AMERICA'S ESSENTIAL HOSPITALS

Sept. 9, 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

Ref: CMS-1809-P: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the efforts of the Centers for Medicare & Medicaid Services (CMS) to advance health equity by considering how the Medicare Outpatient Prospective Payment System (OPPS) and other CMS policies can support the needs of safety net providers and the patients they serve. However, we remain concerned that CMS' proposed policies do not go far enough to advance the agency's stated equity goals. As CMS finalizes this rule, we ask it to consider these comments on how the agency can better support the unique needs of essential hospitals.

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

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state-of-the-art, patient-centered care while operating with an average margin of –8.6 percent, compared with –1.4 percent for other U.S. hospitals.[1]

Essential hospitals are at the forefront of efforts to address health equity, due to 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 regularly 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.

So, it is unfortunate that **essential hospitals' ability to further 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 essential hospitals and their safety net role is more important than ever.

We appreciate that CMS has recognized the importance of supporting safety net providers as part of the equity pillar in the agency's strategic plan.[3] This goal is consistent with President Joe Biden's executive orders for agencies to consider how their policies can better support communities that have endured generations of disinvestment.[4]

However, we remain concerned that CMS' proposed policies do not go far enough to achieve this goal, and so we urge CMS to do more to support hospitals that serve a safety net role. This letter highlights four priorities for action:

- Establishing a federal designation for essential hospitals
- Providing adequate and timely reimbursement for essential hospitals in all sites of care
- Expanding Medicare and Medicaid coverage to better meet the needs of patients that essential hospitals serve

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[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.

[2] Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net, Intact but Endangered*. Washington, D.C.: The National Academies Press; 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.

[4] E.O. 13985 and E.O. 14091.

- Reducing administrative burden of quality measurement for essential hospitals

Establishing a Federal Designation for Essential Hospitals

CMS' annual updates to Medicare hospital payment policies provide an opportunity for the agency to reassess how equitable its payment policies are. Specifically, Section 1883(t)(2)(e) of the Social Security Act (the Act) authorizes CMS to establish "adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals." In this proposed rule and in previous rulemaking, CMS has used this authority to designate classes of hospitals for special consideration in Medicare payment policy.

To advance payment equity, Congress has long recognized the need for increased payments to hospitals that serve a disproportionate share of low-income patients. Shortly after the Medicare Inpatient Prospective Payment System (IPPS) was created in the 1980s, Congress created the Medicare disproportionate share hospital (DSH) program to account for the increased care needs of low-income patients and the financial vulnerability of the safety net providers that care for them. Unfortunately, the Medicare OPPS does not include a similar adjustment for Medicare outpatient payments, despite the fact that outpatient care is now a larger share of essential hospital payment than inpatient care.

Medicare and Medicaid DSH payments provide critical support to essential hospitals, but they are not enough to ensure equitable payments. For example, in 2021, essential hospitals would have experienced an average 13 percent loss without Medicaid DSH payments. But even with these payments, their average operating loss (–8.6 percent) was still six times deeper than the average loss for all hospitals nationwide (–1.4 percent).[5]

The Medicare Payment Advisory Commission (MedPAC) has recognized in recent years that Medicare payments to safety net providers are inadequate and that additional investments are needed. To better target funds to hospitals that need it most, MedPAC has recommended CMS create a new metric to identify safety net providers.[6] Although we disagree with MedPAC's proposed metrics, **we strongly support the concept of establishing a federal designation of safety net providers and using the designation as a tool to target increased funding to providers that need it most.**

In the OPPS proposed rule, CMS acknowledges MedPAC's recommendations for additional support for safety net providers but fails to respond to them in any meaningful way. CMS has also ignored America's Essential Hospitals' repeated comments on this issue by incorrectly claiming that they are outside the scope of proposed rules. However, ignoring the problems faced by essential hospitals won't make them go away.

CMS should commit to robust analysis of an essential hospital designation to fulfill its statutory responsibility to assess the equity of Medicare payment policies. This approach would also be consistent with the president's executive order for agencies to consider how their policies can better support communities that have endured generations of disinvestment.[7]

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[5] 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://essentialdata.info. Accessed May 24, 2024.

[6] Medicare Payment Advisory Commission. *Report to the Congress. Medicare Payment Policy*. March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf. Accessed August 7, 2024.

[7] E.O. 13985 and E.O. 14091.

To facilitate CMS' consideration of establishing a federal designation for essential hospitals, this letter outlines evidence-based metrics hospitals have developed on the front lines of care for disadvantaged patients. **We remain ready to engage with CMS on these issues and urge the agency to recommit to its goal of engaging with safety net providers when designing measures to support them.**

1. CMS should establish a federal designation for essential hospitals using the practical and evidence-based measures developed by essential hospitals.

For decades, there has been broad consensus that safety net providers should be identified based on the share of all types of low-income patients they serve. In 2000, the IOM convened a wide variety of stakeholders and experts to develop a consensus definition of safety net providers as those that serve a high share of uninsured, Medicaid, and other disadvantaged patients.[8] In 2022, when the Medicare Payment Advisory Commission (MedPAC) initially developed its framework for identifying safety net providers, it also acknowledged that Medicaid and uninsured patients should be considered when assessing whether a provider serves a safety net role.[9]

To further inform development of measures to identify essential hospitals, America's Essential Hospitals convened hospital leaders in 2022 to discuss practical considerations for the implementation of a new federal designation. In addition to reaffirming the importance of considering payer mix, these leaders also identified the importance of favoring available metrics, focusing on mission-driven institutions, and considering state variation.[10]

Based on this feedback from essential hospital leaders, we encourage CMS to use three tested measures and to allow hospitals to qualify by meeting at least one of these criteria:

- **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.

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[8] Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net, Intact but Endangered.* Washington, D.C.: The National Academies Press; 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed August 13, 2024.

[9] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 3*. June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf. Accessed August 15, 2024.

[10] Dickson E, Purves S, Shields C. To Protect America's Safety-Net Hospitals, Establish A New Federal Designation. *Health Affairs Forefront*. October 3, 2022. https://www.healthaffairs.org/content/forefront/protect-america-s-safety-net-hospitals-establish-new-federal-designation. Accessed August 19, 2024.

- **Deemed DSH hospital status**, 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.[11]

Medicaid deemed DSH status is based on one of two measures 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
- 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)

These measures are already available to CMS and have long been used in Medicare and Medicaid payment programs. In addition, our proposed use of multiple metrics helps to account for state variation, focuses on mission-driven institutions, and balances the needs of small and large hospitals in urban and rural areas.

Overall, these measures help identify hospitals that serve a high share of low-income and uninsured patients. 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 fiscal year (FY) 2021.[12]

Recently, a bipartisan group of lawmakers in Congress 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.**

2. CMS should use facility-level metrics to identify essential hospitals.

Our proposed metrics identify essential hospitals at the facility level, which is similar to how many other Medicare designations currently work. For example, critical access hospitals are defined based on their bed size, regardless of whether those beds are used to serve Medicare patients or those of other payers. This approach is more meaningful and more reliable than Medicare-only metrics that have been proposed by other stakeholders.

a. Medicare-only metrics omit many vulnerable patients.

[11] Medicaid and CHIP Payment and Access Commission. *Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States*. https://www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/. Accessed August 19, 2024.
[12] *Ibid.*

In recent rulemaking, CMS has increasingly defaulted to using the share of Medicare beneficiaries enrolled in the Part D low-income subsidy (LIS) or dually enrolled in Medicare and Medicaid (dual or LIS percentage) as a proxy for safety net status. **We are concerned this measure is too narrow and results in an inaccurate measure of safety net providers that disproportionately excludes the hospitals that serve the most low-income patients.**

While we agree dual and LIS beneficiaries are disadvantaged and medically complex, they are not the only low-income patients safety net providers serve. For example, this definition excludes uninsured patients and Medicaid-only beneficiaries, including many low-income seniors and people with disabilities who would otherwise be eligible for Medicare if not for their employment history, immigration status, involvement with the justice system, or status applying for supplemental security disability income or the end-stage renal disease (ESRD) Medicare eligibility pathway.

b. The duals or LIS percentage measure disproportionately excludes many large essential hospitals.

In response to CMS' FY 2025 IPPS proposed rule, America's Essential Hospitals provided extensive analysis of the potential unintended consequences of using the dual or LIS percentage measure to identify safety net providers. Most notably, we found that the dual or LIS percentage measure proposed for the Transforming Episode Accountability Model (TEAM) would disproportionately exclude many of the largest safety net providers. For example, 36 percent of hospitals with fewer than 600 beds qualify for CMS' safety net definition for the TEAM, but only 25 percent of hospitals with more than 600 beds qualify. **Although hospital size alone is not the best measure of safety net status, CMS should ensure that hospitals of all sizes have an equal opportunity to be recognized for their safety net role in their communities.**

Excluding the largest essential hospitals from safety net provider definitions is counterproductive to CMS' stated equity goal of supporting low-income Medicare beneficiaries, because small safety net providers do not serve as many patients as large providers.

One reason why some large essential hospitals might not qualify under the TEAM safety net provider definition is that actions hospitals take to expand access might inadvertently lower a hospital's dual or LIS percentage. For example, if a hospital adds a new trauma service that serves all, regardless of ability to pay, the new service might have a lower dual or LIS percentage than other services the hospital provides that are more targeted to low-income patients. In this circumstance, the hospital's overall dual or LIS percentage might decline, even though the hospital serves more low-income Medicare beneficiaries. **CMS should ensure proposed safety net measures do not inadvertently penalize hospitals that are expanding access to essential services in their communities.**

c. MedPAC's Medicare Safety Net Index (MSNI) measure also disadvantages large public hospitals that provide essential community services.

In our analysis of the IPPS proposed rule, we also commented on the shortcomings of MedPAC's proposed MSNI, which also is largely based on Medicare-only measures and has similar shortcomings to the duals or LIS percentage measure. MSNI does include an

uncompensated care factor, which is an improvement over other definitions; but, unfortunately, this factor is weighted too low to make much of a difference in a hospital's overall MSNI.

Although we appreciate that MedPAC recognizes the need to provide additional federal support to safety net providers, **we are concerned MedPAC's proposed MSNI metric would disadvantage large, public hospitals that provide essential community services.**[13] Recently, several MedPAC commissioners have begun to voice similar concerns. For example, one commissioner noted that the MSNI methodology could "erod[e] 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."[14]

d. CMS should not use area-level indices, due to methodological shortcomings.

In the IPPS proposed rule, 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 methodological issues with area-level measures.**

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."[15] 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-

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[13] 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."

[14] The Medicare Payment Advisory Commission. *November 2022 Meeting transcript*. https://www.medpac.gov/wp-content/uploads/2021/10/November-2022-MedPAC-meeting-transcripts-SEC.pdf. Accessed August 19, 2024.

[15] 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.

income, and rural beneficiaries, as well as those with self-reported social needs.[16] 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."[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 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.

e. Our proposed facility-level metrics better identify hospitals that serve a disproportionate share of low-income patients.

Ultimately, our analysis of the IPPS proposed rule found that the measures developed by essential hospitals 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 CMS' proposed TEAM definition, essential health systems serve about twice as many low-income Medicare beneficiaries and provide twice as much uncompensated care (Table 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.**

[16] Ibid.
[17] Petterson S. 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.
[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.

TABLE 1. NUMBER OF HOSPITALS MEETING PROPOSED SAFETY NET DEFINITIONS AND SHARE OF CARE TO LOW-INCOME INDIVIDUALS

DEFINITION	NUMBER OF HOSPITALS	SHARE OF ALL IPPS HOSPITALS	SHARE OF ALL LOW-INCOME MEDICARE DISCHARGES	SHARE OF ALL MEDICAID DAYS	SHARE OF ALL UNCOMPENSATED CARE
Essential health systems (H.R. 7397)	1,035	33%	47%	66%	66%
TEAM definition based on dual or LIS percentage	1,083	34%	26%	39%	37%
Top 75th percentile of MedPAC MSNI	651	22%	12%	22%	27%
Top 75th percentile ADI	982	32%	22%	25%	25%

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 are 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. 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.

3. CMS should meaningfully engage with providers on the front lines of care for underserved populations.

Despite the evidence we provided about the benefits of our proposed measures in the response to the FY 2024 and FY 2025 IPPS proposed rules, CMS has provided only a cursory response to our legitimate concerns. For example, the agency failed to evaluate measures proposed by essential hospitals when it analyzed potential safety net provider definitions for the TEAMs model in the FY 2025 IPPS proposed rule; and in response to our most recent comments, CMS avoided any serious analysis by incorrectly claiming that data on these longstanding metrics are not available. **We encourage CMS to conduct a more thorough analysis of our proposed metrics. We are willing to work with CMS staff to help the agency better use the data it already collects.**

Ultimately, we believe that policies intended to advance health equity are made stronger by fully listening to the communities policymakers are trying to help. CMS' health equity plan also commits to "engagement with and accountability to the communities CMS serves in policy

development and the implementation of CMS programs."[19] 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.**

4. 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 that 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 use a federal designation to support essential hospitals in its Medicare OPPS policies. In particular, we note the importance of ensuring that Medicare payment rates keep up with the rising cost of care and raise concerns about how past cuts in payments for provider-based departments (PBDs) have disproportionately harmed essential hospitals that expanded access to care in underserved communities.

In our comment on the IPPS and PFS proposed rules, we offered additional suggestions for how CMS could consider a federal designation of essential hospitals in other Medicare payment programs. **We remain ready to work with CMS to consider other ways its policies can support essential hospitals and the safety net care they provide.**

Adequate Reimbursement for Essential Hospitals in all Sites of Care

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

A first step to advancing health equity is adequately reimbursing essential hospitals for the care they provide to Medicare patients. Unfortunately, MedPAC recently found in its March 2024 report to Congress that the losses hospitals incur for caring for Medicare patients have now reached record highs, because Medicare payments have failed to keep up with rising costs exacerbated by the COVID-19 pandemic.[20]

CMS proposes a net annual OPPS payment update of 2.6 percent, resulting from a 3 percent market basket update minus a 0.4 percentage point productivity adjustment. **We urge CMS to adjust its methodology for calculating the annual payment update for calendar year (CY) 2025 to ensure it provides a robust payment update that adequately incorporates the effects of inflation and rising workforce costs on hospitals.**

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

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[19] Centers for Medicare & Medicaid Services. *CMS Strategic Plan: Health Equity*. https://www.cms.gov/files/document/health-equity-fact-sheet.pdf. Accessed August 15, 2024.
[20] Medicare Payment Advisory Commission. *Report to the Congress. Medicare Payment Policy*. March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf. Accessed August 7, 2024.

2019 to 2022.[21] The pressure on hospital input costs has continued, with one recent analysis of hospital finances citing increased material costs and increased labor costs attributable to persistent workforce shortages. This analysis showed a 4 percent increase in hospital expenses, comparing year to date in 2024 with the same period in 2023; and an 18 percent increase in expenses so far in 2024, compared with the same period in 2021.[22]

To meet their commitment to ensuring access to care, essential hospitals, in particular, have incurred considerable costs through hiring and retention bonuses and increased salaries to recruit and retain nurses and other staff in short supply. 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 and well below MedPAC's recommendation to provide an additional 1.5 percent increase above the statutory amount.[23] In making this recommendation, MedPAC noted its concern that such increased support is needed to ensure Medicare beneficiaries continue to have access to acute-care hospital services.

In determining the annual fee schedule increase factor for hospitals, CMS used the inpatient market basket update figure. The agency's Office of the Actuary (OACT) estimated the market basket percentage increase, based on data from IHS Global Inc. CMS is not bound to use the IPPS market basket update. The OPPS statutory provision at 1833(t)(3)(C)(iv) authorizes CMS to deviate from the IPPS update by "substituting for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered [outpatient department] services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year." Instead, CMS could consult alternative cost data sources, such as Medicare cost report data, as a truer representation of hospital-reported cost increases. 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.

2. CMS should provide adequate reimbursement rates for essential hospitals' PBDs in light of the unique health and social challenges these facilities serve.

We continue to urge the agency to reverse course on its past policies for PBDs that penalize essential hospitals for expanding access to care in underserved communities. These so-called "site-neutral" payment policies do not have a neutral effect on essential hospitals and the patients that they serve. Instead, they undermine efforts to integrate care and cut funding from providers who are already in a precarious financial position.

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[21] 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.
[22] 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.
[23] Medicare Payment Advisory Commission. *Report to the Congress. Medicare Payment Policy*. March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf. Accessed August 7, 2024.

The current Medicare OPPS recognizes the added value of hospital outpatient departments by including a facility fee that helps to cover the additional services hospitals provide in these sites of care. This fee helps to support a hospital's ability to serve more low-income patients, its standby capacity, and its efforts to integrate care across the health system. Essential hospitals often use these enhanced payments from Medicare to expand outpatient care to offsite PBDs in underserved areas.

Unfortunately, in recent years, some policymakers have sought to undermine the high-quality care provided by HOPDs by proposing to pay hospitals at the physician fee schedule (PFS) rate, the lowest Medicare payment rate for most ambulatory services.

These policies disproportionately harm essential hospitals and the communities they serve. To help correct these inequities, CMS should use our proposed definition of essential hospitals (described above) to protect essential hospitals from these ill-conceived payment cuts.

a. Essential hospital PBDs are gateways to access for low-income beneficiaries.

Essential hospital PBDs often are the only clinics in low-income communities that provide full primary and specialty services. Because of their integrated health systems, essential hospitals can help drive down overall health care costs, including for the Medicare program, by efficiently providing coordinated care through ambulatory networks. Providing care in the outpatient setting allows hospitals to manage patients with chronic conditions, provide follow-up care to patients to avoid readmissions, avoid unnecessary emergency department visits, and reduce costs for the health care system at large. These are goals CMS should promote, not stifle, through policies that protect patient access to vital clinic visits in essential hospital PBDs.

MedPAC has reported that low-income beneficiaries rely on PBDs as their primary source of care and, as a result, site-neutral payment policies affecting PBDs that serve these beneficiaries could adversely affect access for low-income beneficiaries.[24] Indeed, CMS' implementation of Section 603—especially the inadequate payment rate—already has caused essential hospitals to reevaluate plans to expand their provider networks into underserved areas.

b. CMS can use its authority under Section 603 of the Bipartisan Budget Act of 2015 (BBA) to set a more appropriate payment rate for non-excepted PBDs of essential hospitals.

As mandated by Section 603 of the BBA, CMS discontinued paying certain off-campus PBDs under the OPPS and instead chose to pay for this care at the lowest rate for ambulatory care services, the physician fee schedule (PFS) rate. This policy has had a crippling effect on the ability of essential hospitals to expand care to additional offsite locations in underserved areas.

CMS has flexibility to determine a more appropriate payment rate for these services that better meets the needs of essential hospitals. The BBA instructed CMS to pay these non-excepted PBDs under a Part B "applicable payment system" other than the OPPS, but it did not prescribe a specific payment system or amount.

[24] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 15, 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v4_SEC.pdf. Accessed August 9, 2024.

The interim payment rate CMS established under the PFS for non-excepted items and services provided at non-excepted, off-campus PBDs is equivalent to 40 percent of the OPPS payment rate. By paying non-excepted PBDs at 40 percent of the OPPS rate, CMS grossly undercompensates essential hospitals for services they provide to complex patients. **America's Essential Hospitals urges CMS to reimburse non-excepted PBDs of essential hospitals at no lower than 75 percent of the equivalent OPPS payment rate.** Such an increase is essential to ensure rates reflect the requisite resources, staff, and capabilities necessary for PBDs both to comply with the additional CMS regulations that physician offices are not subject to and provide high-quality care to all patients. Essential hospital PBDs offer culturally and linguistically competent care tailored to the disadvantaged patients in their communities. Whether due to the clinical complexity of their patients or the additional resources needed to provide translators and wraparound services, essential hospitals incur higher costs than other facilities.

c. CMS should exempt essential hospitals' excepted PBDs from its clinic visit policy.

Beginning in 2019, CMS reduced payment rates for clinic visits at PBDs that were excepted from the BBA statutory change. This change resulted in an additional cut in payments to hospitals that disproportionately harmed essential hospitals and their efforts to expand access.

Because the clinic visit policy is a discretionary policy CMS has implemented since 2019—not one mandated by statute—CMS can use its regulatory authority to reverse the cuts for essential hospitals' PBDs. In fact, in the CY 2023 OPPS rule, CMS exempted PBDs of rural sole community hospitals (SCHs), highlighting their financial troubles and the unique access challenges their patients face, noting they "are often the only source of care in their communities."[21] Essential hospitals face similar challenges as SCHs, and once CMS designates essential hospitals using the criteria described above, CMS could apply a similar exemption.

3. America's Essential Hospitals supports CMS' proposal to reduce the prior authorization review period.

In addition to adequate payment, timely payment is important to support essential hospitals' financial viability. To that end, we appreciate and support the agency's proposal to reduce the prior authorization review period from 10 to seven days. While we continue to object to CMS' implementation of prior authorization for any outpatient department services and urge the agency to reverse this policy, reductions in the prior authorization time frame are a step in the right direction.

As CMS continues to examine whether to align the expedited review decision time frame from the current time frame of two business days to the 72-hour time frame required of other payers, we urge the agency to revise the expedited review time frame so that a review is completed no later than two business days or 72 hours, whichever is shortest. This will minimize the waiting period should it coincide with a weekend to ensure patients do not have to wait an unreasonably long time for urgently needed care.

Expanding Medicare and Medicaid Coverage to Better Meet the Needs of Patients that Essential Hospitals Serve

We support the provisions of the proposed rule to expand access to Medicare and Medicaid coverage. Although essential hospitals serve all patients regardless of their ability to pay, expanding access to health coverage helps ensure essential hospitals are more appropriately paid for the care they provide.

1. CMS should expand Medicare coverage for formerly incarcerated individuals.

We support CMS' proposal to expand access to Medicare coverage to individuals who are on parole, probation, or home detention. **Jails do not currently have an obligation to pay for care provided to this population, so the care essential hospitals provide to this population often is uncompensated (for uninsured individuals) or under-reimbursed (for patients enrolled in Medicaid).** Allowing Medicare to cover formerly incarcerated individuals who meet other Medicare eligibility criteria would help ensure hospitals can receive Medicare payment rates for this care, which often are higher than Medicaid payment rates (but still below a hospital's costs of care).

We also support CMS' proposal to align the Medicare special enrollment period (SEP) for formerly incarcerated individuals to their incarceration status determination by the Social Security Administration (SSA). This change will provide a longer grace period for individuals to enroll, reducing the likelihood of a penalty for delayed enrollment.

2. CMS should codify 12 months of mandatory continuous eligibility in Medicaid and CHIP.

We support CMS' proposal to codify 12 months of mandatory continuous eligibility in Medicaid and the Children's Health Insurance Program (CHIP) for children younger than 19, as required by the statute. This policy can help to reduce the number of children who churn in and out of Medicaid coverage for paperwork reasons, which benefits patients and the providers who serve them. For example, reducing churn can help reduce the amount of time essential hospital staff need to spend reviewing the Medicaid application process with patients and increase the amount of time they can spend focused on access to essential care.

3. CMS should revise the Medicaid clinic exception to expand access to care and address social determinants of health (SDOH).

We support CMS' proposal to allow some clinics, including those operated by Indian Health Service or Tribes and behavioral health clinics, to provide services outside the four walls of the clinic. CMS' proposal to expand the current exception would expand access for marginalized populations that might face challenges accessing care at clinic sites.

We urge CMS to consider expanding its proposal to allow urban clinics to have the same flexibility as those in rural areas. Many essential hospitals operate clinics in underserved urban areas that face similar challenges as those in rural areas, so it is unfair for CMS to place unnecessary geographic restrictions on where providers can deliver high-quality care.

Reducing Administrative Burden of Quality Measurement for Essential Hospitals

We appreciate CMS' efforts to better document the high-quality care essential hospitals provide by refining equality measures. However, we encourage the agency to fully consider the administrative burden of these measures to make sure new reporting processes do not place an undue strain on essential hospitals.

1. CMS should refine the Hospital Commitment to Health Equity measure to reward progress in each domain.

Conceptually, we support the five domains of CMS' proposed Hospital Commitment to Health Equity (HCHE) measure: (1) equity as a strategic priority; (2) data collection; (3) data analysis; (4) quality improvement; and (5) leadership engagement. The domains are aligned with our members' longstanding commitments to developing tools, programs, and action plans to advance health equity. For example, an essential hospital in North Carolina created a racial justice toolkit to help employees easily access resources to improve cultural competency. [25] Another essential hospital in Delaware teamed up with a local social justice organization for an eight-week training for health care leaders to improve health equity. [26]

We appreciate that the measure is used for reporting only as a tool to help support health care organizations in building a culture of equity. We also appreciate that, to reduce administrative burden on hospitals, the proposed measure is aligned with the inpatient HCHE measure that hospitals already report.

To further improve the usefulness of this measure, it would help if CMS gave hospitals credit for partial achievement in each domain. For example, Domain 2: Data Collection requires that hospitals attest to meeting all three elements to receive credit for this domain: (1) collecting demographic and SDOH information on the majority of its patients; (2) training for staff in the culturally sensitive collection of demographic and SDOH information; and (3) inputting demographic and SDOH information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology. However, hospitals are at different points on their journey to collect SDOH data, so it would be more helpful to reward progress by giving hospitals partial credit for implementing some but not all the measures in each domain.

2. We encourage CMS to finalize the Screening for Social Drivers of Health measure with flexibility to allow hospitals to use different screening tools, two years of voluntary reporting, and increased support for essential hospitals' ability to respond to SDOH needs.

CMS proposes two social drivers of health measures—Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health—that would be voluntary in CY 2025 and mandatory in CY 2026. The Screening for Social Drivers of Health measure assesses the percentage of patients admitted to the hospital who are 18 or older at time of admission and are screened for five health-related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety.

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[25] Racial Justice Toolkit. Atrium Health. https://teammates.atriumhealth.org/diversity-andinclusion/racial-justice-toolkit. Accessed August 14, 2024.
[26] Quinn H. The Proximity Project: Healthcare aims to reduce health inequities in Delaware. *Technical.ly*. April 15, 2021. https://technical.ly/delaware/2021/04/15/proximity-project-healthcare/. Accessed August 13, 2024.

Many essential hospitals already are doing these types of screenings because they recognize the importance of identifying all the needs of the patients they serve. For example, some essential hospitals have developed screenings for food insecurity that are linked to referrals to social programs and community resources to help address concerns.[27]

Essential hospitals currently use a variety of methods to screen for SDOH. For example, some essential hospitals administer screening electronically, while others might have health care workers screen at the point of care. Other essential hospitals use a standard, self-reported questionnaire provided through a patient portal, which has the potential benefit of more accurate answers to sensitive questions but requires that the application used be interoperable with existing EHRs to allow data to be transferred seamlessly into a patient's record. **We appreciate the flexibility CMS proposes in the use of any screening tool to meet the requirements of the proposed measure.**

We also encourage CMS to recognize the time and resources required to implement screening of all patients, as well as to train staff in the collection of such data. Essential hospitals operate on low margins, which can often make it difficult for them to make these types of investments.

We urge CMS to provide two years of voluntary reporting to allow providers, patients, and EHR vendors to improve their capacity for and implementation of more systematic screening for all five HRSNs proposed. This additional transition time also can help ensure that new screening tools can account for the needs of the diverse patients essential hospitals serve, including those with low health literacy and limited English proficiency.

Finally, we encourage CMS to consider ways it can help essential hospitals mitigate the effects of SDOHs identified through the screening process. Essential hospitals are currently working in a variety of ways to sustain effective collaboration between health care delivery and community-based services organizations to meet the unmet needs of underserved populations. However, care coordination is resource-intensive for essential hospitals that serve a population with complex social needs. Significant challenges exist in developing partnerships, building needed infrastructure, engaging patients, measuring progress, and creating sustainable funding models.

At this time, it is not clear how the screen-positive rate for SDOH should be interpreted, because it is influenced by many factors outside the hospital's control. For example, if a hospital reports a high screen-positive rate for housing instability, this could indicate a hospital's commitment to screening all patients and patients' comfort in answering the question, rising housing costs in a particular area, a lack of medical respite programs in the community, or all the above. If publicly posted, there is potential for consumer confusion about the meaning of these rates when seeking care or evaluating care quality. CMS notes this measure is "not for comparison between hospitals." We agree and, therefore, believe this measure should be limited to internal quality improvement, to identify the needs of patients, and to better connect patients with available community resources. **We urge CMS to refrain from publicly**

[27] Susman K. Food Insecurity, Health Equity, and Essential Hospitals. Essential Hospitals Institute. June 2016. https://essentialhospitals.org/wp-content/uploads/2016/06/Food-Insecurity-Health-Equity-Essential-Hospitals.pdf. Accessed August 15, 2024.

reporting this measure and, instead, provide confidential reports to hospitals similar to CMS' Disparity Methods stratified reports in the HRRP.

3. CMS should address barriers to the adoption of the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM).

America's Essential Hospitals supports patient empowerment and quality measures that capture the full spectrum of care. Collection of patient-reported outcome (PRO) data is a method of assessing pre-, peri- and post-operative care quality and functional improvement for procedures.

However, essential hospitals might face barriers to adopting PRO measures, due to the difficulty of administering them in underserved populations with low health literacy and language and cultural differences. These barriers could contribute to lower response rates for essential hospitals, thus making it challenging to interpret the findings correctly. We urge CMS to further examine the impact these barriers might have on PRO measurements among disadvantaged populations, including people with limited health literacy, before including them in the OQR program.

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

As highlighted in our comments on the FY 2025 IPPS proposed rule,[28] we recognize the urgency of addressing the maternal health crisis, particularly among underrepresented populations. But we continue to believe CoPs are not the appropriate mechanism for achieving improvements in maternity care. CoPs are inherently process-oriented and cover a broad spectrum of hospital services and departments, offering limited flexibility for hospitals to tailor their services to the unique needs of their patient populations. **We urge CMS to withdraw this proposal and to consider alternative strategies that offer hospitals the flexibility and support needed to improve maternal health outcomes effectively.**

Our member hospitals are deeply committed to enhancing maternal health and improving obstetric outcomes. However, imposing new CoP requirements risks placing additional burdens on hospitals without providing the necessary support to drive meaningful improvements. We are concerned the proposed CoPs could inadvertently penalize hospitals and their patients, particularly those in underserved or resource-limited areas, rather than fostering the improvements CMS seeks.

Rather than implementing new CoP requirements, we strongly urge CMS to explore alternative approaches that offer hospitals the flexibility to innovate and improve care in ways that best serve their communities. Technical assistance programs, learning collaboratives, and well-developed, thoroughly tested quality metrics are all potential tools that could help hospitals achieve better maternal health outcomes without the punitive implications of new CoPs.

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[28] America's Essential Hospitals. Comment Letter to CMS on FY 2025 IPPS Proposed Rule. June 10, 2024. https://essentialhospitals.org/wp-content/uploads/2024/06/AEH-FY2025-IPPS-Comment-letter.pdf. Accessed August 13, 2024.

For example, CMS could expand support for hospitals through targeted funding opportunities, evidence-based training, and the development of quality improvement initiatives specifically focused on maternal health. By providing hospitals with the resources and guidance they need, CMS can encourage improvements in care while allowing hospitals to maintain the flexibility necessary to address the unique challenges they face.

While we do have concerns about the overall approach to using CoPs, we acknowledge the importance of ensuring hospitals are prepared to respond to obstetrical emergencies and that patients receive appropriate care during transfers. We support CMS' efforts to revise the emergency services CoP related to emergency readiness and the Discharge Planning CoP related to transfer protocols, provided these revisions are crafted in a way that acknowledges the challenges faced by hospitals in rural and underserved areas. **We look forward to continuing our collaboration with CMS to ensure all obstetrical patients have access to safe, high-quality care.**

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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,

Bruce Siegel, MD, MPH
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