AMERICA'S ESSENTIAL HOSPITALS

September 11, 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: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates the Centers for Medicare & Medicaid Services (CMS') proposals recognizing the importance of telehealth for expanding access and encouraging continued flexibility to benefit marginalized populations. We also support the agency's proposals in the Medicare Shared Savings Program (MSSP) to sustain participation by existing accountable care organizations (ACOs), encourage greater involvement of ACOs serving marginalized populations, and advance equity. But we are concerned certain policies exclude essential hospitals working tirelessly to address social drivers of health and provide efficient, high-quality care to all. As the agency finalizes Medicare physician payment policies, we ask it to consider the following comments on supporting the unique role essential hospitals play in promoting health equity, ensuring their continued stability, and enabling them to thrive within value-based care models, including the MSSP.

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 (UC), 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 with an average margin less than half that of other hospitals—3.2 percent versus 7.7 percent for all hospitals nationwide.[1] These narrow operating margins result in minimal reserves and low cash

[1] Clark D, Ramiah K, Taylor J, et al. *Essential Data 2022 Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. https://essentialhospitals.org/wp-content/uploads/2022/09/EssentialData2022.pdf. Accessed July 26, 2023.

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on hand—circumstances exacerbated by financial pressures related to COVID-19. As essential hospitals rebound from the pandemic, they face new challenges, such as rising labor and supply costs and workforce and supply shortages.

Compounding these challenges are essential hospitals' complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospital patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. To meet the needs of these populations, members of America's Essential Hospitals constantly engage in robust quality improvement initiatives and have created programs to break down language barriers, address social determinants, and engage patients and families to improve the quality and equity of care. As the nation emerges from the COVID-19 pandemic, the importance of a robust, resilient healthcare safety net to respond to public health crises and provide high-quality care to all people has become even more apparent. Essential hospitals have yet to return to their pre-pandemic outlook—they still face unprecedented financial and operational challenges—all while continuing to be on standby for surges in COVID-19-related hospitalizations driven by new variants in the fall and winter seasons[2]. **We urge the agency to implement policies that will support essential hospitals serving marginalized patients and promoting health equity.**

We support CMS' work to identify measures and activities that appropriately assess performance, promote quality of care, and improve outcomes through the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs) under the Quality Payment Program (QPP). Improving care coordination and quality while staying true to a mission of helping those in need can pose extra challenges for essential hospitals. To ensure our members have sufficient resources to advance their mission and are not unfairly disadvantaged in providing comprehensive care to complex patients, we urge CMS to consider the following recommendations when finalizing the abovementioned proposed rule.

1. CMS should expand disadvantaged populations' access to lifesaving services by broadening the scope of telehealth reimbursement and lifting barriers to Medicare reimbursement for these services.

During the COVID-19 public health emergency (PHE), CMS enhanced flexibility by expanding the list of reimbursable telehealth services, waiving geographic and site-of-service restrictions on the originating site, and allowing hospitals to bill an originating-site fee. The pandemic demonstrated the effectiveness of telehealth in providing high-quality, cost-effective care while protecting patients and health care personnel from unnecessary exposure to illness. While the telehealth policy flexibility was critical during the COVID-19 PHE, continuing it beyond the PHE will be indispensable to essential hospitals' efforts to expand patient access.

Technology's key role in linking patients to access and high-quality care became increasingly evident amid COVID-19. Telehealth expands the reach of specialists and other providers, allowing hospitals to connect patients to care efficiently and improve population health. While on the front lines of the pandemic, essential hospitals used technology to connect their providers with patients in various settings. At essential hospitals, no-show rates among low-

[2] Kekatos M, Benadjaoud Y. Weekly COVID hospitalizations rose 14%, as numbers still lower than at other points in pandemic. ABC News. August 15, 2023. https://abcnews.go.com/Health/weekly-covid-hospitalizations-rose-14-numbers-lower-points/story?id=102194612. Accessed August 22, 2023.

income patients are significantly lower for telehealth visits than in-person visits. The ability to virtually access care helps low-income populations overcome common barriers to care, such as a lack of transportation. The importance of telehealth will expand well past the PHE to include responding to future outbreaks and ensuring continuity of care for patients with acute and chronic conditions.

In recognition of the long-term importance of telehealth, Congress extended many of the important PHE-related flexibilities until the end of 2024. In its proposals to implement legislative provisions that temporarily extend COVID-19–related flexibility, CMS proposes changes to Medicare reimbursement. We are encouraged by these proposals, but, as noted below, the agency should assess additional ways to promote telehealth to ensure health care access for beneficiaries.

a. CMS should permanently add various services to the Medicare reimbursable telehealth services list.

Through previous rulemaking, CMS added more than 160 new services to the reimbursable Medicare telehealth services list but only for the duration of the COVID-19 PHE. The services added include physical and occupational therapy, behavioral health, audio-only evaluation and management (E/M), emergency department (ED) care, and critical care. The addition of these services has been crucial to essential hospitals' pandemic response, enabling them to assess potential COVID-19 patients and continue monitoring and treating patients with acute and chronic conditions unrelated to COVID-19.

In previous PFS rulemaking, CMS added more than 60 of these greater than 160 codes to the list of category 3 services, which will be temporarily reimbursed after the expiration of the PHE. CMS proposes to revise the current three categories of telehealth services and replace them with a list of permanent and provisional telehealth services. The services added temporarily during the COVID-19 PHE would be placed under the provisional category. **We urge CMS to permanently cover these provisional services that were added during the COVID-19 PHE.**

Provider and patient experiences with telehealth encounters during the pandemic clarify this technology's value to the provider-patient relationship. The ability to remotely continue primary and specialty care visits will be important as essential hospitals and their communities rebound from COVID-19. **To ensure continued access to lifesaving services, particularly for marginalized populations facing barriers to care, CMS should permanently include those services added during the COVID-19 PHE to the Medicare reimbursable telehealth services list**.

b. CMS should provide reimbursement for a wider variety of audio-only services.

Through another rulemaking, CMS allowed certain services to be provided using audio-only technology during the COVID-19 PHE. These codes include audio-only E/M services and various codes for behavioral health assessments and evaluations. CMS also increased the reimbursement rate for audio-only E/M codes to equal payment for in-person E/M visits.

CMS should permanently adopt payment for the other audio-only services for which it provided reimbursement during the COVID-19 PHE. Essential hospitals and their patients have benefited from this flexibility during the pandemic. The use of audio-only capabilities is

beneficial for vulnerable patients who do not have access to computers or phones with video capabilities and those with limited access to broadband that can support synchronous video visits. When the provider can deliver care and assess the patient without seeing the patient, offering these services through audio-only means is entirely appropriate. **We urge CMS to continue reimbursing a subset of services and ensure payment parity for these services, conducted through audio-only technology.**

c. CMS should reimburse practitioners providing telehealth services based on where the provider is located while providing the service.

Medicare pays practitioners for in-person visits at either a facility rate or a nonfacility rate, depending on where the practitioner delivers the service. The practitioner receives the higher nonfacility rate when provided in a physician's office and a lower facility rate when provided in a hospital outpatient department or other facility setting, because Medicare separately reimburses hospitals for their facility costs related to in-person visits. Before the COVID-19 PHE, Medicare paid telehealth practitioners using the lower PFS facility rate, regardless of setting, even if the practitioner provided the service from a freestanding physician office. There is no logical distinction between in-person and telehealth visits that warrants a lower payment rate for practitioners when providing a telehealth service in a physician office.

In recognition of this false distinction, during the PHE, CMS allowed practitioners to bill using the appropriate place-of-service code so they could be paid at the appropriate facility or nonfacility rate comparable to an in-person service. This ensured practitioners offering a service in a physician office were paid at the nonfacility rate, which includes reimbursement for the technical component of providing the service. CMS proposes to continue allowing providers to bill at the nonfacility rate when providing a telehealth service to a beneficiary in their home but proposes to reimburse at the facility rate for all other places of service. **CMS should continue to offer parity between telehealth and in-person services by paying practitioners at the appropriate PFS rate, depending on the place of service.**

d. CMS should remove telehealth restrictions and continue pushing for expanded access to high-quality care via telehealth services.

During the COVID-19 PHE, CMS used its amended Section 1135 authority to waive geographic and site-of-service restrictions on originating sites, allowing Medicare patients to receive telehealth services in various settings, including their homes. In addition, CMS allowed hospitals to bill an originating-site facility fee when the patient gets the service at home. These changes have paved the way for increased access to telehealth services for providers in the early stages of adoption and those with established telehealth footprints. These providers must reach patients facing barriers to care.

As required by the Consolidated Appropriations Act, 2023, CMS proposes to continue telehealth flexibility, such as the waiver of geographic and originating site restrictions, reimbursement of audio-only services, and waiver of in-person requirements for mental health services. **CMS should work with Congress to permanently eliminate the geographic and site-of-service restrictions on Medicare telehealth services.** In practice, a lack of transportation and other barriers to access prohibit more than just rural patients from timely access to care. Large populations in many urban areas are in health care deserts and are classified as medically underserved. Distinguishing rural and urban underserved populations artificially restricts access to health care for some patients. Even if these patients live in heavily

populated urban areas, receiving a timely telehealth service from a physician can result in the early diagnosis of a life-threatening condition and play an important role in providing cost-effective follow-up care. Outside COVID-19, CMS allows originating-site flexibility in limited circumstances, such as telestroke services and ACOs. CMS can encourage the continued push toward coordinated care and improved care access by working with Congress to remove geographic and site-of-service restrictions to care.

CMS should appropriately reimburse hospitals for the costs associated with maintaining technology, staff, and overhead expenses related to health information technology (IT) infrastructure capable of supporting telehealth services. When a Medicare service is provided in person, hospitals typically are reimbursed for the facility fee under the Outpatient Prospective Payment System (OPPS) to cover the costs of personnel, equipment, supplies, and other overhead. Although furnishing telehealth services to patients doesn't require the patient's physical presence within the walls of a hospital, these services nonetheless require significant hospital and staff resources. Hospitals incur substantial costs investing in telehealth technology and maintaining staff and equipment to ensure the operation and security of their platforms. CMS recognized this by allowing hospitals to bill an originating-site facility fee for services provided through telehealth if the patient is a registered outpatient of the hospital, even if the patient receives the service from their home. **We encourage CMS to work with Congress to ensure adequate hospital reimbursement for costs associated with providing Medicare telehealth services.**

2. CMS should finalize its proposal to suspend the appropriate use criteria for the advanced diagnostic imaging program while evaluating how best to promote its objectives.

To allow providers sufficient time to update systems, train staff, and revise workflows, CMS should pause the implementation of appropriate use criteria (AUC) for the Advanced Diagnostic Imaging Program. Under the Protecting Access to Medicare Act, CMS previously finalized a policy requiring practitioners to consult AUC using a clinical decision support mechanism (CDSM) when ordering applicable imaging services, with penalties for failing to do so effective January 1, 2021. Since then, CMS has postponed the penalty phase of the AUC program multiple times, allowing practitioners to continue operating under an educational and operations testing period. CMS now proposes to halt the AUC for Advanced Diagnostic Imaging Program implementation and rescind the AUC program regulations.

America's Essential Hospitals supports the halting of the AUC program phase. Some hospitals experienced delays in implementing the CDSM necessary for the AUC requirements. For some providers, this was because they were undergoing electronic health record (EHR) vendor transitions, and their old EHR system did not have an integrated CDSM. Others have implemented CDSM modules but require additional time to gain experience, conduct testing, and train staff to comply with the new AUC requirements. Suspending the program will allow providers to implement and adopt CDSM modules and ensure their staff is prepared for the requirements before CMS imposes penalties. Further, it will enable CMS to reevaluate how best to meet the program's goals and allow stakeholders time to work with Congress to revise the program. **Therefore, CMS should finalize its proposal to suspend the AUC program indefinitely.**

3. CMS should adopt proposals aimed at identifying and tackling social determinants of health, and we strongly recommend that the agency concurrently provide comprehensive guidance and allocate financial resources to effectively carry out these crucial initiatives.

CMS is proposing introducing new coding under the PFS to better identify and value services that address health-related social needs. The proposed services include community health integration (CHI) services, social determinants of health (SDOH) risk assessments, and principal illness navigation (PIN) services. The proposal will create new codes to distinctly recognize and value these services, differentiating them from existing care management services. The proposal also aligns with CMS' pillars for equity, inclusion, and access to care for the Medicare population. The proposal specifically introduces a new stand-alone G code, GXXX5, for SDOH risk assessment as part of a comprehensive social history. For PIN services, two new codes, GXXX3 and GXXX4, are proposed to recognize the work performed by certified or trained auxiliary personnel in patient navigation for the treatment of a serious, high-risk disease. The proposal also suggests how to value these services based on crosswalks to existing codes, reflecting the resource costs when a billing practitioner performs these services.

Addressing SDOH can lead to better health outcomes for underserved patients, as social and economic factors can drive as much as 80 percent of health outcomes.[3] The marginalized populations essential hospitals serve tend to face disparities in health outcomes due to social, economic, and environmental factors, such as food and housing insecurity. Paying for services that address SDOH aligns with CMS' shift toward value-based care, which focuses on improving patient outcomes and reducing costs.

The proposal's potential impact is significant. A 2019 study in the journal *Public Policy & Aging Report* revealed that the current Medicare annual wellness visit (AWV) does not adequately reach many older people, especially those who are low-income, part of minority populations, or served by safety net providers.[4,5] Despite its introduction in 2011 to promote preventive care, adoption remains low, with only about 20 percent of eligible seniors receiving the assessment in 2015.[6] Underserved populations, such as nonwhite, medically complex, and dually enrolled Medicare and Medicaid beneficiaries, are less likely to receive the AWV.[7] Medicare beneficiaries from white, urban, or higher-income areas were more likely to receive the visit.[8]

The proposal addresses resource gaps by paying 100 percent of the fee schedule for the SDOH risk assessment when provided alongside the AWV and eliminating beneficiary cost sharing.

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[3] Manatt, Phelps & Phillips, LLP. Medicaid's Role in Addressing Social Determinants of Health. Robert Wood Johnson Foundation. February 2019. https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html. Accessed August 7, 2023.

[4] Tipirneni R, Ganguli I, Ayanian JZ, et al. Reducing Disparities in Healthy Aging Through an Enhanced Medicare Annual Wellness Visit. *Public Policy & Aging Report*. 2019;29(1):26-32. . Accessed August 8, 2023.

[5] McMurry T, Lobo J, Kang H, et al. Annual wellness visits are associated with increased use of preventive services in patients with diabetes living in the Diabetes Belt. *Diabetes Epidemiology and Management*. 2022;7:100094. https://doi.org/10.1016/j.deman.2022.100094. Accessed August 24, 2023.

[6] Tipirneni R, Ganguli I, Ayanian JZ, et al. Reducing Disparities in Healthy Aging Through an Enhanced Medicare Annual Wellness Visit. *Public Policy & Aging Report*. 2019;29(1):26-32. https://doi.org/10.1093/ppar/pry048. Accessed August 8, 2023.

[7] Ibid.

[8] Ibid.

This incentive might lead to increased adoption of the AWV among underserved patients and encourage more health care providers to offer SDOH risk assessments, ultimately benefiting disadvantaged older adults.

We appreciate CMS' continued efforts to address health equity through policies that support providers caring for underserved populations. Standardized SDOH data collection is important to identify disparities and target improvements. The proposed SDOH risk assessment code could help capture social needs during visits. **However, we urge CMS to release guidance training, resources, and infrastructure to collect and document sensitive SDOH information appropriately.**

Implementing standardized SDOH data collection and new PIN referral workflows will require investments in staff training, health IT, care coordination infrastructure, and community partnerships. As safety net providers operating on extremely tight margins, essential hospitals often struggle to secure the necessary up-front capital needed to swiftly operationalize proposals such as this and to dedicate time to staff training.

As CMS moves forward, **we strongly urge the agency to consider supporting essential hospitals to help them build necessary capacity and mitigate unintended consequences. Short-term costs may threaten already financially strained safety-net institutions.** We hope CMS will partner with essential hospitals to find sustainable ways to implement these policies, so we can make progress on health justice.

Elsewhere in the rule, CMS notes that ACOs could use the proposed GXXX5 code to screen their patient population for SDOH during primary care visits. As it stands, ACOs have expressed interest in addressing SDOH needs in their practices; but they have encountered challenges due to a lack of data and funding.[9] Because the proposed new SDOH G code is connected to an E/M visit, considered a primary care service for ACO assignment, the proposed GXXX5 code would also be included in the definition of primary care services used for assignment, if finalized. This would enable the GXXX5 visit to be considered when assigning patients to ACOs, further supporting ACOs in providing comprehensive, coordinated care. **We urge CMS to adopt this proposal, as it can potentially improve the health of a wide swath of Medicare beneficiaries by increasing access to social determinants of health risk assessments and making them more affordable.**

4. CMS should implement policies within the MSSP that encourage stronger participation by essential hospitals, which disproportionately serve underprivileged populations and would benefit most from care coordination through ACOs.

We applaud the Biden administration and CMS leadership for engaging stakeholders in combating health inequities that have long plagued the communities essential hospitals serve. Our members understand the coordination required to effectively lower costs and improve care quality for patients with comorbidities and chronic conditions, combined with social risk factors, such as a lack of transportation for follow-up care or limited access to nutritious food. Through their participation in the MSSP, essential hospital–led ACOs work to identify gaps in

[9] Mechanic R, Fitch A. Working With ACOs To Address Social Determinants Of Health. Health Affairs Forefront. January 2023. https://www.healthaffairs.org/content/forefront/working-acos-address-social-determinants-health. Accessed August 7, 2023

care quality and eliminate disparities. America's Essential Hospitals is encouraged by CMS' proposals to provide more stability and predictability for ACOs in the MSSP through policies that would revise the beneficiary assignment methodology to expand the assignment of beneficiaries who receive primary care from nonphysician practitioners, improve access to equity payment incentives, and overhaul current risk stratification policies.

a. CMS should finalize proposed changes to the beneficiary assignment process for MSSP ACOs.

CMS proposes to revise the beneficiary assignment process to allow more beneficiaries to be assigned to ACOs. This change would expand the assignment window from 12 to 24 months to identify beneficiaries from an ACO nurse practitioner, physician assistant, or clinical nurse specialist. CMS states that the proposal aims to expand the assigned and assignable populations, particularly for underserved beneficiaries who tend to see only nonphysician practitioners for primary care. CMS' internal modeling shows the proposal could add more beneficiaries who are disabled, receive a low-income subsidy, or live in a disadvantaged neighborhood. The proposed changes would start in the 2025 performance year.

We urge CMS to finalize the proposal to revise the beneficiary assignment methodology and definition of an assignable beneficiary, as described in the proposed rule. These changes promise to expand access to accountable care, improve outcomes, and reduce disparities for some of the most disadvantaged Medicare beneficiaries. Patients in essential hospitals' communities—including Medicaid, Medicare, and uninsured enrollees, as well as duals—are most likely to face numerous barriers to accessing primary care from physicians.[10,11] The proposed changes would help address this issue by enabling more beneficiaries who receive primary care services from nonphysician practitioners to be assigned to ACOs, leading to them receiving improved care.

b. Even with the limitations of the area deprivation index (ADI), CMS should finalize its proposal to exclude beneficiaries without an ADI rank from calculations, as it will help prevent unfairly penalizing ACOs working to meet the needs of underserved patients.

The current adjustment mechanism rewards ACOs with a significant number of underserved beneficiaries and that deliver high-quality care. The health equity adjustment, finalized in the calendar year (CY) 2023 PFS final rule, grants up to 10 bonus points to an ACO's MIPS quality performance category score, based on specific criteria.

The health equity adjustment bonus points are calculated by multiplying an ACO's performance scaler (reflecting quality measure performance) by the underserved multiplier (reflecting the proportion of underserved beneficiaries served).

This year, CMS' proposals provide more detail in the calculations of the underserved multiplier and bring greater consistency between the calculations of beneficiaries with an ADI percentile

[10] Grumbach K, Hart LG, Mertz E, et al. Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Nonphysician Clinicians in California and Washington, *The Annals of Family Medicine*. 2003;1(2):97-104. https://doi.org/10.1370/afm.49. Accessed August 24, 2023.
[11] Barnes H, Richards M, Martsolf G, et al. Association between physician practice Medicaid acceptance and employing nurse practitioners and physician assistants: A longitudinal analysis. *Health Care Management Review*. 2022;47(1). https://pubmed.ncbi.nlm.nih.gov/33181552/. Accessed August 24, 2023.

rank of at least 85 and those who are enrolled in Medicare Part D low-income subsidy (LIS) or are dually eligible for Medicare and Medicaid. One proposal calls for the exclusion of beneficiaries without ADI rank. In that case, beneficiaries without a numeric national percentile ADI rank will be excluded from the health equity adjustment calculation for the performance year 2023 onward. They will not appear in the numerator or the denominator of the proportion. The agency notes that this proposal would lead to a more equitable approach when determining the underserved multiplier, preventing the penalization of ACOs that have beneficiaries without an ADI rank. **CMS should finalize the proposal to remove beneficiaries without a national percentile ADI rank from the calculation.** This change will help avoid unfairly disadvantaging ACOs serving these patients.

However, we continue to have significant concerns about CMS' reliance on the ADI measure in the health equity adjustment that must be addressed. As previously communicated, ADI has major limitations as a proxy for patient-level social risk factors. It needs to correlate better with factors such as dual eligibility status and income. State and local variations in income are not captured in the ADI. Hospitals serving large shares of disadvantaged patients can be overlooked in higher-income areas. **We encourage CMS to examine other approaches beyond ADI to ensure ACOs that disproportionately meet the needs of the underserved are awarded properly under the equity adjustment.**

c. CMS should finalize the proposed regional risk score growth cap to limit losses for safety net ACOs serving high-risk patients in regions with rising risk scores.

CMS proposes a cap on the annual growth of patient risk scores within an ACO's region. The proposal would cap the annual growth of the ACO's region's individual patient risk scores, with the cap determined by the ACO's market share within the region.

CMS currently limits the ACO's own patient risk score each year but does not limit the region's individual risk scores. CMS has stated that this proposal could help hospitals that serve high-risk patients, such as essential hospitals, by limiting losses for these hospitals when regional risk scores rise quickly. This is because a higher updated benchmark could mean a higher percentage of savings.

Essential hospitals, which serve as the health care safety net in their communities, understand the importance of reducing impacts on ACOs in regions with high-risk score growth, especially when such change is due to something other than the ACO's coding practices. We also recognize the need to limit the impact of coding initiatives, particularly among ACOs with high market share, to avoid potentially adverse incentives. Upon further analysis and evaluation of the proposed methodology, **we support this proposal and urge CMS to finalize the inclusion of a regional risk score growth cap adjustment factor to calculate the regional update factor**. This approach offers a more equitable solution, particularly for ACOs serving high-risk patients in regions experiencing high-risk score growth.

5. CMS should adopt policies to promote more robust participation under the Merit-Based Incentive Payment System (MIPS) by essential hospitals, which disproportionately serve marginalized communities.

We support CMS' work to identify measures and activities that appropriately assess performance, promote quality of care, and improve outcomes through MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP). We urge CMS to be thoughtful in its approach to ensure hospitals are supported as they meet the challenge of improving care coordination and quality while staying true to a mission of helping those in need. To ensure our members have sufficient resources to advance their mission and are not unfairly disadvantaged by providing comprehensive care to complex patients, we urge CMS to consider the following recommendations when finalizing the abovementioned proposed rule.

a. We urge CMS not to finalize its proposal to increase the performance threshold in the QPP from 75 to 82 points.

While we fully support the overarching goal of MIPS to promote high-quality health care, we have serious concerns about the proposal to increase the performance threshold in the QPP from 75 to 82. We believe this proposal will disproportionately affect clinicians primarily working with underserved populations and dual-eligible beneficiaries. CMS estimates that 820,047 physicians and other health professionals will qualify for MIPS during the 2024 performance period. If CMS were to finalize its proposal, it would significantly increase the number of clinicians receiving a negative payment adjustment from 36.75 percent of participating providers under the current threshold to 54.31 percent. Studies have shown that physicians treating more medically complex and socially vulnerable patients are more likely to receive low MIPS scores, even when they provided relatively high-quality care.[12,13] For instance, one study found that physicians caring for more dual-eligible and underrepresented patients received lower MIPS scores. Still, 19 percent of those with low scores of 30 or less still performed in the top quintile on risk-adjusted outcomes.[14] This demonstrates that although the hospital delivered good care, they were penalized due to biases in the program's scoring metrics.[15] The proposed changes could disproportionately impact these physicians, potentially leading to a decrease in resources for disadvantaged patient populations. **We ask CMS to reconsider this proposal to increase the performance threshold, as current evidence suggests that raising the cutoff could undermine care for underserved communities without improving overall quality.**

b. CMS should not end the practice of allowing health IT vendors to submit quality reporting data on behalf of clinicians under the MIPS program.

CMS proposes eliminating health information technology (health IT) vendors as organizations that can serve as third-party intermediaries under MIPS, beginning with the CY 2025 performance period. Third-party intermediaries work on clinicians' behalf to perform various administrative and regulatory tasks under the MIPS program. CMS noted it is making this

[12] Bond A, Schpero W, Casalino L, et al. Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes. *JAMA*. 2022;328(21):2136-46. https://doi.org/10.1001/jama.2022.20619. Accessed August 5, 2023.
[13] Johnston KJ, Wiemken TL, Hockenberry JM, et al. Association of Clinician Health System Affiliation With Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA*. 2020;324(10):984-92. https://doi.org/10.1001/jama.2020.13136. Accessed August 24, 2023.
[14] Bond A, Schpero W, Casalino L, et al. Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes. *JAMA*. 2022;328(21):2136-46. https://doi.org/10.1001/jama.2022.20619. Accessed August 5, 2023.
[15] Ibid.

change due to instances in which health IT vendors submitted inaccurate and unusable data.[16] But the agency did not quantify the prevalence of these instances, raising the question if this is an issue only for a select few organizations.

We urge CMS not to finalize this proposal, as we believe it will disproportionately impact essential hospitals. Health IT vendors are crucial in helping hospitals of all types report data and participate in value-based programs. They assist in collecting, analyzing, and reporting data on various quality measures, such as hospital readmissions, adverse events, population health, and patient engagement. Often, essential hospitals face challenges in implementing health IT systems and participating in value-based programs. They often have limited resources and can struggle to adopt advanced electronic health record (EHR) capabilities.[17,18] **We ask CMS to reconsider this blanket prohibition, given the crucial technical assistance health IT vendors provide, especially to under-resourced hospitals working to improve quality.**

c. We urge CMS not to prematurely finalize the proposal to release aggregated Medicare Advantage data, due to the substantial risks associated with potential data inaccuracies, provider burden, consumer confusion, and undermined stakeholder trust.

CMS is proposing to release aggregated, provider-level Medicare Advantage (MA) data on the same timeline as the release of Medicare fee-for-service (FFS) claims data on the Care Compare website. Currently, regulations prohibit the release of MA encounter data before reconciliation is complete, which takes at least 13 months after the service year ends. The proposal aims to provide more timely and comprehensive information to Medicare beneficiaries by expanding public reporting to include MA data.

The Affordable Care Act required the creation of a Physician Compare website to inform Medicare beneficiaries about providers. This includes reporting the number of surgical procedures performed. However, the current data only reflects Medicare fee-for-service claims. CMS notes that adding MA encounter data would paint a more comprehensive picture of each clinician's practice scope and experience. Publicly reporting utilization data, including Medicare FFS and MA, would be more consistent with MIPS quality information submitted via health IT vendors or registries with other payer data. This would aid beneficiaries in selecting the right provider for their needs.

However, there are potential downsides associated with this proposal. Releasing MA data prematurely could result in inaccuracies or incompleteness, given ongoing concerns related to the accuracy of MA encounter data. In its 2022 report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that the incomplete encounter data has made it difficult

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[16] Centers for Medicare & Medicaid Services. Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) Notice of Proposed Rule Making Quality Payment Program Policy Overview: Proposals and Requests for Information. 2023. https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2483/2024%20QPP%20Proposed%20Rule%20Fact%20Sheet%20and%20Policy%20Comparison%20Table.pdf. Accessed August 5, 2023.

[17] Crable EL, Biancarelli D, Walkey AJ, et al. Barriers and facilitators to implementing priority inpatient initiatives in the safety net setting, *Implement Sci Commun.* 2020;1, 35. https://doi.org/10.1186/s43058-020-00024-6. Accessed August 24, 2023.

[18] Khoong EC, Cherian R, Rivadeneira NA, et al. Accurate Measurement In California's Safety-Net Health Systems Has Gaps And Barriers. *Health Aff* (Millwood) 2018;37(11):1760-69. https://doi.org/10.1377/hlthaff.2018.0709. Accessed August 24, 2023.

to accurately describe the quality of care in MA.[19] To address this issue, MedPAC recommended that Congress improve the accuracy and completeness of encounter data in MA plans to better serve as a source of quality data and facilitate comparisons with fee-for-service Medicare.[20]

Should the prematurely released MA data be inaccurate, it might skew results and portrayals of clinician performance, unfairly penalizing or benefiting certain clinicians. The accelerated timeline also could lead to undetected errors in the MA data, which could distort public reporting and provider comparisons.

While the CMS proposal to release aggregated, provider-level MA data alongside Medicare FFS claims data on the Care Compare website aims to enhance information accessibility for Medicare beneficiaries, potential drawbacks stemming from premature release and less rigorous reporting standards underscore the need for a cautious approach. The urgency to provide timely insights must be balanced with the imperative to ensure data accuracy and completeness, as highlighted by MedPAC's call for improved encounter data quality in MA plans to enable more accurate assessments of care quality and equitable comparisons with FFS Medicare. **America's Essential Hospitals cautions against implementing the proposal to accelerate the timeline on which MA data are published and asks CMS not to finalize it.**

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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

[19] Medicare Payment Advisory Commission. Medicare Advantage encounter data. September 2022. https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf. Accessed August 24, 2023.
[20] Ibid.