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June 8, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1785-P
Box 8013
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment Systems and Proposed Changes and Fiscal Year 2023 Rates Proposed Rule (CMS-1785-P)

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the proposed rule entitled “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2024 Rates,” 88 *Fed. Reg.* 26658 (May 1, 2023), issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC’s U.S. membership and expanded its reach to international academic health centers.

The following summary reflects the AAMC’s comments on CMS’ proposals regarding graduate medical education payments, hospital payment, quality proposals, and requests for information (RFIs) in the Fiscal Year (FY) 2024 Inpatient Prospective Payment System (IPPS) Proposed Rule.

- ***Graduate Medical Education.*** Finalize the proposal to reimburse graduate medical education training at rural emergency hospitals.
- ***Market Basket Update.*** Increase the market basket update to account for increased labor and supply costs.

- **Documentation and Coding.** Fully restore past year adjustments that were made to recoup excess spending that occurred due to improvements in documentation and coding in response to the adoption of the Medicare Severity-Diagnosis Related Groups (MS-DRGs) in FY 2008
- **Disproportionate Share Hospital and Uncompensated Care Payments.** Increase transparency related to the calculation of the “other” factor in the Factor 1 calculation. Account for the potential of higher rates of uninsured individuals due to the ending of the COVID-19 public health emergency (PHE) and the Medicaid unwinding in Factor 2.
- **Wage Index.** Evaluate Whether Wages Have Increased at Low Wage Index Hospitals and Establish a Clear End Date for the Proposal
- **Homelessness Z-Code.** Finalize the Proposal to Change the Severity Level Designation to CC for Z-codes Related to Homelessness
- **Safety-Net Hospital – Request for Information.** Provide additional information on the impact of the implementation of these proposals on safety-net providers and the patients that they serve.
- **Value-Based Purchasing Program.** Adopt the Health Equity Adjustment to Program Scoring as a first step to better account for and reward high quality care for underserved populations.
- **Inpatient Quality Reporting Program.** Ensure that measures are endorsed by a consensus-based entity as valid and reliable prior to their proposed adoption in the IQR and potential future hospital designations should be thoroughly vetted and tested prior to proposed adoption to ensure they are well understood and meet the needs of patients, families, and communities evaluating their options for where to seek care.
- **Promoting Interoperability Program.** Coordinate with the Office of the National Coordinator for Health Information Technology and other federal partners and stakeholders to fully understand electronic health record (EHR) reporting burden prior to future adoption of a longer EHR-reporting period in the Promoting Interoperability Program.

GRADUATE MEDICAL EDUCATION PROPOSALS

Calculating Prior Year IME Resident to Bed Ratio When there is a Medicare GME Affiliation Agreement

The AAMC thanks CMS for including detailed clarification for calculating the prior year intern and resident to bed ratio (IRB) for the indirect medical education (IME) adjustment. Specifically, CMS clarifies the determination of the net increase in FTEs in the current year as compared to the prior year when a hospital participates in an affiliated group agreement. (p. 27017). To make this determination, CMS instructs hospitals to isolate fluctuations in year-to-year FTE count for Form CMS-2552-10, Worksheet E. The step-by-step walkthrough should ensure accurate preparation of future cost reports.

Though CMS has not proposed a policy change, we thank CMS for the responsiveness to concerns raised by hospitals participating in affiliation agreements in completing these forms. These requests for clarification by teaching hospitals demonstrate a good faith effort to capture accurate cost report information. We appreciate the clarification in the proposed rule and ask CMS to continue listening to teaching hospitals when specific policies are unclear.

Graduate Medical Education Training in Rural Emergency Hospitals

The AAMC supports the CMS proposal to reimburse graduate medical education training at rural emergency hospitals (REHs); as a non-provider site where a hospital may capture resident's time when it pays for the direct cost of training residents while at the REH, or reimburse the reasonable costs of training when the REH incurs the costs of direct graduate medical education. (p. 27018). Congress, through § 125 of the Consolidated Appropriations Act, 2021, added § 1861(kkk) to the Social Security Act (the Act), creating a new Medicare provider type, the REH.¹ The new designation is meant to provide rural communities with flexibility to maintain access to care in response to the number of rural acute inpatient hospital closures that have impacted rural access to care.²

Effective January 1, 2023, rural hospitals (or hospitals treated as rural for IPPS purposes) with 50 or fewer beds and critical access hospitals (CAHs) that held these designations as of December 27, 2020, may convert to REH status. REHs do not provide acute inpatient hospital services; instead, REHs provide emergency department services and observation care. At the election of the REH, the facility may provide outpatient services and extended care services when furnished in a distinct unit licensed as a skilled nursing facility. (p. 27018). Hospitals that convert to the REH status are eligible for a subsidy payment and an add-on payment for REH services performed on an outpatient basis.³ Because these facilities do not qualify for direct graduate medical education (DGME) reimbursement under section 1886(h) of the Act and do not receive IME as they are not paid under the inpatient prospective payment system, stakeholders have asked CMS to consider reimbursing for training in REHs similar to Medicare's treatment of CAHs for DGME and IME reimbursement purposes. (p. 27018).

Specifically, CMS considers training time residents spend in CAHs as countable time to the hospital for IME and DGME if the hospital incurs all of or substantially all of the costs of training (defined as the costs of the residents' salaries and fringe benefits).⁴ Therefore, when a hospital meets the requirements for counting resident time at non-provider sites, it may include resident FTE time spent at the CAH in its DGME and IME FTE counts. Alternatively, CMS permits CAHs to incur the direct costs of training residents in approved programs and receive reimbursement for 101 percent of the reasonable training costs.⁵ No hospital may claim the time spent at a CAH when the CAH incurs the direct training costs.

CMS proposes to expand DGME and IME payment to hospitals when residents train at an REH on the same basis as it does when the training occurs in a CAH. Under the proposal, an acute care hospital may include resident training time at the REH in the DGME and IME FTE count when it meets the requirements under 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g) (e.g., when the hospital incurs the costs of the residents' salaries and fringe benefits). Alternatively, CMS proposes to reimburse the REH at 100 percent of the reasonable DGME training costs when the REH facility incurs the direct cost of training residents consistent with § 1861(v)(1)(A) of the Act. Like CAHs, no hospital may claim the resident time spent at an REH when the REH incurs the direct cost of training residents.

The AAMC supports CMS' proposal that will allow either the hospital or the REH to receive payment from Medicare for incurring the cost of training occurring at an REH. The REH program

¹ Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

² Medicare Payment Advisory Committee, Report to Congress: Medicare and the Health Care Delivery System (June 2021).

³ 87 Fed. Reg. 71748, 72162 (Nov. 23, 2022).

⁴ 84 Fed. Reg. 42411 (Aug. 16, 2019).

⁵ 84 Fed. Reg. 42044, 42411 (Aug. 16, 2019).

should provide stability in healthcare delivery systems for communities that would otherwise experience the closure of a hospital. The proposal will allow small rural teaching hospitals or CAHs that convert to an REH facility to minimize unnecessary financial burdens when they convert to an REH and choose to continue their educational mission.⁶

The size of REH facilities and training requirements from the Accreditation Council for Graduate Medical Education will likely limit the number of residents that train at these sites. Still, with new opportunities for hospitals to expand graduate medical education training through rural track programs, REH GME has the potential to create training partnerships in rural areas with larger academic medical centers. The learning experience provided to trainees in rural areas is unique and additional resources like REH GME may have positive patient care outcomes in these underserved areas. We believe that REHs can act as valuable training sites for residents and, to that end, appreciate CMS's consideration of REHs as GME-eligible facilities. Ultimately, this proposal helps limit the financial barriers for any REH with the capacity to operate as a rural training site.

PAYMENT PROPOSALS

PROPOSED MARKET BASKET UPDATE

Increase the Market Basket Update for FY 2024 to Reflect Higher Growth in Labor and Supply Costs

CMS is proposing an increase to the standardized amount of 2.8 percent reflecting a market basket update of +3.0 percent and a total factor productivity adjustment of minus 0.2 percent for FY 2024.⁷ We are concerned that the data used to calculate the FY 2024 market basket update are not representative of the significantly higher growth in labor and supply costs hospitals have experienced as a result of the public health emergency.

The data used to calculate the market basket update does not accurately reflect the dramatic increase in labor and supply costs that hospitals and health systems have experienced in FY 2022 and FY 2023. The Medicare Payment Advisory Commission notes that "hospitals' Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates."⁸ Further, recent reporting indicates that labor costs are 19 percent year-to-date higher in March 2023 as compared to March 2020.⁹ We do not see these cost trends lessening in FY 2024 or the foreseeable future.

Moreover, CMS finalized in the FY 2022 IPPS final rule a market basket update of 2.7 percent based on data that did not anticipate or incorporate the record high inflation and significant increases in the costs of labor, drugs, and equipment. The most recent data available reveals the actual market basket update for 2022 is 5.7 percent, a difference of 3.0 percent from the CMS estimates. CMS calculates the market basket based on forecasts rather than actual historical labor and supply cost increases; it does not

⁶ Pink, GH et al. [How Many Hospitals Might Convert to a Rural Emergency Hospital \(REH\)?](#) N. Car. Rural Health Research Program (2021).

⁷ Hospitals that successfully report quality measures and are meaningful users of electronic health records are eligible for the full payment update.

⁸ Medicare Payment Advisory Commission. March 2023 Report to Congress. https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf

⁹ https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf

incorporate the challenging circumstances brought on by the pandemic. Therefore, using the current methodology to calculate the payment update inaccurately estimates the financial strain hospitals have experienced and will continue to experience in FY 2024 and is insufficient to address these cost increases.

Given the exceptional times we are in, the increase in labor costs that are expected to remain and the continuing financial struggles of hospitals as they try to maintain access to services, we call on CMS to utilize its “exceptions and adjustments¹⁰” to adjust the FY 2024 hospital update for forecast error in the FY 2022 hospital market basket just as CMS is proposing to do for the FY 2024 skilled nursing facility (SNF) update and the FY 2024 capital IPPS update. For the FY 2024 SNF update, CMS is proposing to increase the market basket update of 2.7 percent by 3.6 percentage points for forecast error in application of the FY 2022 update. (p. 21321). For the FY 2023 capital IPPS update, CMS is proposing a forecast error adjustment of 0.9 percentage points for an underestimate of FY 2022 capital inflation. (p. 27229).

In both payment systems, CMS is applying the forecast error adjustment based on previously established policy if the difference between the update and the actual rate of inflation using after-the-fact data differs by more than a threshold amount (0.5 percentage points for the SNF update and 0.25 percentage points for the capital IPPS update). While CMS has not developed an analogous policy for the IPPS operating update, we believe such a forecast error adjustment to the FY 2024 IPPS operating update could be adopted under CMS’ rulemaking authority.

In last year’s IPPS rule, CMS rejected many comments suggesting ways to increase the market basket update on the basis that the ideas had not been proposed. For instance, in response to comments that CMS use its “exceptions and adjustments” authority under section 1886(d)(5)(i) of the Act to apply a forecast error adjustment to the FY 2023 IPPS update, CMS responded that “we did not propose to use our authority under section 1886(d)(5)(I)(i) of the Act to apply a forecast correction in updating the IPPS rates for FY 2023.”¹¹

The implication of CMS’ response is that the policy being suggested had not been proposed and adopting such a policy would not be in accordance with rulemaking procedures under section 1871 of the Act. However, CMS has made the inpatient update and the hospital market basket subject to public comment in the FY 2024 IPPS proposed rule. CMS could adopt a forecast error correction to the FY 2024 hospital market basket on the basis that the comment is a “logical outgrowth” of the proposed policy under consideration consistent with section 1871(a)(4) of the Act.

As there is no statutory or regulatory policy that prohibits CMS from adopting a forecast error adjustment to the FY 2024 IPPS market basket update, CMS would not need to invoke section 1886(d)(5)(i) of the Act authority to adopt our suggestion. Rather, CMS could adopt the suggestion under normal rulemaking procedures as our comment is a logical outgrowth of the market basket update that CMS has made subject to public comment in the FY 2024 IPPS proposed rule.

¹⁰ Section 1886(d)(5)(I) of the Social Security Act

¹¹ 87 FR 49054

DOCUMENTATION AND CODING

Fully Restore Past Year Adjustments That Were Made to Recoup Excess Spending Related to Documentation and Coding

The FY 2024 IPPS proposed rule did not include an adjustment for documentation and coding to FY 2024 IPPS rates. However, section 7(b)(2) and 7(b)(4) of the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (TMA) – as subsequently amended by the Taxpayer Relief Act of 2012, MACRA¹² and the 21st Century Cures Act – requires CMS to fully restore past year adjustments that were made to recoup excess spending that occurred due to improvements in documentation and coding in response to the adoption of the MS-DRGs in FY 2008.

Since FY 2014, CMS had made recoupment adjustments to IPPS rates totaling minus 3.9 percent. However, CMS only restored 2.9588 percentage points of these reductions¹³ – a difference of 0.9412 percentage points. Section 7(b)(2) of the TMA states “an adjustment made under paragraph (1)(B) [documentation and coding] for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges in a subsequent year.” Section (7)(b)(4) of the TMA states:

Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) [documentation and coding] other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.”

Taken together, these provisions indicate that CMS may not carry forward the 0.9412 percentage point reduction to IPPS rates for documentation and coding that has not been fully restored to the IPPS standard amounts beyond FY 2023. AAMC requests CMS make a documentation and adjustment of +0.9412 to the IPPS rates for FY 2024 as required by section 7(b)(2) and 7(b)(4) of the TMA.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL AND UNCOMPENSATED CARE PAYMENTS

CMS is continuing the same methodology for calculating the uncompensated care pool (UCP) and estimates it will amount to \$10.216 billion after Factor 1 is applied for FY 2024 (p. 26990). After Factor 2 is applied, which considers the difference in current uninsured rates as compared to 2013 prior to the enactment of the Affordable Care Act, the UCP estimate is \$6.713 billion. (p.26993). In comparison to the previous years’ UCP this is a 2.35 percent drop in the amount of funds available for distribution to disproportionate share hospital (DSH) qualifying hospitals.¹⁴ Over the past four years, the UCP amounts available each year have steadily decreased with a dramatic decline between FY 2021 and FY 2022. This has raised concerns around the transparency of data used and the effects of the COVID-19 PHE.

¹² Medicare Access and CHIP Reauthorization Act of 2015. (Pub. L. 114-10)

¹³ 87 FR 48800

¹⁴ The FY 2024 proposed UCP pool value of \$6.713 billion compared to the FY 2023 final UCP pool value of \$6.874, pg 49033 Federal Register, Vol. 87, No. 153.

Provide Greater Transparency Around “Other” Factors Used to Determine Factor 1

CMS utilized the Office of the Actuary’s (OACT) January 2023 Medicare DSH estimates that were based on the September 2022 Hospital Cost Report Information System (HCRIS) update and the FY 2023 IPPS/LTCH PPS final rule impact file to estimate Factor 1. (p.26990). CMS bases these estimates on OACT’s Part A benefits projection model which creates a baseline for Factor 1 and is then updated using a number of additional factors including Medicare rates, discharges, case mix, and “other” factors. (p. 26991). For FY 2024, CMS notes some of the “other” factors applied to Factor 1 include payment rate adjustments that are not reflected elsewhere in the applied factors such as the 20 percent add-on payment to the MS-DRG relative weight for certain COVID-19 discharges. However, CMS is not comprehensive in their explanation of the “other” factors and does not detail what data is utilized for this or how it is applied. (p.26991). CMS also references Medicaid enrollment as being included in the ‘other’ factor but does not give adequate information to assess the impact. (p.26991). The AAMC does not feel that CMS is providing sufficient transparency around the data sources or calculations used in the application of these “other” factors. In other words, not all the factors considered as ‘other’ are known or understood by stakeholders to appropriately replicate CMS’ calculations.

As mentioned in our FY 2022 comment letter, we continue to echo our concerns that the information being used in the “other” factor is not accurately accounting for the effects of the COVID-19 PHE.¹⁵ Specifically, it is unclear how this “other” factor takes into account the flexibilities that ended when the PHE ended, including additional payment add-ons and the Medicaid redeterminations (“unwinding”), which is expected to significantly effect Medicaid enrollment. The AAMC strongly urges CMS to provide greater transparency on how OACT determines the “other” factor—including both the calculation and individual numbers included in the estimate—so that stakeholders can adequately understand and assess the appropriateness of the Factor 1 amount and the impact of the COVID-19 PHE and the Medicaid unwinding for FY 2024. The lack of transparency around the “other” factor makes it difficult for stakeholders to properly assess CMS’ proposed Factor 1 amount. While CMS does provide some examples of the types of data that is included in the “other” factor such as Medicaid enrollment and various payment adjustments, not enough specific and meaningful information is provided to allow stakeholders to determine how these affect the factor. Since it is unclear how influential each of these are and it is unknown what other unnamed factors are considered, the AAMC cannot be confident in assessing the reasonability or appropriateness of the proposal especially in light of the unprecedented impact the unwinding of the PHE will have on FY 2024.

One potential way of addressing this issue would be to disaggregate the “other” factor into the main variables that affect its value. For instance, CMS mentions that the “other” factor includes the effect of the difference between total inpatient hospital discharges and IPPS discharges, estimated changes in Medicaid enrollment and the 20 percent MS-DRG relative weight add-on for COVID-19 discharges. CMS could show the impact of each of these named factors and its weight in the “other” factor with a residual for all other items that have less of an impact on the final value.

Account for Expected Higher Rates of Uninsured Individuals Due to the Ending of the Public Health Emergency in the Calculation of Factor 2

Factor 2 of the uncompensated care methodology determines the total available uncompensated care payment pool. This is determined annually by a percentage amount that represents the percent change in

¹⁵ [AAMC Comments on FY 2022 Proposed IPPS Rule](#)

the rate of uninsured individuals in FY 2013 and the estimated percent of uninsured in the most recent year where data is available. OACT determines Factor 2 based on data from the National Health Expenditures Accounts (NHEA). CMS is proposing to continue to use the same methodology to calculate Factor 2 as they have in previous years.

During the COVID-19 public health emergency, many individuals and families became eligible for enrollment in Medicaid who were otherwise previously ineligible. This was made possible through the Families First Coronavirus Response Act¹⁶, which provided states with enhanced Medicaid funding if states maintained continuous coverage for Medicaid beneficiaries during the PHE. States were also able to claim a temporary federal medical assistance percentage (FMAP) increase if they maintained beneficiary enrollment and coverage of all Medicaid beneficiaries through the end of the month in which the COVID-19 PHE ends. Section 5131 of the Consolidated Appropriations Act, 2023¹⁷ separated the end of the continuous enrollment from the end of the COVID-19 PHE. States began Medicaid redeterminations on April 1, 2023. As states unwind the continuous coverage enrollment requirements, a KFF survey revealed that as many as 17 million people could lose Medicaid coverage.¹⁸ The AAMC continues to be concerned about the anticipated loss of insurance coverage for millions of Medicaid-eligible individuals as the unwinding process continues.¹⁹

Due to the anticipated loss of insurance coverage for millions of Americans, we do not feel that the current proposal for Factor 2 takes into account the potential dramatic increase in uninsured rates that are predicted following the ending of the PHE. With this in mind, we urge CMS to consider alternative data sources or calculations that more accurately account for the expected increase in the uninsured rate for FY 2024 due to the unprecedented nature of the Medicaid unwinding.

We are also concerned that the current data from the NHEA that CMS is proposing to utilize for Factor 2 is not up to date. The data used in the current proposed rule appears to be the same data utilized in the FY 2023 IPPS final rule and has not been updated to reflect more current trends, including the Medicaid unwinding. If CMS chooses to continue with their proposal of utilizing the same NHEA data used in the FY 2023 rule, then CMS should also consider implementing a one-time bump in the percentage used in Factor 2 to account for the lag in data and the predicted rise in the uninsured rate following the Medicaid unwinding in FY 2024.

Include Medicaid 1115 Waiver Days in the Calculation of the Medicaid Fraction

AAMC is also concerned about the potential impact of CMS' proposed rule "Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction".²⁰ In that proposed rule, CMS proposed to modify the definition of "regard as' eligible for medical assistance under a state plan approved" for the purpose of Medicare DSH calculations, which will affect the calculation for hospitals' DSH payments. AAMC provided comments to CMS on the proposed rule, which urged the agency not to finalize the proposal. We specifically emphasized that the proposal does not accurately capture the Medicaid-eligible patient population since it does not include individuals who qualify under an 1115 waiver with a limited set of

¹⁶ Pub. L. 116-127

¹⁷ Pub. L. 117-328

¹⁸ KFF, [How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?](#) April 26, 2023.

¹⁹ [AAMC Comments on FY 2023 IPPS Proposed Rule](#)

²⁰ [88 FR 12623](#), Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction

benefits. AAMC interprets these individuals to still be considered Medicaid beneficiaries and therefore should be included in the Medicaid fraction.²¹ With this in mind, we again urge the Agency to consider the potential impact of this policy on uncompensated care payments for disproportionate share hospitals.

MEDICARE WAGE INDEX - *Low Wage Index Policy*

Evaluate Whether Wages Have Increased at Low Wage Index Hospitals and Establish a Clear End Date for the Proposal

In the FY 2020 IPPS final rule, CMS finalized policies aimed at addressing disparities between high and low wage index hospitals that occur in the current wage index calculation. The finalized low wage index policy directly raised the wage index of the lowest quartile wage index hospitals by half the difference between the 25th percentile wage index value and the hospital's individual wage index. The goal for this policy was to provide an opportunity for these low wage index hospitals to increase employee compensation, which would then be permanently reflected in future wage index data. CMS stated that it would retain the policy for at least four years to allow low wage index hospitals to raise wages.

In this proposed rule, CMS is proposing to continue the low wage index policy for FY 2024. Additionally, CMS intends to continue to apply a budget neutrality adjustment to the standardized amount to offset the increase in IPPS payments to low wage index hospitals. The AAMC previously supported the Agency's proposal to raise low wage hospitals' wage indexes but opposed doing so in a budget neutral manner.²² The Association remains opposed to continuing the policy in a budget neutral manner.

When originally finalized, CMS stated that it would apply this policy for a minimum of four years citing the four-year data lag that would occur between increasing wages and seeing these increases reflected in the wage index data. However, four years have passed since the Agency finalized the proposal, yet it is proposing to extend the policy into FY 2024 for a fifth year. CMS supports the policy extension by citing a lack of sufficient data and understanding of the impact of the policy. CMS states that at this time it only has one year of relevant data – FY 2020 data – that it could use to evaluate the impacts of the policy. (p. 26978).

As the AAMC has stated in previous comment letters, we urge CMS to consider the impact the COVID-19 PHE has had on area wage indexes.²³ In recent years, wages have increased across the board. The KFF and Peterson Center on Healthcare have evaluated changes to hospital employment data, including wage data, from February 2020 at the start of the pandemic through November 2022. They found that the average weekly earnings for health sector employees had gone up 17 percent from \$1,039 to \$1,216 weekly during the COVID-19 public health emergency. Even more specifically, the report found that from February 2020 to November 2022, hospital-based workers saw a 16.9 percent increase in weekly wages from \$1,268 to \$1,482 weekly.²⁴ With this in mind, we urge CMS to evaluate and consider more current wage data to understand if disparities in wages still exist and to determine whether the current low wage index policy continues to be necessary.

²¹ [AAMC Comment Letter on Proposed Change to Days Counted for DSH Calculations](#) (April 2023)

²² [AAMC Comment Letter on FY 2020 IPPS Proposed rule.](#)

²³ [AAMC Comment Letter on FY 2023 IPPS proposed rule.](#)

²⁴ Imani Telesford, Emma Wagner, Paul Hughes-Cromwick, Krutika Amin, Cynthia Cox, [How Has Health Sector Employment Recovered Since the Pandemic?](#), Pearson-KKF (2023)

However, if CMS finalizes the continuation of this the low wage index policy for FY 2024, CMS should also establish a clear end date to evaluate the effectiveness of the low wage policy. For a variety of reasons including the PHE and other factors impacting wages, it is likely that changes to employee compensation may not be directly related to the low wage index policy. Therefore, CMS should consider other factors, including other data, to determine if the low wage index policy has resulted in increased wages or if other factors also contributed to increased wages. Additionally, CMS should consider continuing the policy in a non-budget neutral manner if the low wage policy is continued in FY 2024. This will allow the agency to improve the standing of low wage index hospitals without impairing the standing of high wage index hospitals.

PROPOSED CHANGES TO Z-CODES FOR HOMELESSNESS

Finalize the Proposal to Change the Severity Level Designation to CC for Z-codes Related to Homelessness

For FY 2024, CMS is proposing to change the severity level designation for three ICD-10-CM diagnosis codes describing homelessness – Z59.0, Z59.01, and Z59.02 – from NonCC to CC. In the FY 2023 IPPS proposed rule, CMS requested comments on how reporting of diagnosis codes in categories Z55-Z65 might improve its ability to recognize severity of illness, complexity of illness, and/or utilization of resources under MS-DRGs. As part of that request for comment, CMS sought comments on which specific Social Determinants of Health (SDOH) diagnosis codes were most likely to increase hospital resource utilization for inpatient care. The proposed rule notes that prior to FY 2022, homelessness was one of the more frequently reported SDOH codes. (p. 26748).

CMS notes that FY 2019 and FY 2020 MedPAR data suggests that when homelessness is reported as a secondary diagnosis, the resources involved in caring for these patients are more aligned with a CC than a NonCC or an MCC. (p. 26748 - 26749). The AAMC supports the proposal to change the severity level designation to CC for the codes describing homelessness. We agree that these patients can be more medically and socially complex and thank CMS for acknowledging this through the change in severity level designation.

The proposed rule notes CMS' concern that inconsistent reporting of Z codes may inadequately reflect the additional resources hospitals may be required to utilized to care for medically and socially complex patients. (p. 26750). One factor that may negatively impact comprehensive reporting is the limit on the number of diagnoses that can be reported on an inpatient claim. We have heard from our members that the cap on the number of diagnosis codes allowed to be included on Medicare inpatient claims may hamper Z code reporting due to competing reporting priorities for both payment and quality measures. In other words, more than 25 diagnosis codes are needed on inpatient claims. AAMC analysis revealed that 17 percent of inpatient claims reached the maximum limit of 25 diagnoses that can be reported on the claim.²⁵ CMS should evaluate the potential to expand the number of diagnosis codes that can be submitted. Alternatively, CMS should consider ways to capture SDOH Z codes when there are no more

²⁵ Source: AAMC analysis of FY2021 Medicare Provider Analysis and Review (MedPAR) File. Beneficiaries enrolled in Medicare Advantage, those who discharge dead or leave against medical advice were excluded from the analysis.

available spaces for diagnosis codes. For example, CMS could design a separate way to report the Z codes on the claim form, separate and distinct from the diagnosis codes.

The AAMC continues to support the expanded use of SDOH Z codes and believes CMS should continue to evaluate provider use of them before mandating their reporting. It is important to ensure alignment of reporting these codes for payment with the screening quality measure and address potential challenges to include these codes on the inpatient claim. Further, provider education on the reporting Z codes should be a priority if CMS chooses to expand the use and reporting.

SAFETY-NET HOSPITALS – REQUEST FOR INFORMATION

The Agency seeks comments on policy options that align with CMS’ goals to improve health equity while supporting safety-net providers. The proposed rule specifically seeks feedback on the Medicare Payment Advisory Commission’s (MedPAC’s) Medicare Safety-Net Index proposal and the use of the area deprivation index as a measure of underservice for addressing health related social needs. The AAMC supports efforts to address social determinants of health and improve health equity. However, we believe that these proposals, which are directed at safety-net providers, could negatively impact access to needed care for low-income, vulnerable populations. Safety-net providers are often the only access point to medically necessary care for these patients. They deliver care often without regard to whether patients can pay. Policy proposals should support all safety-net providers rather than diverting reimbursement that may negatively impact some providers.

Lastly, these proposals are complicated, and the proposed rule does not provide sufficient detail for stakeholders to fully understand how CMS would implement each proposal. For example, what would be the timeframe for implementation? How would CMS ensure that beneficiaries’ access to medically necessary care is not cut off? How will CMS evaluate the short-term impact of the proposal on hospitals’ financial stability if there is a lag in data collection? We urge CMS to continue to engage stakeholders in discussions on how best to support safety-net providers to ensure access to care for all patients.

Medicare Safety-Net Index (MSNI)

CMS seeks stakeholders’ feedback on MedPAC’s Safety-Net Index recommendation. The MedPAC MSNI proposal would replace the current disproportionate share hospital payment calculation and redistribute DSH and uncompensated care payments to hospitals that treat higher volumes of Medicare beneficiaries. The AAMC is concerned that redirecting DSH and uncompensated care dollars to hospitals that serve large Medicare populations would negatively impact hospitals that do not. Redistribution of DSH and uncompensated care payments diverts from the intent of these payments, which is to assist acute care hospitals (subsection (d) hospitals) that serve a significantly disproportionate number of low-income patients. (p. 26986). Included within the *low-income patient population* (emphasis added) are Medicaid beneficiaries as evidenced by the inclusion of Medicaid inpatient days in the DSH calculation. Strictly looking at Medicare-only beneficiaries excludes a large portion of individuals that benefit from Medicare uncompensated care payments and neglects the nuances that exist among the low-income population and the interconnectedness of the two programs.

AAMC-member hospitals and health systems serve as critical access points for many low-income and underserved populations. Patients’ access to care would suffer under the MSNI proposal, particularly low-income and Medicaid patients that rely on AAMC-member hospitals and health systems for their

care. Moreover, the MSNI proposal would further worsen hospitals' financial struggles and their ability to care for all patients. The redistribution of DSH and uncompensated care payments would exacerbate the financial instability of hospitals that currently have negative overall margins, resulting in closure of those hospitals. This appears in contrast to the intent of the MSNI proposal – to help less profitable hospitals.²⁶

Some AAMC member health systems impacted by this redistribution would see DSH and uncompensated care payments decrease by tens of millions of dollars.²⁷ The MedPAC MSNI proposal includes \$2 billion in additional funding. Even with this infusion of new funding, it appears that many hospitals would still be at risk of closing. MedPAC notes that adding \$1 billion to the FFS MSNI pool, 5 percent of all hospitals impacted by the MSNI would see their all-payer margins decrease by 1.7 percent.²⁸ Hospitals with high uncompensated care costs would be disproportionately impacted. MedPAC goes on to say that about 7 percent of hospitals would lose their DSH and uncompensated care payments and *not* (emphasis added) receive any of the new MSNI payments.²⁹ Finally, FFS Medicare margins under the MSNI would decrease to **negative** 7.9 percent from the actual 2019 FFS Medicare margin of **negative** 7.2 percent.³⁰ These cuts are unsustainable. Diverting funds away from these safety-net providers will further exacerbate access.

According to MedPAC, hospitals that treat higher levels of Medicare beneficiaries, particularly low-income Medicare beneficiaries, generate lower levels of profitability and are at higher risk of closure.³¹ MedPAC also notes that Medicare payments to hospitals were below hospitals' costs in 2021. Further, hospitals' Medicare margins in 2023 will be lower than in 2021 and MedPAC projects them to decrease to about negative 10 percent, similar to 2017 levels.³²

Moreover, many of the hospitals affected by the MSNI proposal also care for a large number of Medicaid beneficiaries and the rates Medicaid pays to hospitals are extremely low, lower than Medicare. In 2021, AAMC-member teaching hospitals accounted for almost 28 percent of all Medicaid inpatient days.³³ According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid fee-for-service (FFS) base payments are significantly below hospitals' costs of providing services to Medicaid enrollees. In March 2023, MACPAC published an analysis showing that Medicaid FFS base payment rates to hospitals were 78 percent of Medicare rates for the 18 MS-DRGs the commission reviewed.³⁴ Although states can supplement these low payments, state supplemental payments would not be able to

²⁶ Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. [Chapter 3](#). June 2022.

²⁷ Source: AAMC modeling of MedPAC's Safety-Net Index hospital payment recommendation.

²⁸ Medicare Payment Advisory Commission. Report to Congress: Hospital Inpatient and Outpatient Services. [Chapter 3](#). March 2023. Table 3-8.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Medicare Payment Advisory Commission. Report to Congress: Hospital Inpatient and Outpatient Services. [Chapter 3](#). March 2023.

³³ Source: AAMC analysis of American Hospital Association (AHA) Annual Survey Database, FY2021. Hospital counts reflect total number of hospitals in the database and excludes federal hospitals, long-term care hospitals, and specialty hospitals. Reflects AAMC membership as of 2022.

³⁴ Medicaid and CHIP Payment and Access Commission. [Issue Brief](#): Medicaid Base and Supplemental Payments to Hospitals. March 2023.

cover the shortfall imposed by the MSNI proposal. Cutting DSH payments to hospitals with higher Medicaid populations will impede their ability to care for all patients, not just Medicaid beneficiaries.

Finally, implementation of the MSNI seems complicated and leaves many questions unanswered. For example, there is not sufficient analysis on the impact of the distribution under the MSNI. The MSNI would shift DSH dollars that fund inpatient care to include outpatient care, which is a dramatic change to the current system. This would negatively impact hospitals that have high volumes of inpatient care. The degree to which DSH dollars are redistributed based on inpatient only and inpatient and outpatient combined adjustments is unclear.

Further, DSH payments are currently tied to traditional Medicare and it seems that the DSH pool would decrease as enrollment in Medicare Advantage increases. What will be the impact on hospital payments as more beneficiaries choose to enroll in Medicare Advantage? Will Medicare Advantage be factored into the MSNI calculation?

Area Deprivation Index (ADI)

CMS also seeks feedback on the use of the ADI as a measure to determine health related social needs and SDOHs. The proposed rule states that the ADI measure is intended to capture local socioeconomic factors correlated with medical disparities and underservice. (p. 27189). As with the discussion of the MSNI in the proposed rule, the ADI write up provides little specificity on implementation, how additional payments to safety-net providers would be calculated, and the impact on safety-net providers and the patients that they serve, leaving many unanswered questions.

The AAMC is concerned that the ADI does not accurately capture areas of underservice in certain geographic areas. Specifically, variables tied to cost-of-living, such as median monthly mortgage, median monthly rent, and median home values are included in the ADI are correlated with areas of low social need. A recent Health Affairs article noted that the emphasis on home value can be an inaccurate predictor of an areas social need.³⁵ The Association is concerned that without sufficient context on how the measures associated with the ADI impact the score, simply assuming that high real estate values equate to low areas of need is misleading. The proposed rule notes that many rural areas may have relatively high levels of neighborhood disadvantage and high ADI levels. (p. 27189). We agree, but the suggestion that rural areas have higher levels of social need as compared with areas that have higher real estate values may not capture the underservice in these areas. We, therefore, urge CMS to evaluate the use of standardized cost-of-living variables in the ADI to remove distortions for national percentile rankings due to large geographic variation.

The RFI touches on how the ADI is used in the Medicare Shared Savings Program; however, it is unclear how this translates to prospective payments to hospitals as it relates to identifying safety-net hospitals. For example, how would patients be assigned to hospitals to determine payment? The proposed rule states that patients living in an area with an ADI score ranked in the 85th percentile nationally or above is a validated measure of neighborhood disadvantage. It goes on to say that a score of 85 or above is a predictor of poor health outcomes. How would this measure be used to prospectively assign patients to a hospital? Assigning a hospital's ADI based on its catchment area or using a cut-off of the 85th percentile could inaccurately capture underservice. The AAMC believes the 85th percentile reflects a high threshold for scoring the ADI and may eliminate a large cohort of individuals that reside in underserved areas that

³⁵ Hannan, E., Wu, Y., Cozzens, K., Anderson, B. The Neighborhood Atlas Area Deprivation Index for Measuring Socioeconomic Status: An Overemphasis on Home Value. Health Affairs. May 2023.

score below the 85th percentile. For example, as described in our comments to proposals for the Value-Based Purchasing Program in this letter, we note it appears that no beneficiary residing in the District of Columbia would reside in an area scored greater than or equal to the 70th percentile nationally.

When referencing how the ADI is used to calculate the payments to accountable care organizations (ACOs) in the Shared Savings Program, the RFI states that CMS assigns each of the ACO's prospectively assigned beneficiaries a risk factors-based score. Specifically, the proposed rule states that the risk factors-based score will be set to 50 if the beneficiary is not enrolled in the low-income subsidy program or is not dually eligible for Medicare and Medicaid and sufficient data is not available to match the beneficiary to an ADI national percentile rank. (p. 27189). This assumption and the generalized categorization of beneficiaries when sufficient data is unavailable may grossly underestimate the needs of some of the most vulnerable patients, such as those experiencing homelessness. In order for stakeholders to assess the impact of this proposal, CMS should clearly articulate what data would be used to assign a beneficiary to a hospital for payment.

Finally, coupling the assumed 50th percentile score policy with a potential threshold of the 85th percentile nationally to recognize neighborhood disadvantages appears on its face to significantly undercount underserved communities most needing safety-net payment support. Therefore, we ask CMS to both reconsider the use of a threshold cutoff at the 85th percentile nationally, and to revisit its policy to assume a beneficiary resides in an area at the 50th percentile when there is insufficient data to match the beneficiary to an ADI national percentile rank.

HOSPITAL QUALITY PROPOSALS

VALUE-BASED PURCHASING (VBP) PROGRAM

Adoption of New or Refined Measures

CMS proposes to adopt one new quality measure and two refined versions of existing measures in the Hospital Value-Based Purchasing (VBP) Program. Comments on specific measure proposals follow.

Severe Sepsis and Septic Shock: Management Bundle (CBE #0500, SEP-1)

CMS proposes to adopt the SEP-1 measure into the VBP under the Safety Domain beginning with FY 2026 payment determinations under the Program. (p. 27027) Performance on the measure would be scored for inpatient discharges in CY 2024 and improvement scoring would be to a CY 2022 performance baseline. (p. 27033)

The AAMC fully supports the development and adoption of a valid, reliable, feasible outcomes measure to inform and improve effective and timely sepsis care. However, we urge CMS to focus on development of a better measure due to current challenges with the measure in the Hospital Inpatient Quality Reporting (IQR) Program rather than adopting this measure into the VBP. The primary challenges with the measure include reconciliation of current specifications with infectious disease expertise on the use of antibiotics and the burden of chart-abstracted measurement. The AAMC is concerned that shifting this measure to a pay-for-performance program amidst clinical disagreement on measure specifications and ongoing abstraction issues will provide no additional benefit to patients, considering the measure's current use in the IQR. Instead, it could frustrate hospital efforts to improve sepsis care by creating a financial incentive to potentially overuse antibiotics against clinical judgment or

treat according to clinical judgment and document (as well as invest in sophisticated data abstractors) to enhance performance scoring. Measurement should always guide and incent quality improvement, especially in pay-for-performance programs.

CMS notes that the pre-rulemaking review process included public comments expressing concern that the measure’s adoption in the VBP “could result in the overuse of antibiotics” due to including “administering antibiotic therapy to all patients with possible sepsis, regardless of severity-of-illness.” (p. 27028) CMS dismisses this concern stating, “[w]e believe there is enough flexibility to incorporate clinician judgment in the measure.” (p.27028) Expanding on this concern, the Infectious Diseases Society of America (IDSA) and five other endorsing societies, called on CMS to address significant concerns that the measure fails to “account for the high rate of sepsis overdiagnosis and encourages aggressive antibiotics for all patients with possible sepsis, regardless of the certainty of diagnosis or severity of illness.”³⁶ To mitigate the potential for antibiotic overuse, the IDSA recommends that CMS modify the measure to focus solely on septic shock, for which there is the greatest evidence supporting the benefits of immediate antibiotics, whereas there is “insufficient data on the necessity of immediate antibiotics to support a mandatory treatment standard for all patients.”³⁷ The AAMC urges CMS to provide greater evidence in response to this critical concern to ensure that the measure is congruent with efforts to combat antibiotic overuse and potential antibiotic resistance and provides actionable information for improvement.

In documentation submitted by the measure developer to the Measure Application Partnership, it was noted that this measure requires data abstractors to review documentation in various formats, including narrative free text, to identify specific information to report the measure and that as currently specified the information cannot be captured electronically in discrete fields. Some of this effort is necessary to ensure documented cases of appropriate clinical judgment against immediate antibiotics are captured to ensure accurate measure scoring but requires significant background expertise identifying and parsing out complex clinical information and time-consuming attention to the abstraction process. The IDSA recommendation to focus the measure on septic shock would simplify data abstraction, in part by limiting measurement to evidence-based elements without greater need to identify and account for more flexible clinical judgment to mitigate unintended consequences of measurement.³⁸ Furthermore, regarding the burden of manual chart-abstraction, CMS has previously committed to moving Medicare quality measurement into the digital age, as early as 2025.³⁹ The AAMC asks CMS to provide greater discussion of the benefits of adopting a burdensome chart-abstracted measure for the VBP in contrast to the agency’s broader goals for digital measurement.

Substantive Measure Updates to Medicare Spending per Beneficiary (MSPB) – Hospital Measure (CBE# 2158)

CMS proposes to adopt the refined MSPB – Hospital Measure previously adopted in the IQR beginning with FY 2028 payment determinations, based on performance on the measure for CY 2026 (p. 27025). The AAMC previously supported the measure refinements for the pay-for-reporting IQR but we

³⁶ C Rhee et al., [Infectious Diseases Society of America Position Paper: Recommended Revisions to the National Severe Sepsis and Septic Shock Early Management Bundle \(SEP-1\) Sepsis Quality Measure](#), Clin Infect Dis. (2021).

³⁷ *Id.*

³⁸ *Id.*

³⁹ 86 FR 44774 (August 13, 2021) at 45345, where CMS lays out potential actions in four areas to transition to digital quality measures for quality reporting and value-based purchasing programs by 2025.

recommend CMS reconsider measure adoption for the VBP in next year's rulemaking. This delay would allow for greater stakeholder understanding of how the measure refinements impact hospital performance (on a measure that accounts for 25 percent of the Total Performance Score) and to be able to provide more robust feedback in response to its proposed adoption. As CMS notes in this proposed rule, the refined measure is not yet available for public reporting and will not be until the January 2024 refresh to *Care Compare* (p. 27025), and hospitals have yet to see confidential feedback on performance under the updated specifications. While this timeline meets CMS's statutory obligation to publicly report a measure prior to adoption in the VBP, the AAMC believes it does not meet the spirit of the law to ensure that hospitals and stakeholders are able to fully vet the measure's inclusion in the pay-for-performance program.

Substantive Measure Updates to the Hospital-Level Risk-Standardized Complication Rate Following Elective THA/TKA (CBE #1550)

CMS proposes to adopt the refined THA/TKA complications measure previously adopted in the IQR beginning with FY 2030 payment determinations, based on performance on the measure from April 1, 2025, through March 31, 2028 (p. 27026). The AAMC previously supported the measure refinements for the IQR and supports the measure updates for the VBP. We implore CMS to commit to evaluating the ongoing shift of site of service for elective lower extremity joint replacement procedures from the inpatient setting to the outpatient setting⁴⁰ and to update its proposals for the VBP should such shifts reduce measure validity or reliability by the time of its proposed adoption for FY 2030.

Adopting a New Health Equity Adjustment to the Total Performance Score

CMS proposes to change the VBP Program's scoring methodology to add a new Health Equity Adjustment (HEA) to reward hospitals with high quality performance in the Program for underserved Medicare patients. (p. 27039) Specifically, CMS proposes to amend maximum Total Performance Scores to 110 points, with up to 10 available bonus points for hospitals under the HEA. The HEA bonus points would be based on a simple calculation of a hospital's performance compared to other hospitals for each of the four Domains in the VBP (the performance scaler) multiplied by the hospitals proportion of Medicare inpatient stays for patients with full Medicare and Medicaid dual eligible status (the underserved multiplier).

The AAMC strongly supports the adoption of the HEA to the VBP as a first step to promoting health equity through Program scoring. We agree that value-based payment policy scoring should account for performance for patients with unmet health-related social needs and should use payment levers to better support those providers treating greater proportions of patients in communities made vulnerable by decades of underinvestment and at greatest risk of negative health outcomes.

We recognize that full Medicare and Medicaid dual eligibility status (DES) is currently the best available predictor of an individual's vulnerability and predictor of poor health outcomes. However, we have long flagged that DES is an imperfect proxy of social need and vulnerability.⁴¹ We ask CMS to commit to

⁴⁰ A Olderog and L Slama, [Predicting Health Care Utilization Over the Decade](#), Ambulatory Surgery Center Association (2018), predicting that THA and TKA procedures will increase from 15% in the outpatient setting in 2018 to over 50% by 2026.

⁴¹ P Alberti and M Baker, [Dual eligible patients are not the same. How social risk may impact quality measurement's ability to reduce inequities](#), *Medicine* (2020), noting that DES impact on readmissions can be partially confounded by three social risk factors, likely due to the great variability in DES populations across hospitals, and thus is an inadequate measure of vulnerability.

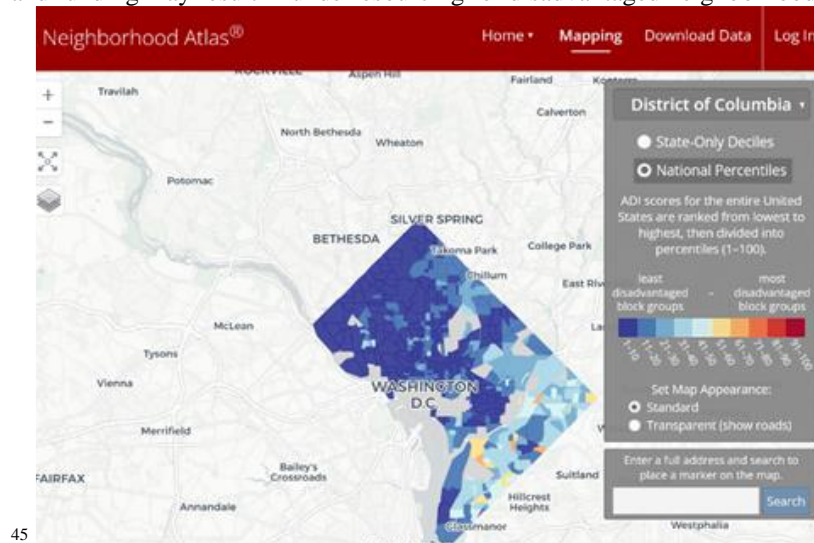
evaluating, and sharing, information on potential new indicators for assessing individual-level health-related social needs (HRSNs) correlated with negative health outcomes to move away from the use of a blunt proxy indicator such as DES. For example, CMS has previously finalized new quality metrics for the IQR that require hospitals to report on their rates of screening inpatients for five core HRSNs and for reporting the percentage of inpatients who screened positive for each HRSN.⁴² CMS could explore whether this data can be correlated to health outcomes such as those measured in the VBP. Additionally, CMS could evaluate the availability of ICD-10 Z-codes documenting HRSNs on inpatient claims, and whether increased coding for HRSNs can be useful to better identify vulnerable Medicare patients for purposes of the HEA in the future.

Regarding geographic-based indicators of social vulnerability, the AAMC remains hopeful that such indicators could be used in the future to help identify community-based social needs that impact health outcomes. Community-based indicators could be incorporated to balance individual indicators to ensure that the HEA fully captures underserved populations, including those least likely to access the health care system for documented individual indicators of social needs. However, the AAMC cautions CMS to fully evaluate the inclusion of geographic-based indicators, like the Area-Deprivation Index (ADI), to determine whether there are unintended pitfalls. To start, it is unclear whether area-based indices can appropriately measure deprivation in urban and rural contexts.⁴³ Recent research points to a potential bias against urban deprivation under the ADI due to its lack of standardization for variables linked to cost of living, finding that overall, ADI scores reflected median home values in New York State.⁴⁴ This does not appear to be unique to New York. Using the Neighborhood Atlas online mapping tool suggests that no area within the District of Columbia scores greater than or equal to the 70th percentile nationally.⁴⁵ This raises face validity concerns with the ADI, considering known inequities in resource allocation and health

⁴² 87 FR 48780 (August 10, 2022), at 49201.

⁴³ M Bertin, et al, [Can a deprivation index be used legitimately over both urban and rural areas?](#) International Journal of Health Geographics (June 20214)

⁴⁴ EL Hannan, et. al., [The Neighborhood Atlas Area Deprivation Index For Measuring Socioeconomic Status: An Overemphasis On Home Value](#), Health Affairs (May 2023), concluding that Neighborhood Atlas-computer ADI scores for New York block groups are mainly representative of median home value, and its use in quality assessment and funding may result in underresourcing for disadvantaged neighborhoods with high housing prices.



Screenshot taken May 30, 2023 from <https://www.neighborhoodatlas.medicine.wisc.edu/mapping>

outcomes in Washington, DC.⁴⁶ The AAMC concurs with researchers who recommend requiring a “ground-truth perspective” from the public when applying community comparisons to policy.⁴⁷

Additionally, other CMS programs’ use of ADI defines underserved as those beneficiaries residing in areas greater than or equal to the 85th percentile nationally and assigns beneficiaries with insufficient residence data available to match the beneficiary to an ADI national percentile rank to the 50th percentile.⁴⁸ The combination of these policies seems counterintuitive, as one might presume beneficiaries with insufficient residential data to be matched to the ADI are more likely to be underserved than not. **We urge CMS to address these concerns with the use of the ADI or other similar geographic-based indicators prior to proposing their use in the HEA.**

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM (HACRP)

Advancing Patient Safety in the HAC Reduction Program

CMS seeks feedback on the adoption of patient-safety electronic clinical quality measures (eCQMs) in the HACRP, whether measures can address equity gaps in the Program, and how weighting and scoring methods could be improved to better assess performance and to promote equity in the Program, among other topics to advance patient safety. (p. 27052)

The AAMC is interested in further examining the adoption of patient-safety eCQMs⁴⁹ from the IQR into the HACRP. One challenge in assessing their potential adoption in the HACRP is the voluntary selection nature of these eCQMs under current IQR policy. This is especially true for three of the six eCQMs called out by CMS in this RFI, as they are currently proposed as voluntary eCQMs under the IQR for reporting for FY 2027 payment. Without understanding voluntary reporting selection by hospitals, it is unclear to the AAMC whether there might be unintended consequences from their adoption as required measures for the HACRP. For example, are there reporting feasibility issues impacting hospital selection or insufficient case volume impacting reporting. **Considering the broad payment impact of the HACRP, we recommend that CMS carefully evaluate reporting constraints on eCQMs prior to adoption in the HACRP.**

As for other measurement recommendations, **the AAMC continues to urge CMS to remove the CMS PSI-90 measure from the HACRP.** The AAMC has long raised concerns with the PSI-90 measure,⁵⁰ notably that some components of the measure focus on surgical care, disadvantaging hospitals with a larger volume of surgical care while other components are susceptible to surveillance bias and disadvantage institutions with robust infection control programs.

⁴⁶ C Busette and S Elizondo, [Economic disparities in the Washington, D.C. metro region provide opportunities for policy action](#), The Brookings Institution (April 2022).

⁴⁷ DH Repkopf and RL Phillips Jr., [The Neighborhood Atlas Area Deprivation Index and Recommendations For Area-Based Deprivation Measures](#), Health Affairs (May 2023).

⁴⁸ 87 FR 69404 (November 18, 2022, at 69800).

⁴⁹ Specifically: Hospital Harm – Opioid-Related Adverse Events, Hospital Harm – Severe Hyperglycemia, Hospital Harm – Severe Hypoglycemia, Hospital Harm – Pressure Injury (proposed), Hospital Harm – Acute Kidney Injury (proposed), and Excess Radiation Dose or Inadequate Image Quality for Diagnostic CT (proposed).

⁵⁰ [AAMC Comments on FY2018 Inpatient Prospective Payment System Proposed Rule](#) (June 2017).

Regarding the promotion of equity with the HACRP, the AAMC acknowledges a critical reality that safety net hospitals are overrepresented as those hospitals routinely penalized under the Program.⁵¹ Additional research has found that, even as they improve their rates of HAIs, safety-net hospitals are unable to escape penalization due to the statutory structure of the Program, which further reduces meaningful financial resources for delivering care as safety-net providers.⁵² **One scoring change, which would likely require a statutory change to the Program, would be to reduce penalties for penalized hospitals that achieve specified improvement targets in subsequent performance years.**

Additionally, the AAMC recommends that CMS commit to use of forthcoming hospital reported data from the recently adopted IQR measures⁵³ of inpatient screening rates for five specified health-related social need (HRSN) domains and screen positive rates for each HRSN to evaluate potential correlations to HAI rates and HACRP performance. If positive correlations are found, CMS should further evaluate whether the data can in turn inform novel clinical (and non-clinical) interventions to reduce and eliminate HAIs for underserved populations. This information could also inform appropriateness of accounting for social risk factors in Program scoring to address equity. For example, researchers found that a peer-grouping approach similar to the Hospital Readmissions Reduction Program, if introduced to the HACRP, would narrow penalty disparities and decrease penalties for safety-net hospitals under the Program.⁵⁴

INPATIENT QUALITY REPORTING (IQR) PROGRAM

Adoption of New Measures

CMS proposes to adopt three new electronic clinical quality measures (eQMs) for hospitals to select from to meet eQm reporting requirements in the IQR, beginning with CY 2025 reporting and impacting FY 2027 payment determinations.

Hospital Harm – Pressure Injury eQm (#3498e – pending endorsement)

CMS proposes the Hospital Harm – Pressure Injury (PI) measure to address one of the most common patient harms, the risk of which can be reduced through widely accepted best practices. (p. 27029) This version of the measure incorporates substantive changes to address feedback from prior pre-rulemaking review, including changes to indicators and a 24-hour window to identify PIs present on admission, and separate and distinct indicators and timelines for identifying deep tissue PIs, subject to exclusion from measurement. (p. 27080) Additionally, for the time being, CMS proposes to exclude COVID-19 patients from measurement, as there is yet to be clear distinctions in the medical record for COVID-19 infection related skin manifestations that might be confused for PIs in the absence of clear coding guidance and

⁵¹ H E Hsu, et. al., [Association Between Federal Value-Based Incentive Programs and Health Care-Associated Infection Rates in Safety-Net and Non-Safety-Net Hospitals](#), JAMA Netw Open (July 2020).

⁵² V Bonisese, [Paying for Performance: How is the Hospital Acquired Conditions Reduction Program Affecting Safety-Net Hospitals and their Infection Rates?](#) (Spring 2018); finding that safety-net hospitals are disproportionately fined under the HACRP, but also despite the difference in penalization, improving their infection rates, and that the Program could benefit from incentives or reduced penalization for lower performing hospitals that reach specified improvement benchmarks.

⁵³ 87 FR 4870 (August 10, 2022), 49202 – 49220.

⁵⁴ SA Shashikum, AB, et. al., [Association of Stratification by Proportion of Patients Dually Enrolled in Medicare and Medicaid With Financial Penalties in the Hospital-Acquired Condition Reduction Program](#), JAMA Intern Med (December 2020).

understanding of COVID-19-related lesions. (p. 27081) The AAMC appreciates CMS efforts to address prior stakeholder feedback on this measure prior to proposing its adoption in the IQR. While we understand that CMS was unable to identify a consensus-based entity (CBE) endorsed measure of PIs, (p. 27080) we urge CMS to delay adoption of this measure until such an endorsed measure is available. CBE measure endorsement assures hospitals that a measure is valid, reliable, and feasible to report. This measure is currently under endorsement review by the Partnership for Quality Measurement⁵⁵ and as such, we urge CMS to consider delay of any final action to adopt the measure, until such endorsement review is complete. The AAMC also encourages CMS to maintain the measure as an optional measure that hospitals may select to report to meet eCQM reporting requirements under the IQR and Promoting Interoperability Programs pending further evaluation of hospital selection and performance. CMS should report on hospital reporting rates and inquire about reporting feasibility and usability for hospitals if reporting remains low.

Hospital Injury – Acute Kidney Injury eCQM (#3713e – pending endorsement)

CMS proposes the Hospital Harm – Acute Kidney Injury (AKI) measure to address the relationship between AKI and longer-term harmful outcomes. CMS notes that “not all AKI is avoidable,” but that measurement can improve attention to eliminate preventable AKI and better treat early-stage AKI for improved outcomes. (p. 27081) The measure has been substantially modified, notably expanding clinical risk adjustment and exclusion criteria, to better target measurement of preventable cases of AKI. (p. 27082) The AAMC appreciates CMS efforts to address prior stakeholder feedback on prior specifications of this measure, which based AKI on a lower threshold of serum creatinine value increase during the inpatient stay and expanding clinical factors for patient exclusion from the measurement population. As CMS notes, the measure is not currently CBE-endorsed, (p. 27082) though is currently under review by the Partnership for Quality Measurement.⁵⁶ To this end, we urge CMS to delay final action to adopt the measure until such endorsement review is complete. The AAMC also encourages CMS to maintain the measure as an optional measure that hospitals may select to report to meet eCQM reporting requirements under the IQR and Promoting Interoperability Programs pending further evaluation of hospital selection and performance. CMS should report on hospital reporting rates and inquire about reporting feasibility and usability for hospitals if reporting remains low.

Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM (#3663e)

CMS proposes to adopt the endorsed Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT measure to better monitor performance of diagnostic CT and discourage unnecessary radiation exposure balanced by preserving image quality. The measure is currently CBE endorsed and reflects clinical guidelines for optimizing CT radiation doses. (p. 27083) The AAMC supports the adoption of the Excess Radiation eCQM as an optional measure that hospitals may select to report to meet eCQM reporting requirements under the IQR and Promoting Interoperability Programs. We encourage CMS to maintain the measure as optional pending further evaluation of hospital selection and performance. CMS should report on hospital reporting rates and inquire about feasibility and usability for hospitals if reporting remains low.

⁵⁵ The [CBE Standing Committee Fall 2022 Measure Endorsement and Maintenance Review Cycle](#) recommended the measure for initial endorsement, with public comment concluding May 5, 2023. The AAMC anticipates final endorsement information soon following post-comment review.

⁵⁶ *Id.*

Measure Refinements

COVID-19 Vaccination Rate Among Health Care Personnel (#3636 – modifications not endorsed)

CMS proposes to modify the existing COVID-19 Vaccination Rate Among Health Care Personnel (HCP) measure effective with CY 2023 Q4 hospital reporting to reflect Centers for Disease Control and Prevention (CDC) updates that expressly specify for HCP to receive the primary series and booster vaccine doses in a timely manner. Specifically, CMS would replace the term “complete vaccination course” with “up to date.” (p. 27076-77) The original version of the measure is endorsed, though that version does not include booster doses. The proposed modified version is undergoing endorsement review as part of the Spring 2023 cycle.⁵⁷ CMS does not propose modifications to the frequent data collection and reporting of the measure, though notes that the measure is based upon the annual reported Influenza Vaccination Coverage among HCP measure and that “it intends to utilize a similar approach to the modified COVID-19 Vaccination Coverage among HCP measure if vaccination strategy becomes seasonal.” (p. 27077) **The AAMC strongly supports vaccination as the most effective means to prevent COVID-19. However, we recommend that CMS hold off on measure modifications to the COVID-19 Vaccination measure until there is greater clarity regarding a seasonal vaccination strategy to support annual reporting.**⁵⁸

We are concerned that CMS is significantly underestimating the burden of this proposed measure modification. As proposed, hospitals would have to make individualized determinations of “up to date,” based on a relatively complex set of potential original course and booster dose combinations. For example, one individual might only be up to date if they received two primary series mRNA doses, one primary booster dose, and two bivalent booster doses, whereas another individual might be up to date with only a single primary dose and one bivalent dose. This level of detailed analysis necessary for reporting, when indications suggest we are nearing a recommendation for seasonal vaccination, suggests the burden under the proposed modification is not commensurate with the potential benefits of modified measurement in this interim phase of vaccination recommendations. This is in part due to challenges for patients to truly understand public reporting of the measure, which lags a year behind when a patient might search for such information.⁵⁹ We advise CMS to step back this rulemaking cycle and revisit the measure’s specifications and reporting cadence next year, when ideally the measure can be modified to reduce burden on hospitals and provide beneficial information to patients and public health officials.

Hybrid Hospital Wide Measures: All-Cause Readmissions (#2879e) and All-Cause Mortality (#3502 – measure inclusive of EHR data not currently endorsed)

CMS proposes to refine both Hybrid Hospital-Wide measures, of readmissions and mortality, to begin to include Medicare patients aged 65 to 94 covered by Medicare Advantage (MA) plans with FY 2027 payment determinations. (p. 27085 and p. 27086). CMS notes that it intends to bring the readmission measure with the expanded patient cohort for re-endorsement by a consensus-based entity in the Spring 2024 cycle. (p. 27088) The electronically specified version of the Mortality measure is not currently endorsed and will be brought forward for re-endorsement with the expanded patient cohort in the Fall

⁵⁷ [Spring 2023 Patient Safety Standing Committee Review Cycle](#)

⁵⁸ M Herper, [FDA proposes annual Covid shot matched to current strains](#), STAT (January 23, 2023), highlighting that seasonal vaccination recommendations may come prior to the end of this calendar year, when CMS proposes incremental burdensome reporting modifications.

⁵⁹ For example, current COVID-19 vaccination rates reported on *Care Compare* are for the period April – June 2022.

2024 cycle. (p. 27086) **The AAMC believes there is great need to better measure quality of care received by Medicare patients covered by MA plans, but we are concerned that it will not be feasible to do so reliably due to incomplete data for the MA population.** Considering the data challenges and potential impact on measure validity and reliability, we recommend that the CMS delay adoption of these measures with expanded measure cohorts until the measures are endorsed by a consensus-based entity. Endorsement review of measure validity, reliability, and feasibility is crucial when including MA data, as it is unclear what data is available and whether that data is accurate. The Medicare Payment Advisory Commission (MedPAC) has noted impediments when assessing the completeness of MA encounter data – in September 2022 it found that only 61 percent of inpatient dates of service had both encounter data and an external source.⁶⁰ Furthermore, MedPAC stated in its March 2022 Report to Congress that “[t]he current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA” due to the incomplete data.⁶¹ Finally, in 2019, MedPAC recommended that Congress take action to ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with fee-for-service Medicare.⁶² Simply put, the AAMC cannot support these measures without confidence in the underlying MA data. To improve these measure specifications, we recommend that CMS consider policies to ensure that MA plans provide complete encounter data that can be relied on for measurement. This could be achieved by setting new data completeness requirements for plan payment and/or adopting sufficient penalties for plans that submit incomplete data.

Measure Removals

CMS proposes to remove the PC-01 Elective Delivery chart-abstracted measure (effective with FY 2026 payment), the refined Medicare Spending per Beneficiary – Hospital (effective with FY 2028 payment), and the refined Elective THA/TKA Complication Rate measure (effective with FY 2030). (pp. 27089-27093) **The AAMC supports these proposals, with one modification.** The AAMC suggests that CMS delay the removal of the MSPB measure from the IQR one year, in concert with our recommendation that CMS delay its proposal to adopt the same measure into the VBP for one year.

Potential Future Measures and Hospital Designation

Geriatric Hospital Measure & Geriatric Surgical Measure

CMS seeks feedback on the potential future adoption of two structural measures of hospital commitment to improving geriatric care through attestation to specific patient-centered competencies. (p. 27103-27109) **The AAMC fully supports efforts to improve patient-centered care, especially for older patients with complex care needs.** That said, we believe these measures should be combined into a single structural measure and be endorsed by a consensus-based entity prior to use in the IQR Program to ensure that the measure is valid and reliable. We agree with members of the Hospital Workgroup who raised concerns during the 2022 pre-rulemaking review of these measures of burden to report both measures. The workgroup also pointed out that there is an opportunity to crosswalk the measures toward a single measure with a more holistic approach to driving commitment to improved care for this patient population. Additionally, we ask CMS to evaluate whether the potential subjectiveness of attestation-

⁶⁰ L Serna and A Johnson, [Medicare Advantage encounter data](#), slide 9, Medicare Payment Advisory Commission (September 2022).

⁶¹ MedPAC March 2022 Report to Congress, [Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans](#) (March 2022).

⁶² MedPAC June 2019 Report to Congress, [Chapter 7: Ensuring the accuracy and completeness of Medicare Advantage encounter data](#) (June 2019).

based measures provides value to patients and their families when balanced with outcomes or process measures that could be developed and used to better capture inpatient geriatric care.

Hospital Designation for Geriatric Care

CMS seeks feedback on whether to establish a geriatric care designation for hospitals to be publicly reported on a CMS website. Such designation would be based on a set of metrics included in the IQR Program measure set and CMS believes “adding this designation to a consumer-facing CMS website would allow patients and families to choose hospitals that have demonstrated a commitment to improving patient-centered geriatric care[.]” (p. 27109) **The AAMC supports efforts to improve transparency of hospital quality measurement information for patients and communities, but we urge CMS to ensure that any new designation meaningfully represents the supporting measure data.** For example, if the initial designation is based on a structural measure of hospital quality improvement practices, the initial designation name should accurately reflect that information rather than portray itself as an expansive statement of overall quality of geriatric care and outcomes.

Additionally, CMS should be careful to ensure that patients and communities have trust in such a designation and believe that it provides them with meaningful information. This is especially true considering CMS has already adopted a system for rating hospitals on quality, largely based on outcomes measures specific to the Medicare aged 65 and older patient population.⁶³ It is unclear to the AAMC how patients and families will use a designation specific to geriatric care separately from the Overall Hospital Quality Star Rating. Indeed, we are concerned that patients and families might be confused to see a Rating that might be interpreted as incongruent with the designation, for example, if a hospital receives the geriatric care designation but receives an overall rating of one star.

CMS must be sure that such designations do not further limit and exacerbate disparities in access to critical hospital care. It is unclear precisely how much choice geriatric patients have when it comes to which hospital they are admitted to for care. Hospital choice can be limited by Emergency Medical Services (EMS) ambulance providers. It can also be limited by physical accessibility barriers and other factors related to health-related social needs, such as transportation access. CMS should examine whether patients, families, and communities feel the designation is helpful to them in making choices about the hospital in which to seek care.

Technical Changes to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure

Updates to HCAHPS Survey Measure Beginning with FY 2027

CMS proposes several technical changes to the HCAHPS Survey, including to allow web-based modalities for administering the Survey and to remove the prohibition of proxy respondents, beginning with January 2025 inpatient discharges. CMS believes these changes will improve the declining HCAHPS Survey response trends observed of late. (pp. 27112-27114) **The AAMC supports these proposed technical changes to the HCAHPS Survey to improve survey response rates and improve patient and family experience completing the Survey.** We encourage CMS to report on any observed uptick in HCAHPS Survey completion rates following the implementation of these changes.

⁶³ 85 FR 85866 (December 29, 2020), 86193 – 86236, establishing a methodology to calculate the Overall Hospital Quality Star Rating.

Request for Information: Inclusion of Psychiatric Patients in HCAHPS Survey Cohort

CMS requests feedback from stakeholders on the potential future inclusion of patients with a primary psychiatric diagnosis in the HCAHPS Survey. Currently the HCAHPS Survey is validated for inpatients in the medical, surgical, and maternity service lines and patients with a primary psychiatric diagnosis are not eligible, though patients with a secondary psychiatric diagnosis are. **The AAMC recommends that CMS take a deliberate and careful approach to assessing the appropriateness of the design of the HCAHPS Survey for inpatient psychiatric patients and fully evaluate the breadth of potential unintended consequences.** To evaluate potential unintended consequences, we must first have a better understanding of primary psychiatric diagnoses,⁶⁴ assess nuances and characteristics of voluntary and involuntary psychiatric admissions,⁶⁵ and analyze variations in state privacy laws.⁶⁶ Together, or individually these variables could create a challenge for making valid and reliable national comparisons for HCAHPS Survey measurement purposes. At a minimum, we suggest that CMS consider convening Technical Expert Panels to bring together patient experience, psychiatric providers, and privacy law experts, to better understand potential benefits and challenges with inclusion of psychiatric patients in the HCAHPS Survey.

PROMOTING INTEROPERABILITY (PI) PROGRAM

Electronic Health Record (EHR) Reporting Periods

CMS notes that it is considering increasing the length of the EHR Reporting Period in CY 2026 (impacting FY 2028 payment determinations) but does not propose such a policy in this rulemaking. CMS states that increasing the reporting period “would encourage” hospitals to prepare to produce more data on the quality metrics they are required to report, noting the increase to a full calendar year reporting period for eCQMs beginning with CY2023 reporting. (p. 27156) **The AAMC understands CMS’s interest in receiving more EHR data through an increased reporting period but encourages CMS to better understand the burden of reporting other EHR use data beyond the tailored data production necessary for eCQM measurement.** As noted by the Office of the National Coordinator for Health Information Technology (ONC), “[a] number of challenges related to participation in quality and health IT measurement reporting programs are fundamentally technical in nature and are related to infrastructure, timelines, and data accessibility.”⁶⁷ The AAMC has heard from members that improvements to interoperability under ONC’s rules for certified HIT products, while helpful, does not ensure that updated data standards are immediately fully realized in daily practice and nomenclature. Regarding the standardization and interoperability of public health information, we understand that different regions, states, and localities are at differing levels of interoperable sophistication, which in turn creates challenges for hospitals to successfully implement EHR data reporting under the 180-day

⁶⁴ Moayyad AlSalem, MD, et. al., [Accuracy of initial psychiatric diagnoses given by nonpsychiatric physicians: A retrospective chart review](#), *Medicine* (December 2020), finding a substantial level of inaccuracy of the initial psychiatric diagnose given by nonpsychiatric physicians.

⁶⁵ Jason Crow and Michael T. Compton, MD, MPH, [Characteristics associated with involuntary versus voluntary legal status at admission and discharge among psychiatric inpatients](#), *Soc Psychiatry Psychiatr Epidemiol* (October 2006).

⁶⁶ Timothy Stoltzfus Jost, [Appendix B Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws](#), *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. The National Academies (2006).

⁶⁷ HHS Office of the National Coordinator for Health IT, [Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs](#) (February 2020).

reporting period. This is all to say that it is unclear whether CMS will have sufficient evidence to support the feasibility of a longer EHR reporting period for CY 2026. CMS should work with the ONC, other federal partners, and stakeholders to truly understand operational burdens of EHR reporting prior to proposing any changes to the current 180-day EHR reporting period and provide hospitals with sufficient lead time to be successful with a longer reporting period in the PI Program.

Measure Scoring Change – SAFER Guides Measure

CMS proposes to revise scoring for the Safe Assurance for Electronic Reporting (SAFER) Guides measure beginning with CY 2024 reporting, impacting FY 2026 payment determinations. Specifically, CMS proposes to begin to require hospitals attest “Yes” to having conducted an annual self-assessment using all nine SAFER Guides. When CMS finalized adoption of the measure it simply required an attestation by hospitals. That is, either “yes” or “no” responses were sufficient to meet EHR meaningful use requirements for an EHR reporting period (p. 27157) **The AAMC supports hospital adoption of self-assessment under the nine constituent Guides for the measure. However, we urge CMS to delay the proposed scoring change for at least one year, to ensure that hospitals have sufficient time to succeed with full adoption.** The measure was adopted for the CY 2022 EHR Reporting Period, where CMS pushed back on potential burden for hospitals stating, “[w]e would like to reiterate that eligible hospitals and CAHs are not being scored on this measure, that an attestation of “yes” and “no” are both acceptable answers without penalty, and that all eligible hospitals and CAHs will vary in their levels of implementation.”⁶⁸ The AAMC does not see sufficient evidence provided in this proposed rule to suggest that levels of implementation for hospitals have sufficiently changed to support a new scoring approach only two years into the measure’s adoption, especially considering other critical hospital priorities during that period due to the COVID-19 Public Health Emergency.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact my colleagues – Mary Mullaney (mmullaney@aamc.org) and Katie Gaynor (kgaynor@aamc.org) on the payment proposals; Bradley Cunningham (bcunningham@aamc.org) on the GME proposals; Phoebe Ramsey (pramsey@aamc.org) on the quality proposals.

Sincerely,



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Chief, Health Care Affairs

cc: David Skorton, M.D., AAMC President and Chief Executive Officer

⁶⁸ 86 FR 44774 (August 13, 2021), at 45481.