AMERICA'S ESSENTIAL HOSPITALS

June 10, 2024

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

CMS–1808–P: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports Centers for Medicare & Medicaid Services (CMS) efforts to advance health equity by considering how the Medicare Inpatient Prospective Payment System (IPPS) and other Medicare policies can support the needs of safety net providers and the patients they serve. However, we remain concerned many provisions of the proposed rule do not live up to CMS' stated equity goals. As the agency finalizes IPPS policies, we ask it to consider these comments on supporting the unique role essential hospitals play in promoting health equity by crafting policies that ensure their continued financial stability.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health, health care access, and equity. We support our more than 300 members with advocacy, policy development, research, education, and leadership development. Our members 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 on margins less than one-quarter that of other hospitals.[1]

[1] Taylor, J, Ramiah, K, et al., *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/institute/essential-data-our-hospitals-our-patients/. Accessed May 24, 2024.

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Essential hospitals are at the forefront of efforts to address health equity because of their complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospitals' 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.

Unfortunately, **essential hospitals' ability to continue to close the health equity gap is threatened by payers that undervalue the care they provide.** Because Medicare and Medicaid payment rates are lower than other payers, essential hospitals have lower operating margins than other hospitals. Over time, this systemic underinvestment also has limited the capital available to these hospitals to invest in the infrastructure needed to participate in delivery system reforms. As the Institute of Medicine (IOM) acknowledged in its landmark report more than two decades ago, America's safety net is "intact but endangered." [2]

During the COVID-19 pandemic, the importance of a robust health care safety net became even more apparent. But without a federal designation for essential hospitals, the Department of Health and Human Services (HHS) struggled to target relief funding to the hospitals that needed it most. Now, as hospitals cope with growing uninsured rates, higher labor costs, and other aftereffects of the pandemic, the need to support safety net providers is more important than ever.

We urge CMS to ensure the final IPPS rule is consistent with the agency's stated health equity goals of supporting hospitals that serve a safety net role. This letter highlights three priority areas for agency action:

- Including essential hospitals in a safety net hospital definition
- Ensuring adequate funding for safety net providers.
- Considering the unique needs of safety net providers in other aspects of Medicare policy.

Including Essential Hospitals in a Safety Net Hospital Definition

In CMS' FY 2024 IPPS proposed rule, the agency acknowledged that a federal designation of safety net hospitals was necessary for advancing the health equity pillar of the agency's strategic plan. One of the key goals of CMS' health equity plan is to support providers of safety net care in underserved communities so they can continue to ensure care is accessible to those who need it.[3] This goal is consistent with President Joe Biden's executive orders for agencies to consider

[2] Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *America's Health Care Safety Net, Intact but Endangered*. 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 15, 2024.
[3] Centers for Medicare & Medicaid Services. *CMS Strategic Plan: Health Equity*. 2023. CMS Strategic Plan Health Equity Fact Sheet. Accessed May 15, 2024.

how their policies can better support communities that have endured generations of disinvestment.[4]

Defining safety net providers is the first step toward achieving these goals. Although various definitions of safety net providers have been proposed, CMS is correct in the preamble of its rule to point to the definition adopted by the IOM in 2000: Safety net providers are those that serve a high share of uninsured, Medicaid, and other disadvantaged patients. In addition, the IOM report identified "core safety net providers" as those public or nonprofit providers that have a legal mandate or explicitly adopted mission to maintain an open door to patients, regardless of their ability to pay.

Unfortunately, the specific safety net definitions CMS proposed for consideration in its FY 2024 proposed rule strayed from this long-accepted standard. Instead of considering all low-income and uninsured patients providers serve, CMS myopically focused only on the share of low-income Medicare beneficiaries. This measure fails to accurately identify institutions committed to serving all patients regardless of their ability to pay, including many essential hospitals.

America's Essential Hospitals provided significant feedback on CMS' request for information (RFI) in the FY 2024 IPPS proposed rule about how to best define safety net providers and about how this federal designation could be used in Medicare policy.[5] We proposed metrics that have been tested in other federal programs and reflect all the patients safety net hospitals serve. These metrics were developed with input from our members on the front lines of providing care to uninsured and low-income patients.

Although CMS indicated our comments on the FY 2024 proposed rule would inform future rulemaking, we are disappointed this input was not considered when developing the FY 2025 IPPS proposed rule. We appreciate CMS' efforts to define safety net providers for the purposes of the Transforming Episode Accountability Model (TEAM), but as noted below, we continue to be concerned about the use of narrow, Medicare-only metrics. CMS also is missing the opportunity to use its authority to create a federal designation that could be used more broadly to advance the agency's goal of supporting safety net providers.

CMS' health equity plan also includes a commitment to "engagement with and accountability to the communities CMS serves in policy development and the implementation of CMS programs."[6] We remain ready to engage with CMS on these issues and **we urge the agency to consult with essential hospitals, the nation's leading providers of safety net care, to develop a federal safety net designation.**

1. Medicare-only definitions of safety net hospitals do not identify hospitals that serve the most low-income patients or need the most federal support.

For the TEAM model, CMS proposes to define safety net hospitals as those that serve a high share of Medicare patients who are dually eligible for Medicaid or are eligible for the Medicare Part D Low Income Subsidy (LIS). This definition ignores the care hospitals provide to

[4] E.O. 13985 and E.O. 14091.
[5] America's Essential Hospitals. Letter from Bruce Siegel to Chiquita Brooks-LaSure. June 9, 2023. https://essentialhospitals.org/wp-content/uploads/2023/06/FINAL-AEH-FY-2024-IPPS-Comment-Letter-6-9-23.pdf. Accessed May 24, 2024.
[6] Centers for Medicare & Medicaid Services. *CMS Strategic Plan: Health Equity*. 2023. CMS Strategic Plan Health Equity Fact Sheet. Accessed May 15, 2024.

Medicaid and uninsured patients. Therefore, it is not a good measure of hospitals that are providing the most access to underserved patients and need additional federal support to participate in value-based care.

CMS' proposed measures were developed by the Center for Medicare and Medicaid Innovation (CMMI) for descriptive purposes and have not been tested for use in Medicare payment policy. CMMI's intent in developing these measures for use in its strategy refresh document was to ensure more low-income Medicare beneficiaries could benefit from CMMI models, but our analyses of the proposed definition show it would have the opposite effect.

Because CMS' proposed safety net definition only looks at the share of Medicare beneficiaries who are low-income, it inadvertently benefits hospitals that serve fewer Medicare beneficiaries. For example, if a hospital expands access to serve more Medicare beneficiaries, its share of LIS or dually eligible Medicare patients might decline, even though it is serving more patients. Overall, we found CMS' proposed measures definition prioritizes smaller hospitals and misses several large essential hospitals that have long played a safety net role in their communities.

By omitting large safety net providers from special consideration in the TEAM model, CMS falls short of its goal to ensure more low-income Medicare beneficiaries benefit from CMMI models. For example, although 37 percent of IPPS hospitals would qualify for CMS' proposed safety net definition, these hospitals only accounted for 29 percent of all discharges for low-income Medicare beneficiaries in 2022.

Instead, **CMS also should consider measures of the share of Medicaid and uninsured patients a hospital serves.** These patients have historically been underserved because of systemic inequities in funding. For example, Medicaid payment rates are well below commercial rates and 22 percent below Medicare rates.[7] In addition, the unpaid costs of care for uninsured individuals remain a substantial financial burden for hospitals and one not fully covered by disproportionate share hospital (DSH) payments or other funding. Safety net providers that serve a high share of Medicaid, Medicare, and uninsured patients also face added financial challenges because they serve few patients with private insurance and, thus, cannot make up for these losses with higher commercial payment rates.

Medicare payment models should consider a hospital's overall payer mix because it is a more reliable and useful measure for identifying facility-level characteristics that affect safety net providers' ability to fund the infrastructure and other investments needed to succeed in value-based care arrangements. We share CMS' concern about improving care provided to the lowest-income Medicare beneficiaries. But to achieve this goal, it is more effective and efficient to focus resources on providers that serve the highest share of all low-income and uninsured patients.

2. Alternative methodologies considered are also untested and shortsighted.

The proposed rule considers two other potential definitions of safety net hospitals for use in the TEAM model: (a) the Medicare Safety Net Index (MSNI), developed by the Medicare Payment Advisory Commission (MedPAC); and (b) the Area Deprivation Index (ADI), developed by the Health Resources and Services Administration (HRSA). America's Essential Hospitals

[7] Mann C, Striar A. How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost. The Commonwealth Fund. August 17, 2022. https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact. Accessed May 15, 2022.

previously expressed concerns with these measures in our comments on the FY 2024 proposed rule RFI, and we continue to have serious concerns that these measures are unreliable and do not measure all the patients that safety-net hospitals serve.

a. MSNI leaves out critical safety net providers and has significant methodological flaws.

MedPAC developed the MNSI for illustrative purposes in a June 2022 report to Congress about the need to support safety net providers. MedPAC's framework for identifying safety net providers notably acknowledges the fact that Medicaid and uninsured patients should be considered when assessing whether a provider serves a safety net role. However, the proposed measures in the MNSI overlook these important, underserved patients.[8]

The MNSI is defined as the sum of three components:

- The Medicare share of inpatient days
- The low-income subsidy share (defined as the share of Medicare patients dually eligible for Medicaid or eligible for the Part D LIS subsidy)
- Uncompensated care as a share of total patient revenue

This formula heavily favors hospitals with higher Medicare volume because the Medicare share of inpatient days is so much larger than the other measures considered. This measure also discourages hospitals from expanding access to care, because hospitals that expand access to more Medicaid and uninsured patients will have a lower share of Medicare inpatient days even if they continue to serve the same number of Medicare beneficiaries. As noted above, relying on Medicare-only metrics is not a good measure of the access a hospital provides to underserved communities or a hospital's financial challenges that might limit its ability to participate in value-based care models.

The proposed low-income subsidy share measure is similar to the measures CMS proposed for the TEAM model, and it suffers from the same flaws of penalizing large providers of safety net care. Because most patients dually eligible for Medicare and Medicaid also are eligible for LIS, these two measures are highly correlated (r=0.99), so there is little difference if these measures are calculated separately (as CMS proposed) or together (as in the MSNI model).

We appreciate that the MSNI includes a measure of uncompensated care; but, unfortunately, this factor is underweighted in the formula. Values for UC as a share of revenue tended to be much lower than the other factors included in the MSNI.[9] As a result, hospitals with a relatively high UC factor in the formula have a lower MSNI than hospitals with relatively high LIS share

[8] Medicare Payment Advisory Commission. June 2022 Report to Congress, p. 57. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf. Accessed May 24, 2024.

[9] For example, in our analysis of Medicare cost report data, the average hospital UC percentage was slightly greater than 2 percent, compared with an average LIS share of 32 percent and an average Medicare share of 36 percent (which would receive a one-half weighting in the MSNI, equaling 18 percent). In the illustrative case of a hospital with average performance on the three components of the MSNI, the UC over patient revenue component would make up only 4 percent of the total MSNI—that is, 96 percent of the hospital's MSNI value would be driven by the LIS and Medicare share components. The MSNI of the average hospital was calculated as the sum of the three percentages (expressed as decimals). The UC over revenue for the average hospital, at 0.02, represents just less than 4 percent of the MSNI for this hypothetical hospital.

and Medicare share values.[10] MedPAC acknowledged this fact in its March 2023 report to Congress, noting that the MSNI "tends to benefit hospitals with high Medicare shares and reduce payments to hospitals with low Medicare shares and high uncompensated care costs."[11]

Several MedPAC commissioners have raised concerns the MSNI would disadvantage large, public hospitals that provide essential community services.[12] Our analyses confirm that many essential hospitals are omitted from this formula, including level I trauma centers, major teaching hospitals, and transplant centers.

Although MedPAC has recommended the use of MSNI for Medicare DSH purposes, MedPAC has not formally recommended that MSNI be used for other policy purposes, such as identifying safety net providers that deserve special consideration in value-based care models. **Given the lack of consensus among MedPAC commissioners about whether MSNI is an appropriate metric for identifying essential hospitals and the fact that this metric deviates from MedPAC's original safety net provider framework, CMS should not use MSNI to define safety net providers in the TEAM model or other aspects of Medicare payment policy.**

b. CMS should not use area-level indices, due to shortcomings of these approaches and their lack of previous use in payment programs.

CMS also considered identifying safety net hospitals using the area deprivation index (ADI), which incorporates 17 measures that capture social risk factors related to income, education, employment, and housing quality. Although the goal of accounting for social risk is commendable, **we caution CMS against adopting the ADI or other area-level indices as a basis for defining safety net hospitals, due to the recent and untested nature of these measures, their relative lack of adoption in federal programs, and methodological issues with area-level measures.**

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[10] The spread across low-performing and higher-performing hospitals is much greater for the LIS share and Medicare share components than for the UC over revenue component. A hospital with a UC percentage of 2.7 percent would be at the 75th percentile relative to other hospitals. By comparison, a hospital with a 1 percent UC over revenue share would be at the 25th percentile. Yet, the hospital at the 75th percentile would see a mere increase of 0.017 in its MSNI compared with the hospital at the 25th percentile because the MSNI is derived as the sum of the three components. Conversely, the variance across hospitals in Medicare share and LIS percentage values is much higher, so that a hospital treating a higher share of LIS patients relative to other hospitals realizes a much larger increase to its MSNI than a hospital providing high levels of UC. Compared with the UC percentage, which has an interquartile range (which represents the spread between the 25th and 75th percentiles) of 0.017, the interquartile range is 0.081 and 0.208 for the Medicare share and LIS share components, respectively. Similarly, the standard deviation, representing the spread of the values from the mean, are 0.0674 for the Medicare share, 0.0422 for the UC percentage, and 0.1861 for the LIS share.

[11] Medicare Payment Advisory Commission. March 2023 Report to Congress. p 87. https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC_v2.pdf. Accessed May 23, 2024.

[12] Transcript of Medicare Payment Advisory Commission November 2022 meeting. https://www.medpac.gov/wp-content/uploads/2021/10/November-2022-MedPAC-meeting-transcripts-SEC.pdf. Accessed May 17, 2023. See comments of commissioners Lynn Barr, Jonathan Jaffery, and Wayne Riley. E.g., "…the sort of erosion that some public general hospitals will have with the new methodology, again, we need to be mindful of that because it does have the effect of eroding critical services that other hospitals do not want to do, such as Level 1 trauma, burns, perinatal center, the really critical things that we look to from our public general hospitals."

The ADI and other area-level indices of social risk factors have not been fully tested for use in Medicare payment policy. In a report surveying the use of approaches to account for social risk and social determinants of health (SDOH) in health care payment programs, HHS noted that area-level indices have not been used in any payment programs other than the MSSP.[13] As the HHS report stresses, significant modifications might be necessary to ensure area-level indices appropriately capture the social risk factors a given policy intends to address and to ensure they account for variations at the community level. Given the relative lack of use in the federal policymaking space, it would be premature to adopt area-level indices to define safety net hospitals.

In addition to the untested nature of area-level indices, these indices are problematic because they do not appropriately capture patient-level social risk factors. Instead, they measure aggregate social risk factor data across a geographic area—for the ADI, the data is aggregated at the census block group level. Therefore, the fact that a patient lives in an area classified as disadvantaged might suggest the patient is more likely to have social risk factors, but that is not always the case. For transient patients, such as those experiencing homelessness and housing instability or seasonal workers, their presence in an area at the time of admission to a hospital does not necessarily mean it is where they permanently live or reflect their individual social risk factors. Similarly, the presence of a hospital in a disadvantaged area or an area not considered disadvantaged lacks a direct correlation to the social risk factors of its patients.

The poor association between the ADI and patient-level characteristics was explored in a recent peer-reviewed study, which found that "the ADI explained little variation in health care spending, was negatively correlated with spending conditional on demographic and clinical characteristics, and was poorly correlated with self-reported social risk factors."[14] The use of ADI without further adjustment or refinements was found to run "counter to the aims of health equity" and, when used in risk adjustment models, ended up reducing spending for Black, low-income, and rural beneficiaries, as well as those with self-reported social needs.[15] Most recently, after a debate among academics about the usefulness of the ADI, a study found that without standardization, the ADI is most associated with median income and home values. The author concluded, "Federal programs that have incorporated the ADI risk poorly allocating scarce resources meant to reduce health inequities."[16]

Our analysis of the ADI information included in the provider characteristics files accompanying the FY 2025 IPPS proposed rule also confirms that the ADI of the geographic region where a beneficiary lives is poorly correlated with their individual health needs. For example, hospitals

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[13] Breslau J, et al. *Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments*. RAND Health Care. Prepared for the Office of the Assistant Secretary of Planning and Evaluation. September 2022. https://aspe.hhs.gov/sites/default/files/documents/8dc674c904723bf8a5ce4cfc8d3dcdaa/Area-Level-SDOH-Indices-Report.pdf. Accessed May 31, 2023.

[14] Powers B, et al. Association Between Community-Level Social Risk and Spending Among Medicare Beneficiaries: Implications for Social Risk Adjustment and Health Equity. JAMA Health Forum. 2023;4(3):e230266. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2803073. Accessed May 24, 2024.

[15] Ibid.

[16] Stephen Petterson, Deciphering the Neighborhood Atlas Area Deprivation Index: the consequences of not standardizing, Health Affairs Scholar, Volume 1, Issue 5, November 2023, qxad063, https://doi.org/10.1093/haschl/qxad063. Accessed May 24, 2024.

that serve patients with an ADI score above the 75th percentile had lower than average Medicare case mix index values, suggesting these patients are not the most medically complex.[17]

Even as a measure of area-level social need meant to be a proxy for individual-level social need, the ADI has significant shortcomings. For example, because the ADI is based on a national ranking, it fails to account for state and local variations in income and other measures of social need. As a result, multiple hospitals in New York and other major metropolitan areas that serve a high share of low-income and uninsured patients score poorly on the ADI metric because of the relatively high property values and average income compared with other parts of the country.[18] The ADI also has a weak correlation to other indicators of health outcomes, such as life expectancy.

3. CMS should consider the tested metrics proposed by safety net providers to identify hospitals serving all low-income and uninsured patients.

In response to CMS' RFI in the FY 2024 IPPS rule, we encouraged CMS to consider three tested measures that identify hospitals that provide care to all low-income and uninsured patients:

- **Disproportionate patient percentage (DPP),** which captures a hospital's proportion of Medicaid and low-income Medicare patients. This measure has long been used in the Medicare DSH program.

- **Medicare uncompensated care payment factor (UCPF),** which is a measure of a hospital's share of UC costs relative to all hospitals' UC costs and can help identify the costs of care delivered to uninsured individuals. This measure also is currently used to distribute UC-based Medicare DSH payments.

- **Deemed DSH hospital designation**, which reflects a commitment to serving a high percentage of Medicaid and low-income patients and accounts for differences in Medicaid programs among states. Defined in the Medicaid statute, the deemed DSH designation has long been used to identify hospitals that are statutorily required to receive Medicaid DSH payments, because they serve a high share of Medicaid and low-income patients.[19]

Medicaid deemed DSH status is based on one of two measures that CMS could calculate through Medicare cost reports or require states to report as part of their implementation of the statutory Medicaid DSH requirements:

- A **low-income utilization rate (LIUR)** of at least 25 percent, which is measured based on charity care and Medicaid revenue for services provided in the inpatient or outpatient setting.

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[17] Specifically, the average transfer-adjusted case mix index for hospitals in the top 75th percentile of the ADI metric was 4 percent lower than the case mix index for all hospitals.
[18] Azar K, et al. ACO Benchmarks Based On Area Deprivation Index Mask Inequities. Health Affairs Forefront. February 17, 2023. 10.1377/forefront.20230215.8850. Accessed May 31, 2023.
[19] Section 1923(b) of the Social Security Act. Additional information about Medicaid deemed DSH status and the characteristics of Medicaid deemed DSH hospitals is provided in Chapter 3 of MACPAC's March 2024 report to Congress. https://www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/. Accessed May 24, 2024.

- A **Medicaid inpatient utilization rate (MIUR)** at least one standard deviation above the mean for all hospitals in the state (a measure that accounts for state variation in decisions about whether to expand Medicaid).

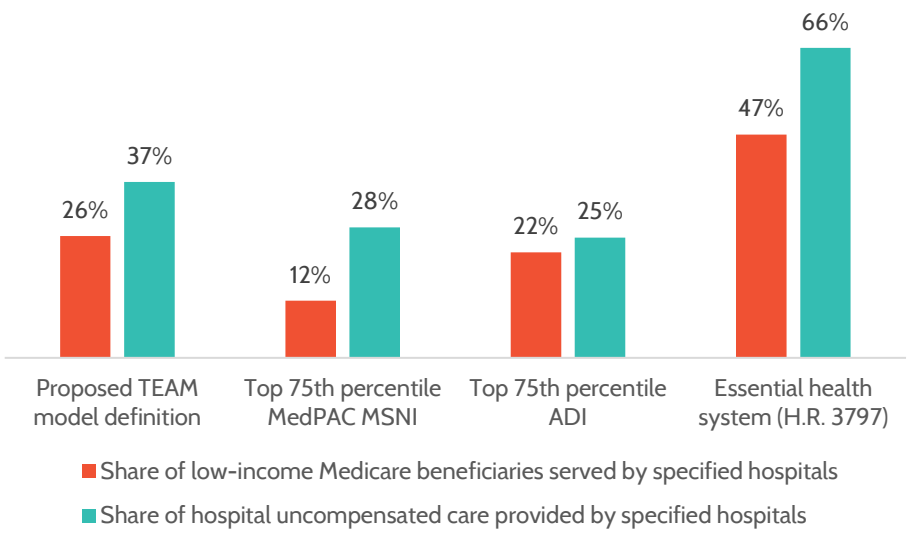
Overall, these measures help to identify hospitals that serve a high share of low-income and uninsured patients, which is consistent with the IOM's 2000 definition of a safety net hospital.[20] These measures also help identify hospitals that face increased financial challenges because of their payer mix, which makes it difficult for these hospitals to participate in delivery system reform initiatives and maintain access to essential services. For example, according to the Medicaid and CHIP Payment and Access Commission (MACPAC), deemed DSH hospitals provide more uncompensated care and access to essential services than other hospitals, but they had much lower operating margins of –4.6 percent in FY 2021.[21]

Although CMS did not consider the measures the association proposed, a bipartisan group of lawmakers in Congress has introduced the Reinforcing Essential Health Systems for Communities Act (H.R. 7397), which would use these metrics to define essential hospital systems in federal Medicare statute. **We urge CMS to consider this bipartisan approach to designating essential health systems that serve a safety net role.**

Ultimately, these proposed metrics, supported by hospitals on the front lines of care for underserved populations, better advance CMS' health equity goals than the other measures CMS has considered. For example, even though fewer hospitals meet the essential health system designation than the number of hospitals identified in CMS' proposed TEAM model definition, essential health systems serve about twice as many low-income Medicare beneficiaries and provide twice as much uncompensated care than those identified through other metrics CMS is considering (Figure 1). **As a result, supporting essential health systems as defined in H.R. 7397 better advances CMS' goals of helping low-income Medicare beneficiaries and more effectively identifies hospitals that face financial challenges because of the care they provide to underserved populations.**

[20] Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *America's Health Care Safety Net, Intact but Endangered.* 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 15, 2024.
[21] Chapter 3, MACPAC March 2024 report to Congress. https://www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/. Accessed May 24, 2024.

FIGURE 1. Essential Health Systems Provide More Uncompensated Care and Serve More Low-Income Medicare Beneficiaries than Hospitals Identified through other Definitions



Notes: TEAM is Transforming Episode Accountability Model. MedPAC is Medicare Payment Advisory Commission. MSNI is Medicare Safety Net Index. ADI is area deprivation index and the ADI measure used in this analysis is the share of discharges in core-based statistical areas with an ADI greater than the 85th percentile nationally. Low-income Medicare beneficiaries defined by eligibility for the low-income subsidy (LIS) or dual eligibility in Medicare or Medicaid. Analysis is based on inpatient discharges and 75th percentile thresholds were determined using a discharge-weighted method. According to our analysis of the most recently available data, 1,083 hospitals qualified for the proposed TEAM model definition, 651 were in the top 75th percentile of the MedPAC MSNI, 982 were in the top 75th percentile of the ADI measure, and 998 were eligible for the essential health system designation proposed in the Reinforcing Essential Health Systems for Communities Act (H.R. 7397). Analysis is limited to short-term acute care hospitals included in the Medicare inpatient prospective payment system (IPPS) and excludes Maryland and Indian Health Service hospitals.

Source: Dobson and Davanzo, 2024, analysis for America's Essential Hospitals of 2021-2023 FFS Research Identifiable Files, 2022 Medicare cost reports, and the FY 2025 IPPS proposed rule impact file.

4. CMS should use its authority to create a federal designation for essential health systems.

The proposed rule discusses developing a safety net designation only for the purposes of the TEAM model and misses an important opportunity to define essential hospitals in regulation for broader use in Medicare policy. CMS has the authority to implement "exceptions and adjustments" under Section 1886(d)(5)(I) of the Social Security Act (the Act) and should use this authority to create policy adjustments for a defined class of essential hospitals.

There is precedent in this rule and in previous rulemaking for CMS to designate a subset of hospitals to help ensure access and respond to crises. For example, the agency recently has used this authority to:

- Provide a supplemental payment to Puerto Rico and Indian Health Service Hospitals to make them whole for reductions to DSH payments.
- Create a new COVID-19 treatments add-on payment.

- Hold teaching hospitals harmless from the impact of increased beds on indirect medical education payments during the COVID-19 public health emergency (PHE).

In this rule, CMS proposes to use its authority under Section 1886(d)(5)(I) of the Act to maintain access to essential medicines at small, independent hospitals. **CMS also should use this authority to ensure support for essential health systems, which currently provide even more access to care despite a lack of sufficient federal support.**

The need to define this core group of hospitals and ensure they have stable, sustainable support to continue fulfilling their missions is long overdue. The IOM's clarion call in 2000 to ensure safety net providers are "sustained and protected" is as relevant today as it was when it was made more than two decades ago.[22] The same issues the safety net faced in 2000—chronic underfunding, reliance on an unstable patchwork of funding sources, a higher uninsured and public payer mix, and treating complex patients—continue to undermine the viability of essential hospitals, and the disruptions of the COVID-19 pandemic have added even more instability.

5. CMS should use a federal designation of essential health systems to target funding and other support across CMS programs.

Once CMS defines essential hospitals, it should ensure Medicare payment policies appropriately support these providers and the communities they serve. This approach aligns with the agency's health equity plan and Biden's executive orders calling for agencies to examine how federal policies can support underserved communities that have endured generations of disinvestment.

In our comments below, we provide specific examples of how CMS could support essential hospitals through the Medicare IPPS rule. In addition, **the agency should consider ways other CMS policies can support essential hospitals and the safety net care they provide.** These include other Medicare payment systems (including fee-for-service and Medicare Advantage), the Medicaid program, and demonstration projects under the purview of CMMI. For example, CMS should consider:

- Exempting provider-based departments of essential hospitals from site-neutral payment cuts to maintain access for underserved communities.
- Ensuring essential hospitals are included in Medicare Advantage plan networks and that payment rates for essential hospitals are sufficient.
- Ensuring adequate Medicaid managed care rates, including flexibility for states to target directed payments to essential hospitals.
- Limiting inappropriate denials in managed care for essential hospitals.
- Developing CMMI models that recognize the financial challenges and unique needs of essential hospitals that have limited their participation.

Ensuring Adequate Funding for Safety Net Providers

[22] Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *America's Health Care Safety Net, Intact but Endangered.* 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 23, 2023.

The COVID-19 pandemic further exacerbated essential hospitals' financial challenges. Now, in the aftermath of the pandemic, essential hospitals are struggling to respond to growing uninsured rates and higher labor costs. While we appreciate that the IPPS rule includes some updates related to these factors, the proposed updates are too little too late. **We urge CMS to use its authority to ensure DSH funding and the annual IPPS payment update reflect current needs and correct historical inequities.**

1. CMS should use more current and accurate measures in the Medicare DSH methodology to support essential hospitals and their safety net role.

The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC costs. Our members represent about 5 percent of all U.S. hospitals yet provided more than a quarter of all charity care (the primary component of uncompensated care) nationwide in 2021, or about $6.4 billion.[23]

As mandated by Section 3133 of the Affordable Care Act (ACA), the majority of DSH payments are distributed based on a hospital's UC level relative to all other Medicare DSH hospitals (Factor 3). While DSH hospitals continue to receive 25 percent of their otherwise payable DSH payments, the remaining 75 percent is modified to reflect the change in the national uninsured rate and distributed based on UC burden (referred to as UC-based DSH payments). This change incorporates UC costs into the DSH formula to better target dollars to hospitals with the greatest need.

During the pandemic, CMS cut UC-based Medicare DSH funding at a time when hospitals needed it the most. For example, FY 2024 UC-based DSH payments were about $2.3 billion less than UC-based DSH payments in FY 2019. The primary driver of this change was the decline in the number of uninsured individuals (Factor 2) during the pandemic because of the growth in Medicaid coverage that was triggered by the continuous coverage requirements of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). Although we support efforts during the pandemic to maintain access to care, these policies did not substantially reduce the hospitals' uncompensated care costs, because Medicaid pays so much less than hospital's costs of care.

This rule proposes to increase Medicare UC-based DSH payments by about $560 million in FY 2025, which is a step in the right direction but far short of the billions in cuts applied during the pandemic. Moreover, **this funding level does not reflect the large growth in the number of uninsured individuals that is expected in FY 2025 because of the end of the Medicaid continuous coverage provisions.** We urge CMS to use its authority to update DSH funding to reflect current needs and correct for the underpayments to safety net providers during the pandemic.

Below, we offer comments about how CMS can more accurately calculate each factor in the Medicare DSH formula.

a. CMS should ensure its estimates of the uninsured rate (Factor 2) account for the end of the Medicaid continuous coverage requirement.

[23] Taylor, J, Ramiah, K, et al., *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/institute/essential-data-our-hospitals-our-patients/. Accessed May 8, 2024.

CMS is statutorily required to use "the most recent period for which data is available" to calculate the uninsured rate for Factor 2 in the Medicare DSH formula.24 Since FY 2018, the agency has used estimates from the National Health Expenditure Accounts (NHEA), produced by the CMS Office of the Actuary (OACT). The NHEA figures used to calculate the uninsured rate for FY 2025 are projections using historical data through 2021.

OACT's projections are outdated and do not incorporate the latest data available about coverage losses that have occurred due to the expiration of flexibilities tied to the COVID-19 PHE. According to state reports submitted to CMS, at least 21.9 million Medicaid enrollees have been disenrolled as of May 10, 2024.[25] As states continue to process Medicaid renewals, this number is expected to grow.

Despite these known coverage losses, CMS projects only a minimal increase in the uninsurance rate, from 7.7 percent in CY 2023 to 8.5 percent in CY 2024 and 8.8 percent in CY 2025. In contrast, the uninsured rate before the start of the pandemic in CY 2019 was 9.7 percent, according to the NHEA data.[26] **CY 2019 data are a more realistic estimate of what the uninsured rate will be after the COVID-19 continuous coverage provisions expire, so CMS should use more current data about Medicaid coverage losses to ensure the uninsured rate used for Factor 2 is at least 9.7 percent.**

b. CMS should ensure that the assumptions used for Factor 1 are internally consistent with the assumptions used in Factor 2 and do not inadvertently reduce payments to safety net providers.

The statute provides CMS considerable flexibility to calculate Factor 1 of the Medicare DSH formula, which is an estimate of the amount of Medicare DSH payments hospitals would have received in the aggregate before reductions.[27] This factor is important because it determines the starting point of the amount of UC-based DSH funding available to safety net hospitals.

Although CMS did not account for the decline in the number of Medicaid beneficiaries when estimating the uninsured rate (Factor 2), CMS does estimate an 18.2 percentage point decline in Medicaid enrollment between FY 2023 and FY 2025, when calculating Factor 1. The net effect of this assumption is a decrease in the total amount of Medicare DSH funding available (since declining Medicaid enrollment likely would result in fewer hospitals becoming eligible for Medicare DSH payments). **We are concerned CMS is applying a double standard to reduce DSH funding by accounting for Medicaid disenrollments to lower the DSH funding available through Factor 1 but not accounting for Medicaid disenrollments to decrease the amount of Medicare DSH reductions applied through Factor 2.**

We also are concerned that the overall methodology for calculating Factor 1 is not fully transparent and cannot be replicated by stakeholders. In the FY 2025 proposed rule, Factor 1 is based on FY 2021 DSH payment data trended forward using four factors: the annual payment

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[24] Section 1886 (r)(2)(B)(ii)(II) of the Social Security Act
[25] Kaiser Family Foundation, *Medicaid Enrollment and Unwinding Tracker*. May 2024. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/. Accessed May 14, 2024.
[26] National Health Expenditure Data. Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. Accessed May 24, 2024.
[27] U.S.C. §1395ww(r)(2)(A)

update; estimated changes in discharges; estimated changes in case mix; and an "other" category, which includes expected changes in Medicaid enrollment. While the payment update factor is determined in each year's rulemaking, CMS estimates the three other factors using incomplete data (due to a data lag in the availability of full discharge information, for example) and various assumptions. **CMS should provide transparent and detailed explanations of how it calculates factor 1 so stakeholders can verify the calculation and ensure it is not inadvertently penalizing safety net providers.**

c. CMS should monitor changes in UC reported during the pandemic to ensure data accuracy and avoid large redistributions of Medicare DSH funding away from essential hospitals.

Factor 3 of the Medicare DSH formula distributes Medicare UC-based DSH payments among hospitals based on the amount of uncompensated care reported on Worksheet S-10 of the Medicare cost report. Similar to our comments in previous years, we urge CMS to continue to refine its methodology to capture these costs and to consider how best to account for changes in uncompensated care reported during the COVID-19 pandemic.

i. CMS should mitigate the effect of anomalies reported during the pandemic that will adversely impact UC-based DSH payments in FY 2025 and future years.

During the COVID-19 PHE, hospitals suspended their regular operations and experienced substantial, temporary changes in payer mix. At the prompting of federal guidance and state orders, hospitals postponed non-emergent and elective procedures. In addition, many patients were reluctant to seek care in emergency departments (EDs) or outpatient clinics, even for severe conditions, such as heart attack or stroke. One survey showed that nearly half of Americans put off seeking care because of COVID-19.[28]

Essential hospitals responded to the needs of their communities in ways that might have led to temporary changes in the types of patients they normally see. Some hospitals focused primarily on care for COVID-19 patients in the hospital, while other hospitals expanded their use of telehealth to provide care in alternative settings. Hospitals in cities with fewer COVID-19 cases might not have seen the same surge in COVID-19 patients but still were required to postpone their non-emergent cases to prepare for a possible surge.

Federal policy changes also affected hospitals' payer mix, including the Medicaid continuous coverage requirement discussed above and HRSA funding to access federal funding to temporarily cover COVID-19-related care provided to uninsured individuals. Both of these provisions temporarily reduced the amount of uncompensated care hospitals reported on worksheet S-10 according to CMS guidance.[29]

These temporary reductions in UC during the pandemic do not reflect the amount of UC hospitals will provide in FY 2025 and subsequent years. As a result, we are concerned about CMS' proposal to use FY 2020 and FY 2021 data to determine Factor 3 for FY 2025.

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[28] Lawrence E. Nearly Half Of Americans Delayed Medical Care Due To Pandemic. Kaiser Health News. May 27, 2020. https://khn.org/news/nearly-half-of-americans-delayed-medical-care-due-to-pandemic. Accessed May 24, 2024.

[29] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. Centers for Medicare & Medicaid Services. April 2023. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf. Accessed May 24, 2024.

CMS should consider steps to dampen the effect of any large downward swings in UC attributable to COVID-19 that will have a large, redistributive effect on UC-based payments. One option to consider is for CMS to use its authority to ensure the inclusion of FY 2020 and FY 2021 data does not reduce Factor 3 for essential health systems (as defined based on H.R. 3797, discussed above).[30]

ii. CMS should include all patient care costs when using the S-10 to determine UC costs and issue other clarifying guidance to improve the accuracy of these data.

We remain concerned that the amount of uncompensated care reported on Worksheet S-10 does not accurately reflect all the uncompensated care hospitals provide. As a result, we continue to urge CMS to make technical changes to capture the full costs of services essential hospitals provide so Medicare DSH payments can be equitably targeted to the hospitals doing the most to provide access to underserved populations.

In general, we are concerned Worksheet S-10 does not currently account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues using Worksheet S-10 as the data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs—including those for teaching—into the cost-to-charge ratio (CCR). In particular, CMS should:

- Use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component.
- Use worksheet C, column 8, line 200, as the charge component.

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently in Worksheet S-10.

CMS should include GME costs when calculating a hospital's CCR. Excluding these costs will disproportionately affect teaching hospitals by reducing their share of the UC pool relative to other hospitals. The costs associated with direct GME constitute a significant portion of overall costs at essential hospitals. Leaving out these costs in the CCR understates teaching hospitals' UC costs when it converts those hospitals' UC costs to charges. Incorporating GME costs into the CCR would reflect the full range of costs teaching hospitals incur. By excluding these costs, CMS' proposed CCR for determining UC costs will penalize teaching hospitals, such as academic medical centers, which tend to provide high levels of UC.

CMS also should include the cost of providing physician and other professional services when calculating UC. In addition to employing physicians and paying community specialists directly for patient care, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other UC, CMS should recognize them when

[30] Section 1886 (r)(2)(C)(i) of the Social Security Act allows the Secretary to select an appropriate time period for the collection of UC data and determine on a case-by-case basis whether alternative data would be a better proxy for uncompensated care costs.

determining UC.

CMS should treat the unreimbursed portion of state or local indigent care programs as charity care. Many state or local indigent care programs are not formal insurance products but, rather, local coverage programs that help reduce hospitals' overall UC costs through de minimis reimbursement for services. These programs typically support the same populations that qualify for hospital charity care policies. Just as the unreimbursed costs for charity care patients are recognized in the S-10, the worksheet also should reflect the unreimbursed portion (i.e., the shortfall) of state or local indigent care programs.

Moreover, the agency should revise the S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. CMS to date has not used Medicaid shortfalls from the S-10 when calculating UC costs. We agree that Medicaid shortfalls, as currently reported on the S-10, should not be included in the calculation of UC. Nonetheless, all information produced on the S-10, including data not used in CMS' DSH calculations, should be an accurate representation of a hospital's UC and other costs. Data on Medicaid shortfalls is useful for informational purposes, as previously uninsured low-income individuals gain access to health coverage through Medicaid. Further, data on the unreimbursed costs of providing care to Medicaid patients (many of whom formerly were uninsured) will provide information on Medicaid underpayment and, thus, should be accurate.

Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs inaccurately measures shortfall. Second, the S-10 should consistently allow hospitals to reduce their Medicaid revenue by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are used to finance the nonfederal share of Medicaid and are critical to a state's ability to fund the program at adequate levels.

Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. Because of this discrepancy in the instructions and the different types of permissible arrangements used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients. CMS' revised cost report instructions and guidance dictate hospitals do not have to multiply non-reimbursed Medicare bad debt by the CCR, because coinsurance and deductibles are actual amounts expected from the patient (as opposed to charges, which are not the actual amounts a patient is expected to pay). However, CMS' September 2017 transmittal states that hospitals still should multiply their non-Medicare bad debt by the CCR.

The different treatment of non-reimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients other than Medicare fee-for-service (FFS) patients, such as those with Medicare Advantage, are actual amounts the hospital expects patients to pay. Therefore, hospitals should list unpaid coinsurance and deductible amounts as bad debt in their

entirety and CMS should not reduce those amounts by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts patients do not have the ability to pay—do not have to be reduced by the CCR. **CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR.**

iii. CMS should provide clear guidelines on its audit protocols and ensure Worksheet S-10 reviews impose minimal burden and are fairly applied across all hospitals.

CMS has yet to make public its audit protocols; it is imperative the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. **We urge the agency to disclose the criteria it uses to identify hospitals for audits. Given the relative and redistributive nature of DSH payments, it is important to ensure audits are conducted consistently and equitably.** Under the methodology of CMS' DSH calculation, a change in even one hospital's reported UC costs will alter its Factor 3 and, in turn, affect all other hospitals' Factor 3 values. Thus, any inaccurate audits or audits conducted selectively for some hospitals but not others will skew DSH payments across the board.

In addition, CMS must minimize the burden associated with audit documentation requests and conduct the audits well in advance of using the data for payment purposes, so hospitals have the opportunity to address adverse findings. We are concerned the audits so far have been extremely burdensome. For example, some Medicare Administrative Contractors (MACs) have asked for hospitals to compile and turn over large amounts of information not already available in their financial recordkeeping systems.

CMS can avoid these issues by providing more transparency for its audit protocols. Publishing audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address findings. CMS also should review audit findings to ensure MACs and subcontractors consistently apply audit protocols across hospitals nationwide. Finally, CMS should complete audits well in advance of its rulemaking for a given year to ensure the cost report data used are accurate and final. The accuracy and uniformity of audits across DSH hospitals are critical to ensure the data CMS uses to calculate UC-based payments are accurate and do not unfairly disadvantage audited hospitals at the expense of hospitals that were not audited.

2. CMS should increase its proposed annual hospital payment update to account for rapidly rising costs of hospital goods and services.

CMS' proposed payment update of 2.6 percent is inadequate to account for the recent rise in hospitals' costs. Unfortunately, Medicare payment rates have not kept up with inflation post-pandemic, as hospitals continue to incur unprecedented increases in labor costs and encounter supply chain shortages. One analysis found hospitals' per-discharge labor costs increased 37 percent from 2019 to 2022.[31] The pressure on hospital input costs has continued, with one recent analysis of hospital finances citing increased material costs and increased labor costs

[31] Kaufman Hall. *The Financial Effects of Hospital Workforce Dislocation. A Special Workforce Edition of the National Hospital Flash Report.* May 2022. https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf. Accessed May 24, 2024.

attributable to persistent workforce shortages. This analysis showed a 4 percent increase in hospital expenses, comparing year to date in 2024 to the same period in 2023; and an 18 percent increase in expenses so far in 2024 compared with the same period in 2021.[32]

Essential hospitals, in particular, have incurred considerable costs with hiring bonuses, retention bonuses, and increased salaries to recruit and retain nurses and other staff in short supply as they maintain their commitment to provide access to services in their communities. These challenges have persisted even as COVID-19–related hospitalizations decrease and stabilize. Ongoing challenges from the protracted battle against COVID-19 and the consequential emotional toll on staff remain evident. The pandemic has led to burnout on an unprecedented scale, and essential hospitals have expended significant resources to recruit and retain clinical and nonclinical staff—a costly undertaking in the already competitive marketplace for health care workers.

In the context of historical inflation and workforce challenges, the proposed net annual payment update of 2.6 percent is woefully insufficient. **We urge CMS to adjust its methodology for calculating the annual payment update for fiscal year (FY) 2025 to ensure it provides a robust payment update that adequately incorporates the effects of inflation and rising workforce costs on hospitals.**

CMS calculated the proposed 2.6 net payment update based on a 3 percent market basket update minus a 0.4 percentage point productivity adjustment. OACT estimated the market basket percentage increase based on data from IHS Global Inc. However, the Medicare statute provides flexibility for CMS to use alternative data sources to estimate this value.[33] For example, CMS could look to data from Medicare cost reports to support a larger market basket that more accurately reflects hospital cost increases. The statute also allows CMS to waive the negative 0.4 percent productivity adjustment using its exceptions and adjustment authority.[34] **We encourage CMS to update the market basket by at least 5 percent and to use its statutory adjustment authority to waive the productivity adjustment in FY 2025.**

Considering the unique needs of safety net providers in other aspects of Medicare policy

CMS' health equity plan calls on the agency to evaluate all policies to identify opportunities to support safety net providers. In this spirit, we offer additional comments on how CMS can consider the unique needs of essential hospitals in other aspects of the proposed IPPS rule.

1. CMS should prioritize the distribution of new resident slots to safety net providers.

The rule proposes a method to distribute the 200 new teaching slots in FY 2026 that were added by the Consolidated Appropriations Act (CAA), 2023. The methodology limits the number of additional residency positions a hospital can acquire so that each qualifying hospital that submits a timely application receives at least one (or a fraction of one) of the positions

[32] Kaufman Hall. *National Hospital Flash Report*. April 2024. https://www.kaufmanhall.com/sites/default/files/2024-05/KH-NHFR_2024-04.pdf. Accessed May 13, 2024.
[33] 42 U.S.C. 1395ww (b)(3)(B)(iii)
[34] 42 U.S.C. 1395ww (d)(5)(I)

made available before any qualifying hospital receives more than one FTE. However, if residency slots remain after distributing up to 1.0 FTE to each qualifying hospital, CMS has the opportunity to define metrics for prioritizing the distribution of these remaining slots.

CMS proposes to prioritize the distribution of the remaining slots based on the Health Professional Shortage Area (HPSA) score associated with the program for which hospitals are applying, with the goal of supporting the training of residents in underserved areas. **However, we urge CMS to prioritize the distribution of remaining slots to programs at essential hospitals.**

Essential hospitals are committed to training the next generation of health professionals and equipping them with the necessary skills to provide culturally and linguistically competent care to all populations, including underrepresented and marginalized people. In 2021, the average member hospital trained 246 physicians, more than three times as many as other U.S. teaching hospitals.[35] Our members often train well above their GME funding cap. Because essential hospitals play such a unique and critical role in preparing health care professionals to care for underserved populations, prioritizing the distribution of residency slots to essential hospitals would help advance CMS' equity goals.

2. CMS should allow voluntary participation in TEAM and provide upfront infrastructure payments and other flexibilities to encourage successful participation by essential hospitals.

The rule proposes requiring some hospitals to participate in the TEAM demonstration, which is a new mandatory alternative payment model for acute-care hospitals that aims to test episode-based payment for five high-expenditure, high-volume surgical procedures. We appreciate the proposed model includes special consideration for safety net providers, but we are concerned about the mandatory nature of the model and that many aspects of it are not designed in a way that supports safety net provider participation. Also, as noted above, we have several concerns about how the rule proposed to define safety net providers for this model.

First, the proposed mandatory participation in the model concerns us, due to the upfront costs required to implement this model and the uncertain benefits for providers and their patients. CMS is proposing a mandatory model to have stronger data for evaluation, but the agency does not fully recognize the potential harms of requiring hospitals to participate in an untested demonstration without their consent. Given the fact that many past CMMI models have increased costs for providers without resulting in substantial benefits for patients, CMS does not have enough evidence now to justify requiring hospitals to participate in the TEAM model.

Second, we are concerned CMMI is imposing an undue burden on essential hospitals by prioritizing core-based statistical areas (CBSAs) with a higher share of safety net providers. We understand the agency's desire to improve safety net provider participation in CMMI models, but it is better to do this by designing models in which providers would participate voluntarily. Without changes to the model, CMS' approach of oversampling

[35] Taylor, J, Ramiah, K, et al., *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/institute/essential-data-our-hospitals-our-patients/. Accessed May 8, 2024.

CBSAs with a high share of safety net providers could backfire and end up placing more financial burden on providers already in a precarious financial position.

Third, we strongly urge CMS to finalize a policy that would provide upfront infrastructure payments to safety net TEAM participants. As CMS correctly observes in its preamble, safety net hospitals typically have less access to capital and more limited financial reserves due to the patient populations they serve. These providers often lack the disposable resources to make investments that are required for the successful acceptance of financial risk, including technology, process redesign, personnel, care coordination, quality measurement and evaluation, risk management, compliance, and network development. CMS should learn from the experience of past CMMI models about how the start-up and ongoing implementation costs of many models typically exceed expectations and should provide hospitals that fill a safety net role with sufficient funding to fully offset these added costs.

Fourth, CMS must allow safety net hospitals maximum flexibility in choosing among participation tracks. CMS should allow, but not require, essential hospitals and others with a safety net role to remain in Track 1 for all performance years, which would give these providers the option to avoid downside financial risk during their participation in the model. In Track 2, we believe it is most equitable for CMS to adopt asymmetric stop-loss and stop-gain limits, allowing safety net participants to achieve the same level of upside potential as Track 3 participants (up to 20 percent) while establishing more limited downside financial risk (up to 10 percent). Allowing safety net hospitals the maximum benefit of shared savings in Track 2 will support their investments in necessary infrastructure and help to fund the ongoing operational costs of participating in TEAM, while protecting against severe financial losses as they transition to value-based payment.

Fifth, we urge CMS to hold TEAM participants' safety net status constant for the duration of their participation in the five-year model. Providers need certainty to plan successfully for the future. Hospitals prepare their annual budgets well in advance, and they plan additional community investments in services and facilities even further in the future. To do this well, they need to be assured of stability from government payers. Because it is an untested demonstration program, the TEAM model inherently creates financial uncertainty for participating providers. To mitigate additional uncertainty, CMS must ensure participating providers of their safety net status for the duration of the demonstration. If it does not do this, we are concerned hospitals forced to shift between the safety net and non–safety net tracks (if safety net status is revisited each year) would see negative disruptions that could undermine their success in the model.

Finally, we urge CMS to ensure the payment model does not inadvertently disincentivize hospital outpatient care. The proposed methodology for establishing target prices for the TEAM model is extraordinarily complex, which makes it difficult to understand how it might account for existing differences in payment. The current Medicare fee schedule recognizes the added value of hospital outpatient departments (HOPDs) compared with other ambulatory care settings by providing an additional facility fee to support the additional services hospitals provide. HOPDs are particularly important sites of care for the underserved populations the TEAM model aims to benefit, and for these patients with complex medical needs, hospitals can provide higher quality care if the inpatient and outpatient care is fully integrated into a single health system. The TEAM model should fully recognize the benefits of HOPDs and not reward providers for shifting costs to lower-value ambulatory care settings.

3. CMS should support all essential hospitals' efforts to decarbonize and develop climate resilience.

TEAM includes an optional climate initiative, and CMS offers to provide additional technical assistance to hospitals that participate. We appreciate that the climate initiative is voluntary, but we are concerned this technical assistance is not available to all essential hospitals.

When considering the many threats of climate change and environmental hazards, patients of essential hospitals—disproportionately low-income, uninsured, racially and ethnically diverse, and medically complex—are among the most exposed and most susceptible to health and economic problems, and they have the fewest resources to prepare for and respond to health threats.[36] For example, communities of color face higher-than-normal exposure to pollutants that cause health problems, and during severe weather events, such as flooding or hurricanes, low-income communities are exposed to higher physical and mental stress.

Essential hospitals are vital anchor institutions profoundly connected to the well-being of the people and communities they serve. This connection extends beyond the treatment of illness and disease and into work to influence the social factors and lived environments that impact health. As climate change alters that lived environment, essential hospitals recognize the importance of their role in addressing this crisis. However, essential hospitals' slim financial margins affect their ability to fund infrastructure changes and other practices that mitigate climate change or build climate resilience.[37]

As we discussed in our FY 2023 IPPS comments on the Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity—Request for Information, and in further detail in *The State of Climate Resilience and Climate Mitigation Efforts at Essential Hospitals*,[38] essential hospitals need funding and technical assistance for their climate resilience and mitigation projects. Since then, HHS and the Office of Climate Change and Health Equity have provided significant resources,[39] while the Inflation Reduction Act has provided funding and tax incentives that have helped some essential hospitals further their climate goals.

However, while working with essential hospitals to navigate available resources and funding opportunities to determine the best climate solutions for their organizations, it is clear many essential hospitals need individualized guidance to start this process. While hospital leaders are committed to engaging in climate resiliency work, there is little to no funding or guidance on how to approach this work. As they remain focused on their foremost goal of providing high-quality patient care, hospitals will need significant technical assistance to implement climate-related initiatives. As discussed in the follow-up report, *Advancing Climate Resilience and*

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[36] How the United States Is Experiencing Climate Change. The Fifth National Climate Assessment. https://nca2023.globalchange.gov/#overview-section-2. Accessed May 23, 2024.
[37] Taylor J, Ramiah K, Greig M, et al. *Essential Data 2021: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2021 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/institute/essential-data-our-hospitals-our-patients/. Accessed May 9, 2024.
[38] Frentzel E, Roberson B, Madan I, et al. *The State of Climate Resilience and Climate Mitigation Efforts at Essential Hospitals: Findings and Recommendations from a Formative Evaluation*. Essential Hospitals Institute. November 2019. https://essentialhospitals.org/wp-content/uploads/2019/11/EHI-Climate-Resiliency-Report-November-2019.pdf. Accessed May 9, 2024.
[39] Health Sector Resource Hub. U.S. Department of Health and Human Services. https://www.hhs.gov/climate-change-health-equity-environmental-justice/climate-change-health-equity/health-sector-resource-hub/index.html. Accessed May 23, 2024.

Mitigation at Essential Hospitals, hospital leaders have expressed concerns that sustainability projects carry high costs and that technical assistance is scarce.[40]

All essential hospitals should have access to climate resilience and mitigation technical assistance. Providing technical assistance to only some hospitals is misaligned with the administration's goals to promote climate resiliency and improve equity. It also is inefficient. We urge CMS to delink the climate resilience and mitigation technical assistance from the TEAM demonstration and provide this support to all hospitals. Further, the technical assistance should provide flexibility for hospitals to access information on the focus areas most relevant to where they are on their climate journeys, as individualized assistance will be most beneficial and actionable for hospitals.

6. CMS should support essential hospitals with funding and technical assistance to implement maternal health programs tailored to their patient populations' unique needs.

CMS requested information on how the agency can support hospitals in improving maternal health outcomes. Essential hospitals are already committed to this goal, especially efforts to reduce longstanding racial disparities in obstetric outcomes. However, in our discussions with member hospitals, they often highlight the need for additional funding and technical assistance to expand their efforts in this area.

Essential Hospitals Institute, the research, education, and dissemination arm of America's Essential Hospitals, recently released *Improving Black Obstetric Outcomes in Essential Hospitals*,[41] which reviews essential hospital programs that seek to improve obstetric outcomes in Black birthing individuals by targeting systemic inequities and SDOH. The report outlines lessons learned and recommendations from essential hospitals on improving maternal health outcomes. We encourage CMS to incorporate recommendations from this report into policy that will help drive improvements in maternal health.

Implementing education to combat structural racism and target health inequities within health care organizations is critical to improving maternal health outcomes and often requires cultural shifts that can be challenging to achieve. Hospital leaders and staff benefit from comprehensive education tailored to the specific needs of their hospitals, patient populations, and communities. In addition, adequate resources, such as financing, availability of diverse staff, and the community relationships needed to facilitate program activities, are key to setting up programs for success. **We urge CMS to provide funding and technical assistance for training that builds a culture of health equity at health care facilities and allows for the successful implementation of maternal health improvement programs.**

Because of the data-driven nature of these programs, it is important that hospital teams establish strategies for health equity data collection and use. This will help program staff understand the overall purpose, value, and use of the health equity data collection. Additionally,

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[40] Ramiah K, Hiers S, Greig M, et al. *Advancing Climate Resilience and Mitigation at Essential Hospitals*. Essential Hospitals Institute. October 2022. https://essentialhospitals.org/wp-content/uploads/2022/10/Essential-Hospitals-Advance-Climate-Resilience-Mitigation-October-2022.pdf. Accessed May 8, 2024.

[41] Lambalot H, Ramiah K. *Improving Black Obstetric Outcomes in Essential Hospitals*. Essential Hospital Institute. January 2024. https://essentialhospitals.org/wp-content/uploads/2024/01/2024-Black-Obstetric-Outcome-Report.pdf. Accessed May 8, 2024.

this will inform hospital teams about additional IT efforts that might need to occur for successful program implementation. For example, data might need to be stratified in a way not currently supported by the electronic health record system, and further work might be required to obtain necessary data. **CMS must support IT investment and data training for health equity data collection and use.**

Active community participation and the fostering of community relationships are imperative to the success of health equity programs. The lasting partnerships our members build allow them to enroll new patients, make appropriate referrals, and even secure a talent pipeline of Black birth workers. Partnership also is key to ensuring program sustainability, as community partners can help secure and leverage resources necessary for program success. **CMS should invest in capacity building to foster community partnerships to improve obstetric care outcomes.**

7. CMS should not add obstetrical service requirements to the Medicare conditions of participation (CoPs).

CMS also requested information on whether it should develop an obstetric service condition of participation as a tool to improve maternity care. **America's Essential Hospitals supports CMS' efforts to reduce disparities in maternal mortality and morbidity, but we do not believe CoPs are the appropriate channel for this.** Overall, we urge CMS to provide hospitals the flexibility to shape their obstetrical services in the way that best and most efficiently serves the needs of their patients, particularly as hospitals consider new and innovative ways to deliver care to their communities.

As major providers of care to Medicaid and Medicare patients, essential hospitals adhere to the regulatory requirements and CoPs they must meet to participate in these programs. CoPs are process-oriented and cover every hospital service and department; they were put in place to protect the health and safety of patients. As noted above, essential hospitals are dedicated to improving maternal health and obstetric outcomes. Technical assistance programs, learning collaboratives, and even well-developed, thoroughly tested quality metrics have the potential to assist hospitals in improving maternal outcomes. In contrast, implementing new requirements through the CoPs, which offer no assistance for improvement and would only punish hospitals and their patients instead of promoting improvement is the wrong approach. **We strongly urge the agency to withdraw this proposal and to identify other means through which it can reduce disparities in maternal mortality and morbidity.**

8. CMS should not add COVID-19, influenza, and respiratory syncytial virus (RSV) reporting as a Medicare CoP.

Hospitals, including essential hospitals, were among the first providers to voluntarily supply quality data for the public during the COVID-19 pandemic. These data on intensive care unit bed capacity, drug and personal protective equipment supply, and incidence of confirmed COVID-19 cases offered insight into how the federal government could work with our members to identify trends and address issues of critical importance.

While we appreciate CMS' efforts to inform the coordination of hospital operations and monitor the impact of respiratory illness and the implications for patient care and public health mitigation, CoPs are inappropriate levers to accomplish CMS' goal of gaining situational awareness from the field about respiratory illness impact and resource challenges.

Essential hospitals continue to pivot to address the ever-changing landscape of acute respiratory illness and provide reliable, high-quality care for all. Essential hospitals have responded diligently to gather, report, and update data related to respiratory illness and will continue to do so. **CMS must ensure the collection of COVID-19, influenza, and RSV data and the data reporting process do not add complexity and burden to a workforce already under immense pressure.** Further, given that most states collect, compile, and analyze information on respiratory illness activity year-round, with weekly reports during flu season (October through May), we urge CMS to use existing public health data reporting methods to the greatest extent possible, so hospitals can focus on patient care and responding to surges or future PHEs.

This administration has emphasized the importance of reducing provider burden and focusing on patient care in its National Quality Strategy.[42] But CMS' data requirements are operationally complex and bound to increase regulatory burden, straining hospital systems and staff resources. **We urge CMS to withdraw proposed requirements that hospitals report respiratory illness and related data as part of CoPs and to work with hospitals to ensure necessary information is voluntarily reported.**

9. CMS should continue refining the Hospital Inpatient Quality Reporting (IQR) Program measure set to contain only reliable, valid measures that accurately represent care quality.

CMS should continue to tailor the IQR Program measure set so it helps hospitals improve care quality and benefits the public by accurately reflecting hospital care. America's Essential Hospitals supports creating and implementing measures that lead to quality improvement. However, CMS must verify the measures are appropriately constructed and do not lead to unintended consequences.

We appreciate CMS' continued commitment to identifying high-priority areas for quality measurement and improvement and reducing provider burden. As a result, we urge CMS to finalize the provision to remove the five proposed measures in the IQR program, as this would align with the National Quality Strategy and the Meaningful Measures initiative and reduce administrative burden on essential hospitals, enabling them to prioritize patient care and quality improvement initiatives more effectively.

10. CMS should not finalize the proposed Patient Safety Structural Measure.

America's Essential Hospitals appreciates CMS' attention to patient safety. But we do not support including the Patient Safety Structural Measure in the IQR program, as attestation measures are subjective in nature and might not accurately capture the quality of care offered at hospitals.

The Patient Safety Structural measure includes attestation-based questions across multiple domains that aim to capture the most salient, systems-oriented actions to advance safety. A

[42] CMS National Quality Strategy. The Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/quality-motion-cms-national-quality-strategy.pdf. Accessed May 13, 2024.

hospital must affirmatively attest to each statement within a domain to receive credit for that domain.

Collecting data from the attestation-based questions across all the domains outlined is labor-intensive, and CMS has not appropriately shown how these statements and domains improve patient outcomes. It also remains unclear what value these measures add for patients, as care quality metrics, such as CMS' Overall Hospital Star Ratings and condition-specific quality metrics, are already available to help consumers make informed care decisions.

We are concerned about the accuracy of the data these measures generate and the potential administrative burdens the measures pose. Inaccurate data ultimately could undermine public trust in all reported quality data. We urge CMS to reconsider including the Patient Safety Structural Measure in the IQR program, given that this measure lacks sufficient testing and evidence to demonstrate improved patient outcomes, and the labor-intensive data collection process through attestation-based questions does not appear to be directly linked to improved care.

11. CMS should finalize proposed changes to the severity level designation for Z codes describing inadequate housing and housing instability.

CMS is proposing to reclassify the severity level designation for seven diagnosis codes describing inadequate housing and housing instability from "non-complication or comorbidity" (NonCC) to "complication or comorbidity" (CC) for FY 2025. We support this proposal as a critical step toward supporting health care access for underserved and under-resourced communities. This change acknowledges the impact of inadequate housing and housing instability as a social determinant of health, including increased resource utilization and costs associated with providing care to this specific patient population.

Essential hospitals understand that issues associated with housing have profound impacts on health. Housing instability and inadequate housing also include difficulty paying rent, spending more than 50 percent of household income on housing, frequently moving, living in overcrowded conditions, or staying with friends and relatives.[43] Housing instability and poor health can create a vicious cycle. Homelessness and unstable housing produce significant stress and make it difficult to adhere to medications, healthy eating, and proper hygiene.

Essential hospitals serve communities where more than 370,000 individuals struggle with homelessness, housing instability, and inadequate housing.[44] These individuals are more likely to use the ED and be admitted to the hospital for conditions that would have been amenable to primary care.[45]

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[43] Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019. CMS Office of Minority Health. September 2021. https://www.cms.gov/files/document/z-codes-data-highlight.pdf. Accessed May 1. 2024.
[44] Taylor J, Ramiah K, Greig M, et al. *Essential Data 2021: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2021 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/institute/essential-data-our-hospitals-our-patients/. Accessed May 1, 2024.
[45] Schrag J. Health Care for the Homeless: Essential Hospitals and Community Partnerships. June 2015. https://essentialhospitals.org/wp-content/uploads/2015/07/Homelessness-Quality-Brief-June-2015.pdf. Accessed May 1, 2024.

Essential hospitals work to mitigate this SDOH by offering temporary housing or long-term rental assistance, developing new affordable housing capacity, and other approaches. For example, in Illinois and Vermont, essential hospitals provide temporary housing and case management to meet the needs of patients experiencing homelessness.

We urge CMS to finalize this proposed change, which acknowledges the role of inadequate housing and housing instability as social determinants of health and drivers of resource utilization and costs.

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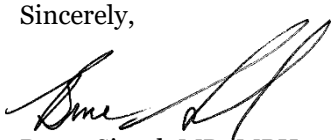
America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Rob Nelb, MPH, at rnelb@essentialhospitals.org or 202.585.0127.

Sincerely,



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