospitals, and recoupments that would have occurred if not for the enactment of Section 4143 of the CAA 2023 will not occur.

For 17 years, this systematic underpayment of MA DGME programs directly resulted in hospital training programs across the country being unable to train more physicians, contributing to growing physician shortages. We as a nation will continue to feel the devastating long-term effects of this for years to come.

The AMA believes that no money should be siphoned away from DGME funding to pay for non-physician training. The $60 million that is taken away from DGME funding every year results in significantly fewer physicians being trained each year. **Though we appreciate the role that non-physician providers play, they should have their own funding source separate from GME funding.**

While the AMA appreciates that CMS is now working to retroactively fix the update this time, we remain concerned that the rule does not contain proposals to ensure this problem does not occur again in the future and recommend CMS put robust guardrails in place to ensure that GME funding updates are made accurately every year moving forward.

V. Hospital Value-Based Purchasing (HVBP) Program: Updates

In the 2024 IPPS proposed rule, CMS proposes to substantively modify two existing measures. The AMA offers the following measure specific comments:

Medicare Spending per Beneficiary (MSB) - Hospital Measure

The AMA does not support the inclusion of this updated measure in the program. We continue to believe that the current risk adjustment model is not adequate due to the unadjusted and adjusted R-squared results ranging from 0.11 to 0.67 across the Major Diagnostic Categories, nor is the measure adequately tested and adjusted for social risk factors. It is unclear to the AMA why the developer would test social risk factors after adjusting for clinical risk factors rather than assessing the impact of both clinical and social risk factors in the model at the same time. These variations in how risk adjustment factors are examined could also impact how each variable (clinical or social) performs in the model and remain unanswered. In addition, we note that in the information submitted to the National Quality Forum (NQF) during the recent endorsement maintenance review, hospitals' measure scores shifted when some or all the social risk factors were applied within the risk model and particularly just over 15 percent of safety-net hospitals moved above or below the delta. We believe that this concern must be addressed prior to its inclusion in the program. We recognize that CMS is now applying an equity adjustment to the VBP program, but it is unclear whether the equity adjustment is sufficient to handle the difference in social risk factors and there is a need to study and test to determine the best approach.[54]

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[54] Please see our comments on *HVBP Program Scoring Methodology—Health Equity Adjustment below*.

In addition, we remain concerned that there will be two different performance scores publicly reported until CMS is able to replace the existing measure with this new one. We believe that CMS should halt reporting of the existing measure including any public release of performance results once this updated measure is publicly reported. Continued use of the existing measure would be inappropriate and could produce conflicting information to providers and patients.

Total Hip and Knee (THA/TKA) Complication Measure

Before moving forward with this measure in the program, the AMA recommends that CMS have the contractor who oversees the Consensus Based Entity (CBE) review the changes to the measure to determine whether the additions impact the reliability and validity of the measure.

HCAHPS Technical Changes

CMS also proposes to make technical changes to the administration of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Beginning with January 2025 discharges, CMS proposes the following changes:

- three new modes of survey administration;
- removing the requirements that only the patients may respond to the survey (allowing a proxy to respond);
- extending the data collection period from 42 to 49 days;
- limiting the number of supplemental items to 12;
- requiring hospitals to collect information about the language that the patient speaks while in the hospitals and requiring the official CMS Spanish translation of the HCAHPS Survey to be administered to all patients who prefer Spanish; and
- removing two options for administration of the HCAHPS Survey (Active Interactive Voice Response and the "Hospitals Administering HCAHPS for Multiple Sites" option).

The AMA supports the changes and believes allowing the survey to be administered in Spanish will most likely improve response rates. We also urge CMS to consider expanding the requirement to other languages in the future. We believe that the results of the survey would better reflect the true perspectives of patients if they were provided in their preferred language.

VI. Proposed Updates to the HCAHPS Survey Measure (CBE #0166)

Request for Information: Potential Addition of Patients with a Primary Psychiatric Diagnosis to the HCAHPS Survey Measure.

Ideally, within HCAHPS we should include psychiatric patients when measuring patient experience. However, the psychiatric patient population faces a rate of housing insecurity higher than patients with other clinical conditions and therefore, it is more challenging to follow-up with a survey typically administered by mail or phone. Therefore, robust testing must first occur to determine whether it is feasible and how best to capture the perspective of patients with psychiatric diagnoses. By continuing to exclude psychiatric patients, we are missing feedback from a population very impacted by hospital care.

We are also concerned with appropriately capturing patients who are in the emergency department (ED). One in eight ED visits are for behavioral health reasons and the proportion is rising. It is well known that

"psych boarding" is a problem, yet we have created systems that do not measure the experience of the patients who likely have the most terrible experience. They are restrained (at a higher rate if they are Black, Indigenous, People of Color), made to wear special-colored gowns to identify them as psych patients, which is extremely stigmatizing, guarded by security or police, and boarded for hours or sometimes days without any treatment waiting to be transferred somewhere else for treatment. In addition, their voice is systematically excluded from patient satisfaction surveys due to stigma and hospital administrators afraid of the negative feedback they may receive.

Proposal to Revise the HVBP Program Scoring Methodology to Add a New Adjustment That Rewards Hospitals Based on Their Performance and the Proportion of Their Patients Who Are Dually Eligible for Medicare and Medicaid—Health Equity Adjustment (HEA).

CMS proposes, beginning with the FY 2026 program year, to add Health Equity Adjustment (HEA) bonus points to a hospital's TPS. The HEA bonus points would be calculated using a methodology that incorporates a hospital's performance across all four domains for the program year and its proportion of patients with Dual Eligibility Status (DES). The AMA supports the concept of adding a health equity adjustment but recommends improvements to the methodology. Specifically, CMS should consider factoring in the size of the hospital's (or its parent health system's) budget relative to the amount of uncompensated care provided, or consider creating at least two separate calculations, to account for distinct types of safety net hospitals. The formula as currently written will likely favor larger urban hospitals that have a higher proportion of DES but are also part of health systems with more diversified finances. Small, independent urban or rural hospitals with a lower proportion of DES, sometimes related to absence of Medicaid expansion in their state, also need additional support because of the absolute amount of uncompensated care relative to their overall budget and lack of a large network to absorb losses.

There are at least two or three major groupings of safety net hospitals that have limited overlap in their characteristics, so this will need to be factored into generating at least two options for qualifying criteria. "SNHs identified by a high DSH index are larger, urban, teaching hospitals and more often part of a health system. They … have lower uncompensated and unreimbursed costs and relatively better operating margins than SNHs identified by other definitions. ... SNHs identified by uncompensated care costs are smaller, nonteaching institutions less often affiliated with health systems, more often located in rural areas, and providing fewer specialized services related to vulnerable populations. These hospitals have lower Medicare DSH payments and the lowest profit margins… hospitals identified by uncompensated care burden are the most financially vulnerable."[55,56]

CMS should also consider including a socioeconomic index in the formula, and further consider including race or ethnicity, or at least racial segregation, since these are missing from most indices and not accounted for when only considering DES.

Request For Information on Potential Additional Changes in HVBP to Address Health Equity

CMS invites public comment on the following:

[55] Comparison of 3 Safety-Net Hospital Definitions and Association With Hospital Characteristics | Health Disparities | JAMA Network Open | JAMA Network
[56] Refining the Definition of US Safety-Net Hospitals to Improve Population Health | Health Disparities | JAMA Network Open | JAMA Network

Should CMS consider using any of the previously detailed variables, area deprivation index (ADI) of greater than or equal to 85 and Medicare Part D LIS, in combination with or instead of DES? For example, should CMS use the higher of a few selected factors based on a hospital's inpatient population in a given program year, including (1) the proportion of the hospital's patient population residing in a census block group with an ADI national percentile rank of at least 85 (or another threshold); (2) the proportion of the hospital's patients that are dually eligible for Medicare and Medicaid; or (3) the proportion of the hospital's patients receiving LIS? Should CMS consider patients with partial-dual eligibility in addition to full-dual eligibility? Are there additional variables CMS should consider using to identify populations that have been disadvantaged, marginalized, and/or underserved by the healthcare system?

CMS should factor in a socioeconomic index. ADI does not include race or ethnicity, which is a concern. Acknowledging the potential legal considerations of using an index that is explicit on race or ethnicity, there are considerable risks in ignoring race, and consideration should be given to factoring in residential segregation if not race or ethnicity itself. Racial segregation is an independent predictor of health outcomes, with people of different racial or ethnic identities having access to very different resources and opportunities even at the same educational level.

Based on our understanding. CMS has leaned toward the University of Wisconsin's ADI, which excludes race or ethnicity as a factor. Research related to COVID-19 suggests that ADI outperforms race-explicit alternatives like the CDC's social vulnerability index (SVI) in predicting mortality.[57] However, these two indices vary dramatically in their geographic distribution, and to a lesser degree, their urban-rural distribution. A broader selection of indices varies dramatically in their designation of high-need areas, especially when disaggregated by race or ethnicity.[58]

Race-evasive options may avoid potential legal challenges. However, ignoring race or ethnicity comes with risks of underestimating adverse local factors and their impact on health. "For example, compared to [White people], college-educated [Black people] are more likely to experience unemployment, employed [Black people] are more likely to be exposed to occupational hazards and carcinogens even after adjusting for job experience and education, and have less purchasing power because the costs of a broad range of goods and services are higher in Black communities. A recent study of children in the 100 largest metropolitan areas in the U.S. found that 76 percent of [Black] children and 69 percent of Latino children live under worse conditions than the worst-off White children. [Black people] currently live under a level of segregation that is higher than that of any other immigrant group in U.S. history. In addition, the association between segregation and SES varies by minority racial group. For Latinos and Asians, segregation is inversely related to household income, but segregation is high at all levels of SES for [Black people]."[59] Therefore, research suggests that direct inclusion of a measure of segregation, if not race itself, is important to capture core factors impacting on differential health outcomes.[60]

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[57] Association of Area Deprivation Index vs. Social Vulnerability Index and COVID-19 Outcomes in Michigan. https://ihpi.umich.edu/sites/default/files/2021-06/ADIvSVI-COVID-MI_brief_Tipirneni_050521.pdf. Downloaded 05-22-2023.

[58] How We Define 'Need' For Place-Based Policy Reveals Where Poverty and Race Intersect. Brookings Institute. https://www.brookings.edu/research/how-we-define-need-for-place-based-policy-reveals-where-poverty-and-race-intersect/. Downloaded 05-22-2023.

[59] Williams, David, et al. Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. Annals of the New York Academy of Sciences. 02-18-2010. https://nyaspubs.onlinelibrary.wiley.com/doi/10.1111/j.1749-6632.2009.05339.x.

[60] Wong, Michelle S., et-al. Inclusion of Race and Ethnicity With Neighborhood Socioeconomic Deprivation When Assessing COVID-19 Hospitalization Risk Among California Veterans Health Administration Users. J*AMA Netw Open.*03-03-2023. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2801940.

Should CMS consider other thresholds for scoring, such as using a quintile-based scoring approach whereby hospitals are awarded measure performance scaler points based on five levels of performance rather than three?

A more equitable approach would consider whether institutions make improvement relative to where they started rather than which quintile or quartile, they are in. This might involve giving greater weight for improvement starting from a lower quintile than a similar improvement starting from a higher quintile.[61]

CMS is considering further refining this scoring methodology change in the future to only look at a hospital's quality performance on patients in the focus population (for example, patients with DES). CMS collects patient-level data on claims measures in the clinical domain and the MSPB measure, but not on all other measures in the HVBP Program. CMS seeks feedback on ways to assess patient-level data in the future.

Only focusing on DES populations is problematic because of the differential expansion of Medicaid from one state to the next.

Should CMS use a linear scoring function or actual scoring for calculating the underserved multiplier instead of the proposed logistic exchange function?

Whichever algorithm is used (for the scoring function and for any calculations described in this proposal), it should be transparent, explainable, and interpretable to those most likely to be impacted, with an opportunity for patients and communities to understand how it is impacting their care compared to other groups and suggest alternative approaches.

Are there other approaches that the HVBP Program could propose to adopt in order to effectively address healthcare disparities and advance health equity? For example, should measure performance scaler points be awarded to only the top third of performance whereby a hospital in the middle and bottom thirds of performance would receive 0 performance scaler points? Alternatively, should CMS only provide measure performance scaler points to the Clinical, Safety, and Patient and Community Engagement Domains, excluding the Cost and Effectiveness Domain from performance scaler points?

An approach like this is likely to perpetuate inequities. Health outcomes are often worse in particular hospitals because of chronic disinvestment in the institution and in their surrounding communities. Continuing to starve institutions of resources will trap them in a cycle of poor performance. Instead, CMS should consider assigning greater weight to the local socioeconomic index and amount of uncompensated care.

VII. Hospital-Acquired Conditions (HAC) Reduction Program - Request for Comment: Advancing Patient Safety

CMS invites comment on potential future measures on how the HAC Reduction Program can further promote patient safety, specifically:

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[61] Koenig L, Soltoff SA, Demiralp B, et al. Complication Rates, Hospital Size, and Bias in the CMS Hospital-Acquired Condition Reduction Program. *American Journal of Medical Quality*. 2017;32(6):611-616. doi:10.1177/1062860616681840.

How can weighting and scoring methods be improved to better assess hospital performance and promote equity in the HAC Reduction Program payment assessments?

Current differences in penalties for HACs are in part driven by disproportionate share and crowding, which reflect neighborhood or community context and hospital resources.[62] Updated formulas or measures should factor this in, so hospitals are encouraged to improve quality rather than penalized for being inadequately resourced or serving a marginalized community.

How can the HAC Reduction Program be strengthened to encourage patient safety best practices, which also prioritize the delivery of equitable care, in inpatient facilities?

To strengthen the HAC program to encourage patient safety best practices the AMA recommends CMS promote routine disaggregation of data so that current disparities and subsequent progress in addressing disparities can be tracked, as well as encourage adoption of system responses that directly address variations in quality of care received by different groups. In addition, focus on HAC and harm measures in the IQR program on items that are truly meaningful to discriminate hospital performance. The most recent hospital harm measures in IQR that CMS has developed have focused on events that seem to result in generally low numbers and when you look at the performance scores produced across the hospitals included in the testing data it is unclear whether they are measuring items that really distinguish hospital performance (e.g., Hospital Harm—Pressure Injury and Hospital Harm—Acute Kidney Injury). While the measures may address patient safety, we do not believe they are useful for a payment program.

We also urge CMS to re-evaluate CMS PSI 90 measure (CBE 0531). It has been nearly ten years since the NQF's never events were reviewed and updated, and we believe some of the evidence has changed.

VIII. Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes adoption of three new eCQMs to include in the eCQM measure set, from which hospitals can self-select measures to report to meet the eCQM requirement, beginning with the CY 2025 reporting period/FY 2027 payment determination. We offer the following measure specific comments:

Hospital Harm - Pressure Injury eCQM

The AMA questions whether the measure, per the information provided as part of the testing materials, 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 18 hospitals ranging from 0.00 percent to 2.02 percent. We do not believe measures that currently only identify such small differences in performance allow users to distinguish meaningful differences in performance.

Hospital Harm - Acute Kidney Injury eCQM

The AMA questions whether the measure as drafted truly differentiates patient harm rather than the underlying disease that resulted in the patient being admitted to the hospital. The current set of exclusions may not adequately address the delay in kidney injury seen due to progression of disease particularly in patients with complicated medical conditions that require complex interventions or those receiving palliative care. We are also concerned, per the information provided as part of the testing materials,

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[62] Cochran, Emily. Hospital Characteristics Associated with Hospital Acquired Condition (HAC) Reduction Program Payment Penalties across Program Years. 2019 Thesis. Virginia Commonwealth University. https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=7069&context=etd.

whether the 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 20 hospitals ranging from 0.76 percent to 4.43 percent. We do not believe a measure that currently only identifies such minor differences in performance allows users to distinguish meaningful differences in performance.

Proposed Measure Removals for the Hospital IQR Program Measure Set and Proposed Codification of Measure Removal Factors

CMS proposes to codify the Measure Removal Factors previously adopted and remove the following three measures:

- *Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* measure (THA/TKA Complication measure) beginning with the April 1, 2025, through March 31, 2028, reporting period/FY 2030 payment determination;
- *Medicare Spending Per Beneficiary (MSPB)—Hospital measure* beginning with the CY 2026 reporting period/FY 2028 payment determination; and
- *Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC–01) measure* beginning with the CY 2024 reporting period/FY 2026 payment determination.

The AMA supports the removal of the measures from the IQR program as they are duplicative to measures in the VBP program.

Refinements to Current Measures in the Hospital IQR Program Measure Set

CMS proposes to modify three measures within the Hospital IQR Program measure set:

- The Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure beginning with FY 2027 payment determination.
- The Hybrid Hospital-Wide All-Cause Readmission (HWR) measure beginning with the FY 2027 payment determination.
- The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure beginning with the Quarter 4 CY 2023 reporting period/FY.

Future Considerations—The following potential future measures

In the FY 2024 IPPS proposed rule, CMS is requesting feedback on the potential inclusion of the Geriatrics Hospital and the Geriatrics Surgery measures in the IQR program that aims to capture the quality and safety profile of patient-centered geriatric care. The AMA supports the inclusion of a Geriatrics Hospital measure in the IQR program that would include combining the two measures into a single hospital measure based on stakeholder feedback. The measure is an important step in improving the care of geriatric patients.

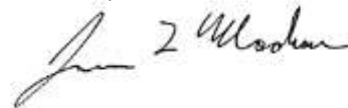
Hospitals are increasingly faced with older patients who have complex medical, physiological, and psychosocial needs that are often inadequately addressed by the current health care infrastructure. The Geriatrics Hospital Measure and the Geriatrics Surgical Measure(s) aim to fill this gap. The measures

developed by the American College of Surgeons (ACS) were created as "programmatic composite" measures that identify clinical frameworks based on evidence-based best practices to provide goal-centered, clinically effective care for older patients. These measures have appeal because they focus on team-based care of patients, help guide patients seeking safe and good care, and reduce measurement burden because they are tied to optimal care delivery and improvement.

Both measures were reviewed by the Measures Application Partnership (MAP) for consideration in the IQR program. The MAP was supportive of the Geriatric Hospital Measure and the Geriatric Surgical Measure. In response to the MAP's feedback regarding burden, the ACS is working to combine the two geriatric measures and resubmit a combined Geriatric Hospital measure. We believe a geriatric programmatic hospital measure will help build a better and safer environment for the geriatric patient.

We greatly appreciate this opportunity to share the views of the AMA regarding the proposals, issues, and questions that CMS has raised in the 2024 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,



James L. Madara, MD