August 17, 2023

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 Ave. SW
Washington, DC 20201

Ref: Request for Information; Episode-Based Payment Model

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS') request for information on a potential new episode-based payment model. Essential hospitals play a unique and vital role in the health care delivery system. Our members have the expertise, passion, and commitment to apply and adapt proven models of care to benefit their patients and to pioneer new models to meet their specialized needs. Consistently, members of America's Essential Hospitals find increasingly innovative and efficient strategies for providing high-quality, complex care to their patients, all while functioning with limited resources.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins two-fifths than that of other hospitals—3.2 percent on average compared with 7.7 percent for all hospitals nationwide.¹

Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face socioeconomic and socioeconomic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven and a half million people in communities served by essential hospitals have limited access to healthy food, and nearly 16 million live below the poverty line.²

² Ibid.
Topic 1: Designing the Model for Underserved Populations

As CMS looks to design future episode-based models, it is critical that the agency target specific medical conditions or populations with known disparities in health care outcomes to improve care for underserved groups. Non-white and low-income patients often experience worse outcomes for various medical conditions due to disparities in health insurance coverage, access to health care services, and SDOH.\(^3\) We believe that a focus on chronic conditions, which disproportionately affect underrepresented racial and ethnic groups, would be especially important to include in future models. Given the underrepresentation of certain underserved groups in existing surgical models, such as the Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement (BPCI) models, we recommend prioritizing medical episodes.

Target Specific Conditions with Known Disparities

**CMS should target specific conditions or populations with known disparities to improve outcomes for underserved groups.** These disparities are particularly evident in chronic conditions; patients from underrepresented racial and ethnic groups are 1.5 to 2 times more likely than white patients to have major chronic conditions such as diabetes, hypertension, obesity, asthma, heart disease, and cancer.\(^4\)

The BPCI Advanced model, while showing promise in reducing costs for Medicare beneficiaries, had mixed results in mitigating disparities.\(^5\) Although episode-based payments for historically underserved populations declined, there were no significant differences in mortality and readmission rates compared with non-Hispanic white beneficiaries and beneficiaries who are not dually eligible for Medicare and Medicaid. Survey responses from underserved groups also indicated less favorable care experiences than those from non-underserved groups.\(^6\) The model's focus on cost reduction might have overshadowed improvements in care coordination and patient experiences for underserved populations, primarily driven by reductions in post-acute care without corresponding overall care improvements.

Similarly, baseline disparities under the CJR model in lower extremity joint replacement (LEJR) rates were significant, with underserved populations experiencing rates 40–60 percent lower than reference populations.\(^7\) The CJR model, designed to incentivize high-value care, did not effectively reduce these disparities and even led to a slight widening. While LEJR rates

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\(^6\) Ibid.

declined in both CJR and control areas during the intervention period, the declines were more pronounced for underserved populations in CJR areas, exacerbating existing disparities.\(^8\)

Targeting specific conditions or populations with known disparities is essential for improving health care outcomes for underserved groups. The prevalence of chronic diseases and poorer health outcomes among non-white and low-income patients underscore the urgency of targeting these disparities. While models like BPCI Advanced and CJR show promise in reducing costs for Medicare beneficiaries, they have had mixed results in mitigating health care disparities. The focus on cost reduction in these models may have overshadowed the need for improved care coordination and patient experiences for underserved populations. Moving forward, CMS should increase emphasis on implementing interventions that directly target disparities and promote equitable access to quality health care, ultimately ensuring better health outcomes for all Americans.

### Importance of Appropriate Risk Adjustment

The development of an episode-based payment model presents a unique opportunity to incorporate appropriate risk adjustment methodologies that account for social risk factors. Current quality metrics used in Medicare payment models do not always sufficiently incorporate these factors, which can disadvantage hospitals serving medically and socially complex beneficiaries.

A growing body of evidence demonstrates that sociodemographic factors such as age, race, ethnicity, and language, alongside socioeconomic status indicators, including income and education, significantly influence health outcomes.\(^9,10\) These factors can skew results on specific quality measures, such as readmissions, making it challenging for certain hospitals to achieve the quality levels required for reconciliation payments under the proposed episode-based models.\(^11,12,13,14\) Without appropriate risk adjustment, providers serving complex patients may face challenges unrelated to the quality of care delivered, exacerbating health care disparities and depleting resources needed to treat adverse health outcomes caused by social barriers to care.

In the design of new episode-based payment models, it is critical that performance measures account for the socioeconomic and sociodemographic complexities of patient populations. This ensures a level playing field across all hospitals and prevents the penalization of those providing vital services to medically and socially complex beneficiaries.

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\(^8\) Ibid.


\(^11\) Ibid.


We urge CMS to integrate a comprehensive and nuanced risk adjustment methodology in the design of all future payment models, including one focused on episode-based care. Risk adjustment is not only a matter of fairness in performance assessment but also a crucial step in the broader mission of advancing health equity. By doing so, CMS can ensure that hospitals serving people who face economic and social hardships are supported and not unfairly penalized, fostering a health care system that truly works for everyone.

**Medical versus Surgical Episodes**

As CMS evaluates elements of future episode-based payment models, it is important to explore the role of medical versus surgical episodes. As part of the RFI, the agency has shared findings from both the BPCI Advanced 4th Annual Report and the Comprehensive Care for Joint Replacement Model: Performance Year 5 Evaluation Report that found Black beneficiaries, dually eligible patients, and Black dually eligible patients were underrepresented in the CJR and BPCI surgical models. Given these findings, we recommend that the next episode-based payment model prioritize medical episodes. Alongside the proposed model focused on medical episodes, it's crucial CMS continue studying why surgical episodes pose barriers to underserved populations. In the BPCI Advanced model, the representation of Black beneficiaries and dually eligible beneficiaries was higher for medical episodes and lower for surgical episodes. Understanding these disparities will enable CMS to design interventions that can improve access to surgical care for these populations.

In general, underserved populations such as racial and ethnic minorities, low-income groups, and those with disabilities or language barriers tend to have higher needs for medical services for chronic disease management. This is due to higher rates of chronic conditions, barriers to preventive care, and SDOH.

In the section “Medical vs. Surgical Episodes,” CMS highlights disparities in access to and utilization of certain surgical procedures, and research corroborates the agency’s findings. For example, studies have found lower rates of knee/hip replacements, cardiac surgeries, and cancer surgeries among Black patients relative to white patients. Multiple barriers can limit access to surgical services for underserved groups, including lack of insurance, underinsurance, high out-of-pocket costs, transportation limitations, distrust of providers, and systemic racism.

We also based our recommendation on BPCI evaluation findings, which noted a higher representation of Black and dually eligible patients in medical episodes than surgical episodes. This reiterates that these populations have higher medical needs but face barriers to surgical care.

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The BPCI report noted some reductions in readmissions and mortality for PGP medical episodes but no significant changes for surgical episodes. Similarly, the CJR model noted no improvements in baseline disparities in quality of care between underserved populations and their reference populations.

Given the findings that underserved populations have been underrepresented in surgical episode payment models and that targeting medical episodes may better align incentives for hospitals serving underserved groups, CMS should design the next episode-based payment model with a primary emphasis on medical rather than surgical episodes. The agency also should plan future surgical episode-based models once there is a better understanding of the best interventions for eliminating disparities in this space.

**Topic 2: Adjustments and Incentives**

Years of demonstration projects have shown a significant connection between financial incentives in episode-based payment models and their potential to mitigate health equity concerns. To promote equitable health care, CMS could implement an equity adjustment based on participants' performance on equity-relevant measures, incentivizing providers to improve outcomes for underserved populations.

Furthermore, upfront funding and resources for episode-based model participants can enhance their capacity to improve health equity, building on the Biden administration’s commitment to invest in efforts to reduce disparities in health outcomes for underserved communities. By integrating financial incentives and targeted strategies, CMS can foster an inclusive health care system that delivers high-quality care to all patients, regardless of their background or socioeconomic status.

**Equity Bonus**

CMS should implement an equity adjustment based on participants' performance on equity-relevant measures. Similar to how quality scores affect payments under quality payment programs, such as the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing (VBP) programs, incorporating an equity adjustment into an episode-based model could incentivize participants to improve outcomes for underserved populations. CMS recently finalized plans to adopt a similar modification to the VBP Program to address health equity concerns. This policy change will add a Health Equity Adjustment bonus to hospitals that serve a high proportion of underserved patients. CMS believes that the bonus will increase incentive payments for hospitals that serve underserved populations, thus encouraging hospitals to serve these populations and provide high-quality care to all patients they serve.

**Upfront Investment**

We urge CMS to provide upfront funding and resources for new episode-based payment model participants to build capacity and infrastructure for improving health equity. Essential hospitals face challenges in achieving effective care transitions and

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19 Ibid.
improved outcomes for patients with social risk factors due to limited resources. Upfront funding is crucial for these hospitals to develop innovative strategies, overcome barriers to care access, and engage patients in their own care. The funding can be used to update technology and electronic health records for better SDOH data collection, provide staff training for SDOH screenings, and recruit specialists for multidisciplinary teams. It also can support language and cultural consultation services, foster community partnerships to expand access to nonmedical services, and leverage data to reduce disparities in patient outcomes. By receiving upfront funding, essential hospitals can thrive in value-based payment models and continue their mission of delivering high-quality care to all, especially socially disadvantaged populations.

**Topic 3: Data**

Data plays a crucial role in health care delivery and patient engagement, especially within value-based payment models. In addition to exploring data sources outside of claims data, we encourage CMS to target data collection challenges, particularly for providers serving marginalized communities and people of color. Efforts should be made to collect patient demographic data, including race, ethnicity, and preferred spoken and written language, in culturally sensitive and linguistically appropriate ways. This will enable providers to identify and mitigate health disparities and understand the effect of SDOH on patient outcomes.

To achieve accurate and valid data collection, CMS should establish standards for SDOH data collection methods and validation. Z codes, a subset of ICD-10-CM codes, offer an opportunity to capture SDOH data, but they are underutilized in Medicare claims. Challenges to collecting SDOH data include the sensitive nature of these conversations, lack of alignment across screening tools, data collection silos, and the need to link data from medical and nonmedical sources.

Finally, interoperability is crucial for seamless data exchange among providers and community partners, but barriers remain, particularly for those serving marginalized populations. Improved interoperability is vital for sharing data between health care systems and community-level providers, helping to achieve health equity. Incorporating real-time data into value-based payment models can aid in identifying disparities and standardizing improvement efforts.

To address these challenges, **CMS should include standardized SDOH data collection in its episode-based payment models and offer technical assistance to essential hospitals to leverage existing data infrastructures and share best practices for addressing patient needs.** Improved data collection and interoperability will pave the way for better patient care and informed research, ultimately leading to more equitable health outcomes.

**Topic 4: Defining Safety Net Hospitals**

We appreciate that CMS has continued to focus on equity, including through potential new payment models that aim to target health disparities. To achieve the administration’s and essential hospitals’ shared goal to promote health equity, it is crucial for CMS to recognize the unique role that essential hospitals play in the nation’s effort to advance health equity.

In designing and evaluating new payment models, it is critical to keep the needs of under-resourced communities and safety net providers at the forefront. We are encouraged that CMS is already thinking about ways to define safety net hospitals through Medicare payment
policies. As CMS noted in the fiscal year 2024 Inpatient Prospective Payment System proposed rule, these hospitals “play a crucial role in the advancement of health equity by making essential services available to the uninsured, underinsured, and other populations that face barriers to accessing health care, including people from racial and ethnic minority groups, the LGBTQ+ community, rural communities, and members of other historically disadvantaged groups.”

Essential hospitals are distinguished by the diverse patients they treat, serving high proportions of Medicaid, Medicare, and uninsured patients, in addition to racial and ethnic minority groups. Due to their payer mix, they also provide a much higher share of uncompensated care (UC) than the average hospital. To capture safety net hospitals’ mission and the types of low-income patients they serve by, we urge CMS to incorporate these metrics when defining essential hospitals:

- The Medicare disproportionate patient percentage (DPP). The DPP captures a hospital’s proportion of Medicaid inpatient days and low-income Medicare inpatient days.
- A measure of a hospital’s share of UC costs relative to all hospitals’ UC costs, such as the Medicare uncompensated care payment factor (UCPF). CMS currently measures each hospital’s share of UC costs using the Medicare UCPF.
- Designation as a deemed DSH hospital. Defined in the Medicaid statute, the deemed DSH designation is used to identify hospitals that have high Medicaid and low-income utilization rates.

These three metrics are currently used in different policy contexts to identify hospitals with a high level of need and that qualify for additional financial support. By using these metrics, CMS will ensure it is capturing the full breadth of the safety net—that is, by incorporating these different metrics, CMS is not focusing on one segment of low-income patients but is capturing the full scope of low-income patients essential hospitals treat.

Having a clearly defined definition of essential hospitals is crucial to shaping the success of episode-based payment models that will target the nation’s underserved patients. By further targeting specific medical conditions or populations with known disparities, we can improve care for underserved groups and mitigate health equity concerns.

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

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