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June 10, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1808-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

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

The Association of American Medical Colleges (AAMC or the association) welcomes this opportunity to comment on the proposed rule entitled “Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes,” 89 *Fed. Reg.* 35934 (May 2, 2024), 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 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, 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, academic health systems 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 participation in the AAMC by U.S. and 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) 2025 Inpatient Prospective Payment System (IPPS) Proposed Rule.

- ***Graduate Medical Education.*** CMS should not finalize a distribution for new residency positions made available under Section 4122 that incorporates a Health Professional Shortage Area prioritization. CMS should be more transparent regarding the factors considered for new

- residency training programs. Any refinement of the definition of “newness” should not create an unworkable, overly burdensome process that inhibits the choices of training programs.
- **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.
 - **Outlier Threshold.** Calculate the operating outlier threshold for high-cost cases using a cost-to-charge ratio adjustment more reflective of recent data.
 - **Z-Codes.** Finalize the proposal to change the severity level designation to CC for Z-codes describing inadequate housing and housing instability.
 - **Wage Index.** Evaluate factors affecting wages at low wage index hospitals and maintain a clear end date for the proposal.
 - **Essential Medicines ‘Buffer’ Stock.** Evaluate additional root causes impacting the drug supply chain and implement policies to directly address them.
 - **Reporting of Acute Respiratory Illnesses.** Do not finalize the proposal to require COVID-19 and respiratory illness reporting as a hospital condition of participation but identify opportunities to improve automated reporting and encourage voluntary reporting.
 - **Maternal Health Care Request for Information.** Ensure adequate payment rates for all Medicare and Medicaid services, including maternal health, to maintain access to needed services.
 - **Obstetrical Service Standards Request for Information.** Maternal health outcomes are a critical issue that must be addressed, but CoP changes are not the appropriate vehicle to address this issue.
 - **Inpatient Quality Reporting (IQR) Program.** Where feasible, ensure that new measures are endorsed by a consensus-based entity as valid and reliable prior to their proposed adoption in the IQR and ensure proposed measures are well understood and meet the needs of patients, families, and communities to inform their decisions of where to seek high quality care.
 - **Value-Based Purchasing Program.** Adopt proposed scoring changes for the Person and Community Engagement Domain to limit burden on patients and caregivers while CMS completes a transitional update to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
 - **Promoting Interoperability Program.** Delay the proposal to increase the minimum scoring threshold for hospitals to demonstrate meaningful use of electronic health record (EHR) technology to allow stakeholders to independently vet Program performance data that will be published for the first time later this year.

Specific to the proposed Transforming Episodic Accountability Model (TEAM):

- **Eligible Participants.** Allow hospitals that are not selected in TEAM to join on a voluntary basis. In addition, raise the volume threshold for eligible hospitals to no fewer than 30 episodes per episode type in the baseline period.

- **Risk Arrangements.** Increase guardrails for safety net hospitals such as lower stop-loss thresholds or lower quality adjustment to ensure a better glide path to success in episodic care.
- **Clinical Episode Specifications.** Stratify TEAM episodes by elective vs non-elective procedures and do not test new clinical episode categories in TEAM.
- **Quality Measures.** Include additional quality measures to create alignment across programs and allow for system-wide improvement efforts to better support high quality, person-centered care such as the Advance Care Plan measure, and use registry-based measures as they create the opportunity for multi-payer alignment within value-based care programs.
- **Payment Methodology.** Use TEAM as an opportunity to test the administrative trend and reduce the discount factor, include more extensive variables to the risk adjustment to account for hospital-level factors such as rural/urban location, safety net status, size, and teaching status as well as patient-level factors such as housing instability, food insecurity, financial needs, transportation problems, education, language, and interpersonal safety.
- **Health Equity.** Align health related social needs data collection with measure specifications established in the Hospital IQR program and provide an upfront infrastructure investment for safety net providers without requiring a payback to CMS.
- **Waivers.** Apply waivers to all fee-for-service (FFS) Medicare patients with billing codes that could trigger an anchor hospitalization or anchor procedure for TEAM at participating hospitals. Also, create a post-discharge home visit waiver to match the methodology established in BPCI Advanced.

GRADUATE MEDICAL EDUCATION (GME) PROPOSALS

CMS requested comments on the proposed distribution methodology for GME slots made available under Section 4122 of the Consolidated Appropriations Act, 2023 (CAA, 2023), and considerations regarding the newness of residents within a residency program. CMS also published three RFIs related to certain aspects of residency training to inform the agency regarding potential future rulemaking.

The AAMC has concerns with the proposed distribution methodology for Section 4122 slots and highlights issues that CMS should address to make the application and distribution process as seamless as possible for institutions and programs. In its RFI, CMS put forward several policies regarding the newness of residency programs that could impede the development of new residency programs if proposed and finalized in future rulemaking. The AAMC urges CMS to strongly consider the intention of residency training programs as educational endeavors that capitalize on the strengths of clinical training in academic medical centers. As such, the factors for consideration when reviewing a new residency program should not create unworkable requirements that will negatively impact the development of residency programs which, ultimately, could impact safety and the quality of patient care.

DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS UNDER THE PROVISIONS OF SECTION 4122 OF SUBTITLE C OF THE CONSOLIDATED APPROPRIATIONS ACT, 2023

Through the CAA, 2023, Congress authorized the creation of 200 new Medicare-funded graduate medical education positions (or slots), with no fewer than 100 of the positions made available for psychiatry or psychiatry subspecialty training programs. The legislation created four categories of “qualifying hospital” eligible to receive awards: rural hospitals, or hospitals treated as rural; hospitals that are training residents

in excess of their GME caps; hospitals that are in states with new medical schools or branch campuses; and hospitals that serve Health Professional Shortage Areas (HPSAs). No fewer than 10 percent of the available slots are to be distributed to each of the four categories of qualifying hospitals. By statute, hospitals that receive awards are limited to a total of 10 full-time equivalent (FTE) slots, and by statute, no hospital may receive an award until all qualifying hospitals that submit timely applications receive one or a fraction of one FTE (the “pro-rata” distribution requirement).

CMS Proposal and Pro-rata Distributions

In distributing positions under Section 4122, the AAMC requests that CMS not use the HPSA prioritization established under Section 126. CMS should evaluate the application pool and, if able to meet the statutory distribution requirements, award all slots on a pro-rata basis. In the alternative, if CMS is unable to meet statutory distribution requirements, the AAMC requests that CMS prioritize those hospitals that meet all four qualifying criteria first, and then hospitals that meet three criteria and so on until all slots are distributed.

Complying with section 1886(h)(10)(B)(iii), CMS proposes to apply a pro-rata distribution to all qualifying hospitals that submit timely applications. The pro-rata distribution would award up to 1.0 FTE to qualifying hospitals and distribute any remainder of slots to hospitals based on the same HPSA distribution methodology used to prioritize awards under Section 126 of the CAA, 2021. This means that the remaining slots will go first to qualifying hospitals with the highest HPSA scores from the pool of applying hospitals. If slots remain, CMS will award slots to hospitals with the next highest HPSA score and so on until all remaining slots are awarded.

The AAMC has concerns with this proposed distribution methodology. In the proposed distribution for Section 126 slots, CMS attempted to award slots in a similar manner, limiting the award to each qualifying hospital to 1.0 FTE.¹ There was consensus from the GME community that the 1.0 limitation on awards would not be a meaningful increase for institutions. Additionally, because of the longitudinal requirement to train residents over the course of several years, the limitation to 1.0 FTE would limit the development of a full complement in subsequent postgraduate years (PGYs). Ultimately, this policy would require hospitals awarded a pro-rata distribution of 1.0 FTE under Section 4122 to self-fund full complement increases beyond the 1.0 FTE awarded. Additionally, the AAMC and other organizations opposed CMS’ HPSA prioritization, because “HPSA scores speak to the need for more practitioners in a given [region] but do not speak to the ability of the hospitals in those states to train more residents or to provide care for patients who live in HPSAs.”² Over the last two distribution cycles, the AAMC has heard from many frustrated member institutions that are adjacent to a HPSA, but resident training time does not take place in a HPSA. These institutions need additional slots to expand training and treat HPSA populations but are not eligible to receive prioritization in the distribution of Section 126 awards.

In the distribution proposal for Section 4122, CMS has not addressed the structural shortcoming of the HPSA prioritization distribution methodology. Specifically, CMS has not established how the agency would meet the 10 percent statutory distribution requirement for Section 4122 slots. The AAMC and

¹ In the FY 2022 IPSS proposed rule, CMS stated that “...we are proposing to limit the increase in the number of residency positions made available to each individual hospital to no more than 1.0 FTE each year.” After reviewing comments from stakeholders, CMS chose not to finalize this policy. 86 FR 25508.

² AAMC, [Comments to CMS on the FY 2022 IPSS Proposed Rule](#) (June 2021).

other organizations warned CMS that prioritizing distributions based on HPSA scores could lead to issues with meeting the 10 percent required distribution to the four categories of qualifying hospitals.

It is crucial for CMS to ensure that the distribution process is in full compliance with the law, as any deviation could have serious implications for the fairness and effectiveness of the program. CMS must now modify rounds 4 and 5 to accommodate the low number of distributions to geographic HPSAs, prioritizing one category of qualifying hospital more than the other three. This could have been avoided if CMS had considered factors beyond HPSA scores in the Section 126 distribution prioritization. CMS will likely face the same issue with Section 4122 slot distributions as well. Prior to opening an application for Section 4122 slots, CMS should explain to stakeholders how the agency will ensure that 10 percent of slots are distributed to the four categories of qualifying hospitals.

A limited number of psychiatry programs have received awards under Section 126, and CMS should consider scenarios under which the agency receives applications for fewer than 100 psychiatry FTEs for FY 2026. Specifically, in the final rule, CMS should address two scenarios:

- Where fewer than 100 FTEs are awarded to psychiatry or psychiatry subspecialty programs; or,
- Where fewer than 200 positions are awarded in total.

The AAMC interprets the statutory language in Section 4122 to mean that slots will become effective as of “July 1 of the fiscal year of the increase,” which should allow CMS to award positions through another application cycle if fewer than 100 positions are awarded to psychiatry programs or fewer than 200 positions are awarded in total.³

CMS provides an alternative distribution proposal and the AAMC requests that the agency not finalize this proposal. Under this alternative methodology CMS would award .01 FTE to each qualifying hospital that applies, and if slots remain, distribute the rest based on Section 126 HPSA prioritization. (P. 36643). With significant projected physician workforce shortages, it would be ill-advised to award fractions of FTEs that will diminish the substantive distribution of slots to hospitals.⁴ Hospitals awarded fractions of slots would be required to account for these positions on the cost report, which could create an administrative record keeping issue. Additionally, the statutory language under 1886(h)(10)(C)(ii) states that hospitals awarded slots under Section 4122 agree “to increase the total number of full-time equivalent residency positions under the approved medical residency training program of such hospital by the number of such positions made available by such increase under this paragraph.” The AAMC fears that hospitals could be obligated to demonstrate an increase in the applying program resident FTE count consistent with an award.

DISTRIBUTIONS TO HOSPITALS THAT ARE AWARDED INCREASES FOR PSYCHIATRY OR PSYCHIATRY SUBSPECIALTY PROGRAMS

Applications for Section 4122 mirror applications for Section 126 in that psychiatry programs are required to subtract the time residents rotate to inpatient psychiatric facilities (IPFs) from their indirect medical education (IME) FTE requests for award. Resident time at IPFs is removed from the IME

³ 1886(h)(10)(B)(A)(vi).

⁴ [The Complexities of Physician Supply and Demand: Projections From 2021 to 2036](#), Association of American Medical Colleges, March 2024.

application because IPF facilities and units file a separate cost report under the Inpatient Psychiatric Facility Prospective Payment System and receive a facility-level payment adjustment for teaching status.

The amount of required training time for psychiatry residents in inpatient or outpatient settings is significant. For instance, the Accreditation Council on Graduate Medical Education (ACGME) requires psychiatry residents to receive between 6 months and 16 months of inpatient psychiatry training and at least 12 months of outpatient psychiatry experience.⁵

Resident time at IPFs is reimbursed under the IPF PPS through the teaching status adjustment, a payment meant to compensate IPF facilities for the increased patient care costs associated with higher patient acuity at teaching IPFs. Key to the teaching status adjustment is the teaching ratio, which is calculated as one plus the ratio of interns and resident FTEs to the average daily census. While IME FTEs are capped by the Balanced Budget Act of 1997, there is no statutory limitation on the number of resident FTEs that CMS may reimburse IPFs for under the IPF PPS. CMS has limited the number of residents that an IPF can count towards the teaching ratio, as a matter of policy, since the implementation of the IPF PPS in FY 2005.

Awards made under Section 4122 will likely represent the largest increase in Medicare-funded psychiatry or psychiatry subspecialty training since Congress capped hospitals' FTE counts in 1997. Because psychiatry residents often spend a significant amount of time training at IPF hospitals and units, CMS should use its authority to increase the number of FTEs at IPFs excluded from requests for increases for IPPS purposes, for slot distributions through Section 4122 and Section 126.

Interaction Between Section 126 Applications and 4122 Applications

The application and award for distributions under Section 126 round 4, and Section 4122 will run concurrently. Hospitals should know ahead of the application process if there are special rules for hospitals that apply to both Section 126 and 4122. The AAMC requests that CMS publish considerations for institutions applying to both programs. Specifically, we ask that CMS clarify the following:

- May a hospital apply for an increase through Section 126 Round 4 and Section 4122; and,
- May a hospital apply for increases in the same residency program for both Section 126 Round 4 and Section 4122?

PROPOSED MODIFICATION TO THE CRITERIA FOR NEW RESIDENCY PROGRAMS AND REQUESTS FOR INFORMATION

Whether a program is “new” holds tremendous significance for hospitals establishing FTE caps. New teaching hospitals that have not previously trained residents and rural hospitals or hospitals treated as rural may receive FTE cap adjustments when they participate in the training of residents in a new residency program or programs.⁶ To determine if a program is “truly new” and not a transfer of an existing program, CMS has placed significant weight on three factors: the newness of residents, program directors, and faculty.

While stakeholders appreciate CMS' effort to be more transparent in making these determinations, the proposed policies and RFIs are concerning. First, it would be unfair to hold hospitals that are currently in

⁵ Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Graduate Medical Education in Psychiatry, P. 28-9, 2023.

⁶ 1886(h)(4)(H)(i).

the cap-building period, or whose cap-building windows have closed and whose caps are still subject to audit, to a standard that they were not aware of when starting new programs. Given the considerable time and cost of developing new programs, CMS should ensure any new policies are only applied to programs that begin training residents after the date of enactment.

The stakes for new teaching hospitals and hospitals that start new programs eligible to receive FTE cap adjustments are incredibly high. The cost of developing new programs is completely borne by the institutions; the Medicare program does not reimburse hospitals for these start-up costs, and hospitals do not receive reimbursement until residents rotate to the hospital.⁷ The cost of developing new programs or becoming a new teaching hospital is significant, and as such, a considerable amount of resources are put into the development of new programs.⁸ Most new teaching hospitals rely on Medicare funding to help offset the substantial costs associated with training residents. If a program receives a determination that it is not new, the hospital may not count the resident FTEs participating in that program towards establishing its FTE caps. CMS has created an overly complicated policy, often to the detriment of well-intentioned programs, to determine if a program is "truly new."

CMS' interpretation and administration of this policy is unnecessarily cynical towards teaching hospitals, as reflected at length in FY 2010 IPPS Final Rule. The factors or criteria utilized by CMS to evaluate if a program is truly new are not reflected in the statutes or regulations. The determination of "newness" under 42 C.F.R. § 413.79(l) is based on when a residency program "receives initial accreditation by an appropriate accrediting body or begins training residents on or after January 1, 1995."⁹ In the FY 2010 IPPS final rule, CMS argued against using the ACGME definition for initial accreditation because the American Osteopathic Association (AOA) did not use the term "initial accreditation" in its accreditation processes.¹⁰ In 2020, however, the ACGME became the single accrediting body for MD and DO GME programs, obviating this concern. CMS states that ACGME allows programs to apply for initial accreditation "to a previously accredited program or to a program that applies for reaccreditation," such that "initial accreditation" is not, in CMS' view, a sufficient indicator of whether a program previously existed.¹¹

The regulations and guidance related to new programs should not impede the good faith effort to develop new residency programs. We recommend that CMS establish a policy that identifies a program as new when it "receives initial accreditation *for the first time*."¹² It would be simple, efficient, and administratively easy for CMS to follow the plain reading of the regulation the agency developed and to look to the accrediting bodies' determination of initial accreditation as the determinative factor of "newness." A letter from an accrediting body and a cursory overview of the program, with an attestation from the hospital that the program had not been transferred or duplicates resident FTEs, should be enough to establish "newness."

⁷ Physician Workforce Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals, Government Accountability Office Report to Congress, May 2021.

⁸ *Id.* The Government Accountability Office (GAO) found that "[h]ospitals starting their first GME training program spend an estimated \$2 million to \$8 million over 3 to 7 years to establish GME programs, according to information from hospital representatives."

⁹ 413.79(l).

¹⁰ 74 FR at 43911.

¹¹ *Id.*

¹² The process to receive initial accreditation is lengthy, with direct oversight from the ACGME through a multi-step process <https://www.acgme.org/programs-and-institutions/programs/program-application-information/>. The initial accreditation period is generally two years followed by continued accreditation.

Newness of Residents

CMS proposes a policy that would require 90 percent of residents who train in a program over the five-year cap-building period to not have previous experience in the same specialty as the new program. The determination of newness would be made at the end of the cap-building process, and a program that does not meet the 90 percent threshold would not qualify as new.

The AAMC does not recommend that CMS adopt a new policy based on the review of “new” residents, but *if* it does, the agency should give programs the presumption of newness if they can demonstrate that at least 90 percent of trainees do not have previous experience in the new program specialty. In the case of a program that falls below 90 percent, hospitals should be allowed to demonstrate through other known factors (program letter of accreditation, a reduced 50% “newness of residents” for small programs, no overlap between program director, administrative staff, and the residents in a prior program, etc.) that the program is not transferred from an established teaching hospital. Hospitals should know with certainty that the program will meet the “newness” criteria without interpretation by CMS or its intermediaries.

The proposed rule describes a resident as being “accepted, enrolled, and participated in” the residency training program. (P. 36222). Residents are generally placed into residency programs through the match process, and those brought in later in their training may fill vacancies from residents who have left a program. For smaller programs, it is likely that residents brought in after PGY1 are meant to maintain program stability, and CMS’ policy should allow for latitude. For example, if a three-year residency or fellowship program with only three residents per year hires just one individual at the PGY2 level, that program would automatically fail the proposed 90 percent threshold requirement.

As a point of clarification, CMS does not explicitly state in the proposed rule how fellows in fellowship programs would be treated under this policy. Fellows often have prior experience in the specialty with which they receive subspecialty training. CMS should clarify that subspecialty training would be analogous to a “different specialty program” for fellows and they will be considered “new residents” in a new fellowship program. Additionally, if residents have only participated in a transitional or preliminary year program or are displaced from a closed hospital or program, they should meet the definition of “new resident.”

RFI - Newness of Program Director and Faculty

CMS is requesting information regarding what determinations should be considered for the newness of residency program directors and the newness of faculty. CMS considers a proposal that a program director would not be considered “new” if they have had prior experience as a program director. Similarly, 50 percent of teaching faculty could not have previous faculty positions in the program specialty, and 50 percent could have experience but could not have come from the same existing residency program. CMS references the FY 2010 IPPS final rule, which states that the intent of the newness criteria is to ensure that hospitals are not duplicating resident FTEs at existing residency programs.¹³

Many AAMC members have expressed significant concerns over this RFI regarding the newness of the program director and faculty. Hospitals fear that any policy that restricts the prior experience of faculty members removes their ability to select the best candidates to lead and participate as faculty in newly created programs. In some instances, especially for those programs outside of major metropolitan areas or

¹³ 74 FR at 43911-16.

highly specialized programs, there are limited numbers of qualified physicians able to participate as faculty.

AAMC members have pointed out that holding a program director or faculty member position requires a commitment to continuous learning and professional development. Requiring program directors or faculty to spend a certain amount of time away from one program before they can be considered new *by CMS* with regard to a different program means those physicians are likely less qualified to hold a faculty position than someone who has continued participation with a residency training program. The AAMC appreciates CMS considerations toward time away from a program, but this seems like an unnecessary requirement when prior experience is not determinative that a program has been transferred.

Several members of larger academic health systems pointed out a scenario in which the system and associated medical school(s) have partnered with a new non-teaching hospital. The health systems have well-qualified faculty that could participate in the development of a new residency program, but the rules as proposed would mean those faculty members jeopardize the program's newness. To be clear, nothing about that arrangement would create a scenario where the health system is duplicating resident FTEs across the two hospitals.

In another scenario, a small, rural-focused academic health system expressed the same concern, not for the availability of teaching faculty but rather a dearth. The physicians available for the geographic area willing to participate in graduate medical education training are already doing so, as faculty in established programs. There are non-teaching hospitals in the region that could expand training, and future development would not be possible if they had to meet CMS' proposed definition for new faculty and a new program director.

It is concerning that CMS would entertain a policy that would *require* hospitals to hire program directors or faculty members who lack previous experience in those roles. The prime concern for new programs is maintaining accreditation. That means meeting the requirements of an accrediting body (ACGME) that has specific (and sometimes differing, depending on specialty) requirements for faculty education, experience level, board certifications, etc.¹⁴ These requirements are in place to protect learners and ensure the educational mission of the training program. The ACGME requirements also set the appropriate standards and qualifications for these roles. CMS is proposing a policy that unnecessarily limits the choice of leadership and teaching faculty for newly developed residency programs. Again, the statutory and regulatory framework does not contemplate this kind of restrictive policy that ultimately interferes with the decision-making of people who are much more knowledgeable about the inner workings of residency programs.

This policy will also significantly increase the administrative burden on hospitals, CMS, and its Medicare Administrative Contractors (MACs). The ACGME definition for "'faculty' refers to the entire teaching force responsible for educating residents. The term 'faculty,' including 'core faculty,' does not imply or require an academic appointment."¹⁵ Depending on what type of policy CMS adopts, programs could be under a mandate to track and cross-check all faculty members during the five-year cap-building period to

¹⁴ As an example, the [ACGME Program Requirements for Graduate Medical Education in Psychiatry](#), the qualifications for a program director "must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee", and "[t]he choice of a program director should be informed by the mission of the program and the needs of the community." P. 10.

¹⁵ Accreditation Council for Graduate Medical Education, Common Program Requirements (Residency), 2023.

determine if they have any overlap in experience. CMS may have to verify this information by reviewing their curriculum vitae as well. This could mean an expansive review even for small programs with fewer faculty. This kind of review would be onerous, even if applied exclusively to core faculty, considering that the window of review for the program would be over the five-year cap-building period.

In the FY 2010 IPPS final rule, it is not clear nor commonly understood that these newness factors require program directors to have *no previous experience as program directors* and faculty to have not previously been faculty. In the intervening years since publishing the final rule, it appears that CMS has developed an interpretation of “newness” that is abstract and beyond the common understanding of what this term means. In that FY 2010 final rule, CMS put forward an additional factor to consider beyond the newness of program directors, faculty, and residents: “Is this program part of any existing hospital’s FTE cap determination?”¹⁶ This question is where all other questions of newness should begin. Having a program director who has experience as a program director does not mean the program is transferred. Likewise for core faculty or faculty.

CMS puts forward a hypothetical “...scenario where recruitment of most or all of the experienced staff from a particular existing program may even result in the disintegration of and possible closure of that existing program.” (P. 36222). CMS acknowledges that this is an extreme scenario, but this is one of the only arguments on which it bases the need to create such an intrusive policy for new residency programs.

Again, CMS should consider the goal of such a policy. If the intent is to ensure that programs are not transferred, or cannibalized, how does inflicting this burden on hospitals meet that end, and at what cost?

The AAMC would respectfully ask that CMS attempt to refine this policy in a way that is less burdensome and allows teaching hospitals the flexibility to hire the appropriate faculty and program directors for new residency programs. The AAMC believes that there are less restrictive and more administratively simple methods for determining if a program is new. Specifically, relying on the determination of initial accreditation, for the first time, by ACGME would alleviate the confusion and burden on new teaching hospitals and new programs. Ultimately, teaching hospitals and CMS want the same thing: the best-trained physician workforce that provides unparalleled patient care.

RFI - Commingling of Residents

CMS requests information on the commingling of residents from new programs with established programs. Rural hospitals and hospitals treated as rural may receive a cap increase for the time residents in new programs spend in the institution. CMS has not articulated a specific change in its current policy but points out in the RFI that the commingling of residents is often essential to meeting educational requirements. The AAMC would agree with CMS’ assessment of the reason for commingling residents and would add that changes to the current policy could have a significant impact on new training programs. CMS uses an extreme scenario as an illustration of commingling that leads to a “carbon copy” of an established program but fails to explain if this is a prevalent or pervasive issue.

In response to commingling broadly, many AAMC members have highlighted that it is often necessary to rotate residents in established programs to other hospitals to meet accreditation requirements, provide unique educational experiences, or expose residents to different patient populations. For new programs, commingling can be the only opportunity residents have to complete certain rotations (*e.g.* specialized pediatric training at children’s hospitals). The AAMC would caution CMS against developing a policy

¹⁶ 74 FR at 43914.

that would chill programs' ability to commingle, as it will likely negatively impact the development of new residency programs.

RFI - One Hospital Two Residency Programs in the Same Specialty

CMS requested information regarding one hospital that sponsors two programs in the same specialty. To date, CMS has permitted this policy so long as each program is, in fact, separate with a separate match, program directors, and staff. (P. 36224). The Social Security Act does not contemplate this as a restricted activity. So long as hospitals can justify the cost of operating two programs in the same specialty, this could be a useful allowance for special circumstances. CMS references Rural Track Programs (RTPs) as a policy consideration for having a hospital with two residency programs in the same specialty but does not connect RTP policies with the RFI. The AAMC would welcome the opportunity to discuss how these two policies interact.

PAYMENT PROPOSALS

PROPOSED MARKET BASKET UPDATE

Increase the Market Basket Update for FY 2025 to Reflect Continued Growth in Labor and Supply Costs

CMS is proposing an increase to the standardized amount of 2.6 percent, reflecting a market basket update of positive 3.0 percent and a total factor productivity adjustment of minus 0.4 percent for FY 2025.¹⁷ We are concerned that the data used to calculate the FY 2025 market basket update are not representative of the significantly higher growth in labor and supply costs hospitals continue to experience after the end of the COVID-19 PHE. The inadequate proposed FY 2025 update, coupled with market basket updates in preceding years that fell short of the actual pace of inflation, necessitate a course correction from CMS to ensure Medicare payments are accurately updated to reflect hospital input costs.

The data used to calculate the market basket update do not accurately reflect the dramatic increase in labor and supply costs that hospitals and health systems have experienced since FY 2022. A recent report found that labor expenses in 2023 were a staggering 20 percent higher than 2020, with no signs that this trend will abate.¹⁸ In its March 2024 report, the Medicare Payment Advisory Commission (MedPAC) found Medicare margins of negative 8.1 percent in 2021 and a record-low negative 12.7 percent in 2022.¹⁹ The financial outlook for academic health systems is even more grim—AAMC member hospital overall Medicare margins were negative 17.5 percent in 2021.²⁰ We do not see these cost trends lessening in FY 2025 or the foreseeable future. In recognition of the unabating cost increases hospitals face, MedPAC recommended that to ensure beneficiary access to care and hospital access to capital, Congress

¹⁷ Hospitals that successfully report quality measures and are meaningful users of electronic health records are eligible for the full payment update.

¹⁸ Kaufman Hall January 2024 National Hospital Flash Report. Jan. 30, 2024.
https://www.kaufmanhall.com/sites/default/files/2024-01/KH_NHFR-2024-01-V2.pdf.

¹⁹ MedPAC March 2024 Report to Congress. Chapter 3.

²⁰ Note: AAMC margin data for 2022 are not yet available for comparison to MedPAC's 2022 all-IPPS hospital Medicare margins. Source: AAMC analysis of FY 2021 hospital cost reports from the Hospital Cost Reporting Information System (HCRIS) September 30, 2023, update obtained from CMS.

should direct CMS to provide a payment update 1.5 percent above the market basket update.²¹ This is the second year in a row that MedPAC has called for an update above the market basket update, recommending an additional one percent increase in FY 2024.²²

The insufficiency of the FY 2025 proposed market basket update is compounded by the underestimate by CMS in FYs 2022 and 2023 of actual cost increases. 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 percentage points from the CMS estimates. In the FY 2024 IPPS final rule, CMS finalized a market basket update of 4.1 percent based on projections at the time—actual market basket data now shows this projection fell short by 0.7 percentage points. CMS calculates the market basket based on forecasts rather than actual historical labor and supply cost increases; it does not incorporate the challenging circumstances brought on by unprecedented labor, supply, and drug cost increases. 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 2025 and is insufficient to address these cost increases. We recommend CMS look to alternative data sources that better and more timely reflect true labor and input 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 adjustments”²³ authority to make a one-time adjustment to the FY 2025 hospital update for forecast error in the FYs 2022 and 2023 hospital market baskets. Just as CMS has done in recent years for skilled nursing facilities (SNFs) and the capital IPPS update to adjust for discrepancies between the projected and actual market basket updates, CMS should make an adjustment for IPPS operating costs. Because CMS has not traditionally applied a forecast error adjustment in the IPPS, we emphasize this would be a one-time adjustment to correct for significant underestimates of the market basket update amidst historical hospital input cost growth. For the FY 2025 SNF update, CMS is proposing to increase the market basket update of 2.8 percent by an additional 1.7 percentage points.²⁴ For the FY 2024 SNF update, CMS finalized an increase in the market basket update of 3.0 percent by an additional 3.6 percentage points for forecast error in application of the FY 2022 update.²⁵

In both payment systems, CMS applied 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 2025 IPPS operating update could be adopted under CMS’ rulemaking authority.

In recent IPPS rules, CMS rejected 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

²¹ MedPAC March 2024 Report to Congress. Chapter 3.

²² MedPAC March 2023 Report to Congress. Chapter 3.

²³ Section 1886(d)(5)(I) of the Social Security Act

²⁴ 89 FR 23424, at 23427 (April 3, 2024).

²⁵ 89 FR 53200, at 53205 (Aug. 7, 2023).

under section 1886(d)(5)(I)(i) of the Act to apply a forecast correction in updating the IPPS rates for FY 2023.”²⁶

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 2025 IPPS proposed rule. CMS could adopt a forecast error correction to the FY 2025 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.

DOCUMENTATION AND CODING

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

The FY 2025 IPPS proposed rule does not include an adjustment for documentation and coding to FY 2025 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, MACRA²⁷ 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 reductions²⁸ – 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 2025 as required by section 7(b)(2) and 7(b)(4) of the TMA.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) AND UNCOMPENSATED CARE PAYMENTS

Medicare DSH payments are a vital source of support for academic health systems, which provide a disproportionate amount of uncompensated care (UC) compared with all hospitals nationally. While representing only 5 percent of all short-term general acute care hospitals nationally, AAMC member

²⁶ 87 FR at 49054

²⁷ Medicare Access and CHIP Reauthorization Act of 2015. (Pub. L. 114-10)

²⁸ 87 FR at 48800

hospitals provide 30 percent of all UC.²⁹ The DSH payments these hospitals receive enable them to continue to provide the care to their low-income patients and offset their high levels of uncompensated care.

Since the Affordable Care Act's (ACA's) revised DSH methodology went into effect in 2014, CMS makes DSH payments to hospitals in two forms: as empirically justified DSH payments and as UC-based DSH payments. A hospital's empirically justified DSH payment amount is 25 percent of the DSH add-on payment it would have received using the traditional DSH formula. The UC-based DSH payment is calculated as the product of three factors: Factor 1, which represents 75 percent of aggregate projected traditional DSH payments across all eligible hospitals; Factor 2, which is equal to one minus the change in the uninsured rate from 2013 (the year before the ACA's coverage expansions took effect) to the fiscal year in question; and Factor 3, which represents each DSH hospital's UC costs as a proportion of all DSH hospitals' UC costs. By multiplying factors 1 and 2, CMS arrives at the total pool of UC-based DSH payments. Multiplying this pool by each hospital's factor 3 results in the hospital's individual UC-based DSH payment. Each of these factors is dependent on the data sources and assumptions CMS uses to calculate them and can vary significantly if those sources or assumptions change.

For FY 2025, CMS estimates Factor 1 (the total pool of DSH funds before it is reduced to reflect the change in the uninsured rate) to be \$10.457 billion (p.36191). After Factor 2 is applied to reflect the changes in the uninsured rate, CMS calculates a total UC-based payment pool of \$6.498 billion (p.36193). In comparison to the previous years' UC-based payment pool, this marks an uptick in the amount of funds available for distribution to DSH hospitals. Prior to FY 2025, the UC-based payment amounts available each year steadily decreased from FYs 2020 to 2024, with a dramatic decline between FY 2021 and FY 2022. This has raised concerns around the transparency of data used and the inability to validate the accuracy of CMS' overall DSH projections without having full visibility into the inputs that determine DSH payments. For example, the effects of the COVID-19 PHE on Medicare discharges, case mix, Medicaid enrollment and subsequent disenrollment through determinations, all have an effect on CMS' estimates.

These reductions in DSH payments have proved problematic for hospitals as they continue to incur significant amounts of uncompensated care, face unprecedented cost and workforce pressures, and recover from the challenges posed by the COVID-19 pandemic. CMS' projection that Medicare DSH payments are expected to increase by \$560 million in FY 2025 marks a reversal of the downward trend in DSH payments. Going forward, CMS must ensure robust, accurate, and transparent calculations of DSH payments so that they remain a sustainable source of funding for hospitals treating low-income patients and are protected from large swings attributable to fluctuations in the uninsured rate or inaccuracies in CMS' projections.

Provide Greater Transparency Around "Other" Factors Used to Determine Factor 1

CMS utilized the Office of the Actuary's (OACT's) January 2024 Medicare DSH estimates that were based on the December 2023 Hospital Cost Report Information System (HCRIS) update and the FY 2024 IPPS/LTCH PPS final rule impact file to estimate Factor 1 (p.36191). 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 annual Medicare payment updates, discharges, case mix, and

²⁹ Source: AAMC analysis of a special tabulation of the FY2022 American Hospital Association (AHA) data. AAMC membership data, December 2023.

“other” factors (p. 36192). For FY 2025, 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 its explanation of the “other” factors and does not detail what data is utilized for this or how it is applied (p.36192). CMS also references changed Medicaid enrollment as being included in the ‘other’ factor but does not give adequate information to assess the impact (p.36192). The AAMC does not believe 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 IPPS 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.³⁰ 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 has already significantly affected 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 2025. 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, particularly with regard to Medicaid redeterminations and associated disenrollments.

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.

In addition to the opacity around the inputs into the “other” factor, CMS adjusted the FYs 2023 and 2024 discharge factors downwards by 1.4 percent and 0.5 percent, respectively, compared with the values finalized in the FY 2024 rule (p. 36192).³¹ CMS updates the discharges and case mix factors as more recent claims data becomes available. In the proposed rule, CMS does not explain what is driving the decrease in the discharge factors for FYs 2023 and 2024 compared with the finalized FY 2024 values, which were finalized just last August. Because the downward revision of the discharge factor reduces Factor 1 (and thus the pool of money available for UC-based payments), we urge CMS to provide additional explanation of the decrease in discharges in FYs 2023 and 2024.

³⁰ *Supra*, note 2.

³¹ Comparison of proposed FY 2025 factors applied for FY 2022 through FY 2025 with FY 2024 final rule factors applied for FY 2021 through FY 2024. 88 FR 58997.

Account for Expected Higher Rates of Uninsured Individuals Due to Rapid Pace of Medicaid Disenrollments in the Calculation of Factor 2

Factor 2 of the uncompensated care methodology determines the total available UC-based payment pool. This is determined annually by a percentage amount that represents the percent change in 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 the agency has in previous years. To calculate the uninsured rate in FY 2025, CMS uses a weighted average of the projected uninsured rates in calendar years 2024 and 2025.

During the COVID-19 PHE, 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 Act³², 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, 2023³³ 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 analysis revealed that nearly 22 million Medicaid beneficiaries have lost Medicaid coverage as of May 10, 2024.³⁴ The unwinding process is expected to continue until June 2024. Data shows that only slightly more than halfway into the unwinding process, states were disenrolling Medicaid beneficiaries at a much faster rate than projected. Through November 2023, total net disenrollment among children was 84.2 percent of the expected total, while total net disenrollment among adults was 50.7 percent of estimates. In 12 states, net disenrollments had already exceeded 100 percent of projections by November 2023.³⁵ The AAMC continues to be concerned about the anticipated loss of insurance coverage for millions of Medicaid-eligible individuals as the unwinding process continues.³⁶

We do not feel that the current proposal for Factor 2 takes into account the magnitude of the dramatic increase in uninsured rates that have occurred (and will continue to occur) due to the rapid pace of Medicaid disenrollments. 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 2025 due to the unprecedented nature of the Medicaid unwinding. We are concerned that the current data from the NHEA that CMS is proposing to utilize for Factor 2 is not up to date. If CMS chooses to continue with its proposal of utilizing the NHEA data, which do not appear to be accurately accounting for Medicaid disenrollments, 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 rise in the uninsured rate following the Medicaid unwinding in FY 2025.

³² Pub. L. 116-127

³³ Pub. L. 117-328

³⁴ KFF, [Medicaid Enrollment and Unwinding Tracker](#), May 10, 2024.

³⁵ The Urban Institute, [State Variation in Medicaid and CHIP Unwinding for Children and Adults as of November 2023](#), May 2024.

³⁶ AAMC, [Comments to CMS on the FY 2023 IPPS Proposed Rule](#) (June 2022).

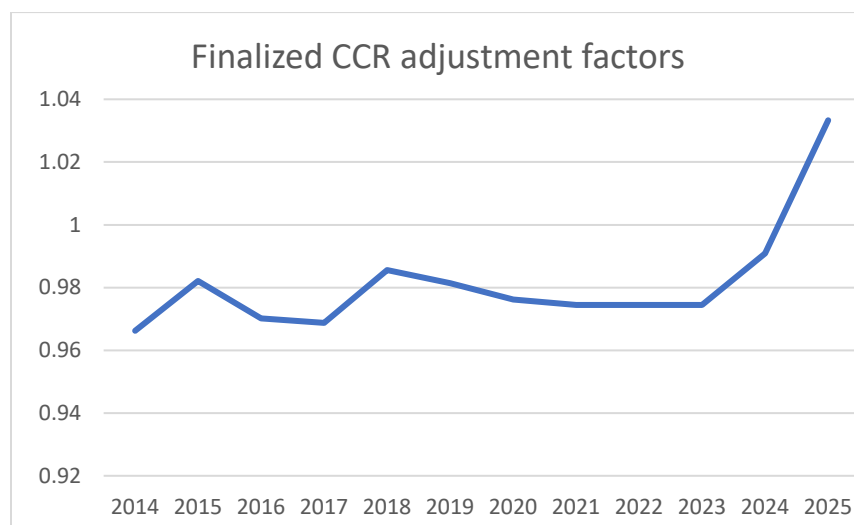
HIGH-COST OUTLIER PAYMENTS

Calculate the Operating Outlier Threshold for High-Cost Cases Using a Cost-to-Charge Ratio Adjustment More Reflective of Recent Data

The AAMC urges CMS to evaluate the factors affecting the calculation of the operating fixed-loss amount to ensure accuracy in operating outlier payments and that hospitals are adequately reimbursed for high-cost cases. For FY 2025, CMS proposes a fixed-loss amount (or outlier threshold) of \$49,237 for operating cases, a 15 percent increase from the finalized FY 2024 threshold of \$42,750. Outlier payments are intended to cover a portion of the expenses associated with extraordinarily high-cost cases. A hospital qualifies for an outlier payment for a given case if the costs of the case exceed the fixed-loss cost threshold, which is the sum of the hospital's Medicare prospective payment system payments (base DRG payments plus add-on payments) and the fixed-loss amount of \$49,237. An increase in the fixed-loss amount results in fewer IPPS cases being eligible for high-cost outlier payments, and in this case, the stark 15 percent increase will translate to fewer cases qualifying for outlier payments.

To calculate the fixed-loss amount, CMS uses charges from historical claims data (FY 2023 for the FY 2025 proposed rule) and updates the charges with a charge inflation factor. CMS converts these charges to costs using hospital-specific cost-to-charge ratios (CCRs), which are adjusted for expected year-over changes in CCRs using a CCR adjustment factor. Since at least FY 2014, the CCR adjustment factor CMS used in each IPPS final rule has been under 1, meaning CCRs have been expected to decrease year-over-year. For the first time in recent memory, CMS is proposing to use a CCR adjustment factor greater than 1.0, specifically 1.03331, which is an over four percent increase compared with the FY 2024 finalized CCR adjustment factor (and the highest year-over-year increase registered as far back as 2014). A CCR adjustment factor over 1.0 ultimately results in a higher estimate of the fixed loss amount, which sets a higher threshold for qualifying for outlier payments.

Figure 1: CCR Adjustment Factors from FYs 2014-2025



Source: Finalized CCR adjustment factor values from IPPS final rules. 2025 value is proposed.

While costs increased substantially from 2022 to 2023 due to increases in hospital labor and supply costs, we believe that the CCR adjustment that CMS proposes to use overstates the effect that these cost increases have on CCRs. This is primarily because the CCR adjustment factor used in the proposed rule

was derived from CCRs included in the December 2023 and December 2022 updates of the provider-specific file (PSF). However, we expect that as new CCR data becomes available, 2023 CCRs will continue to trend downward compared with 2022 CCRs. For example, CMS typically uses the March update of the PSF to calculate CCRs and the CCR adjustment factor in the final rule. The March update will include data from more recently filed cost reports, which will substantiate the fact that CCRs are trending downward.

Due to the anomalous increase in CCRs from 2022 to 2023, and the incompleteness of the data used to calculate the CCR adjustment factor, CMS should revise its operating CCR adjustment factor. CMS could, for example, use the previous year's operating CCR adjustment factor or set the CCR adjustment factor for use in calculating the FY 2025 fixed loss amount to 1. There is precedent, including in recent years, of CMS adjusting the inputs used in calculating the fixed loss amount. In the FY 2024 IPPS final rule, CMS used previous years' (FY 2022 and FY 2023 final rule) charge inflation and CCR adjustment factors in setting the long-term care hospital (LTCH) fixed loss threshold because of concerns that more recent data were overstating charge inflation.³⁷ In FYs 2022 and 2023, for IPPS hospitals, CMS used the CCR adjustment factor from FY 2021 (which used pre-COVID-19 data) because of the effect of COVID-19 cases on the calculation of the fixed loss amount. In the FY 2023 rule, CMS specifically noted that had it used the data it would ordinarily use to calculate the charge inflation and CCR adjustment factors, it would result in a CCR adjustment factor above 1.0, which is atypical for CCR adjustment factors and would result in an "abnormally high" charge inflation factor.³⁸ Given similarly anomalous data CMS uses to calculate the FY 2025 CCR adjustment factor, CMS should substitute a different operating CCR adjustment factor that will be more aligned with actual year-over-year changes in CCRs and will be borne out as more recent data become available.

PROPOSED CHANGES TO Z-CODES FOR HOMELESSNESS

Finalize the Proposal to Change the Severity Level Designation to CC for Z-codes Describing Inadequate Housing and Housing Instability

For FY 2025, CMS is proposing to change the severity level designation for seven ICD-10-CM SDOH Z codes describing inadequate housing and housing instability from Non-CC to CC. The agency defines housing inadequacy as an occupied housing unit that has moderate or severe physical problems, such as deficiencies in plumbing, heating/cooling, lack of electricity, etc. and defines housing instability as a number of potential challenges, such as trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing. The seven codes being considered include Z59.10 (Inadequate housing, unspecified), Z59.11 (Inadequate housing environmental temperature), Z59.12 (Inadequate housing utilities), Z59.19 (Other inadequate housing), Z59.811 (Housing instability, housed, with risk of homelessness), Z59.812 (Housing instability, housed, homelessness in past 12 months) and Z59.819 (Housing instability, housed unspecified). (P. 35999). The AAMC supports the proposal to change the severity level designation to CC for the codes describing inadequate housing and housing instability. 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. As CMS continues to evaluate additional SDOH Z-codes to move from non-CC to CC, we urge the agency to consider changing the

³⁷ FY 2024 IPPS final rule. 88 FR 59375.

³⁸ FY 2023 IPPS final rule. 87 FR 49425. "With regard to the CCR adjustment factors, the operating and capital CCR adjustment factors based on the data we ordinarily would use are above 1.0 while the operating and capital CCR adjustment factors have typically been below 1.0."

severity level designation of additional SDOH Z-codes that go beyond housing needs as these other needs may also affect the health outcomes, complexity of care, and well-being of Medicare beneficiaries.

Additionally, CMS notes within the rule that there are fluctuations in reporting of these Z codes; however, the agency is uncertain whether these fluctuations are due in part from skewed data due to the COVID-19 PHE or if there is a lack of knowledge on the use of these codes. (P.35998). One additional factor that may be negatively impacting comprehensive reporting is the limit on the number of diagnoses that may be reported on an inpatient claim. As we noted in our comment letter in response to the FY 2024 IPPS proposed rule,³⁹ our members have cited that the cap of no more than 25 diagnosis codes that are allowed on Medicare inpatient claims, may hamper Z code reporting due to competing reporting priorities for both payment and quality measures. AAMC analysis revealed that 17 percent of inpatient claims reached the maximum limit of 25 diagnoses that can be reported on the claim.⁴⁰ CMS should evaluate the potential to expand the number of diagnosis codes that can be submitted on inpatient claims to increase the uptake of Z code reporting. Alternatively, CMS should consider ways to capture SDOH Z codes when there are no more available spaces for diagnosis codes. For example, CMS could design a separate way to report the Z codes on the claim form that is separate and distinct from the diagnosis codes.

The AAMC continues to support the expanded voluntary use of SDOH Z codes and believes CMS should continue to evaluate providers' use of the codes before mandating any related reporting. We appreciate CMS' efforts to continue monitoring SDOH Z code reporting, including the reporting based on SDOH screenings performed as a result of quality measures in the Hospital IQR Program. It is important to ensure reporting these codes for payment aligns with the screening quality measure as well as address any potential challenges to include these codes on the inpatient claim. Further, provider education on reporting Z codes should be a priority if CMS chooses to continue expanding the use and reporting of these codes.

MEDICARE WAGE INDEX - LOW WAGE INDEX POLICY

Evaluate Factors Affecting Wages for Low Wage Index Hospitals and Commit to 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 raises 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. However, due to the impact of the COVID-19 PHE on the wage index, the agency decided to extend this policy for another year in FY 2024. In this proposed rule, CMS is proposing to extend the low wage index policy and related budget neutrality adjustment for at least an additional three years to make up for the data lost in the original four years of implementation due to the PHE. (P. 36185). The AAMC continues to

³⁹ AAMC, [Comments to CMS on the FY 2024 IPPS Proposed Rule](#) (June 2023)

⁴⁰ 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.

emphasize our concerns with the continuation of the low wage index policy and budget neutrality adjustment as voiced in our response to the FY 2024 IPPS proposed rule.⁴¹

In the initial proposal of this policy in FY 2020, the AAMC voiced concerns around CMS' authority to implement this policy. The AAMC detailed these concerns in our response to the FY 2020 IPPS proposed rule in which the association raised concerns that CMS has broadly and inappropriately interpreted its authority to artificially raise the wage index values of the bottom quartile hospitals at the expense of the top quartile hospitals.⁴² This policy has similarly been challenged in the courts, where the district courts in *Bridgeport Hospital, et al., v. Beccera*, No. 1:20-cv-01574 (D.D.C.)⁴³ and *Kaweah Delta Health Care District, et al. v. Becerra*, No. CV 20-6564-CBM-SP(x) (C.D.Cal.)⁴⁴ found that the secretary did not have the authority under Sections 1886(d)(3)(E) and 1668(d)(5)(I)(i) to implement this policy for FY 2020. While these decisions have been appealed and are still under consideration, the AAMC still believes that this policy exceeds CMS' statutory authority.

Beyond this concern, the AAMC appreciates the analysis CMS has conducted on the wage index data currently available from FY 2021, inclusive of the initial implementation of the low wage index policy and the effects of the policy observed thus far. (P. 36185). CMS notes within the proposed rule that the distribution of changes in the average hourly wages for the low wage index hospitals were similar to the distribution of changes in the average hourly wages for non-low wage index hospitals for FY 2019-FY 2021, inclusive of data for when the low wage index policy was in place beginning in FY 2020. In addition to this similarity, CMS noted that some low wage index hospitals confirmed that the payments they received because of the low wage index policy were directly used to increase wages more than they would have without the payments. (P. 36185). CMS states that since the data analyzed has not shown a substantial effect on reducing wage index disparities, the agency cannot evaluate what, if any, portion of wage index changes for low wage hospitals are attributed to the low wage index policy. The AAMC agrees with CMS that this analysis did not show a substantial effect on reducing wage disparities; however, we urge CMS to evaluate whether this is due to other factors affecting the wage index or if this is due to the ineffectiveness of the low wage index policy.

In addition to CMS' analysis, it is important to re-emphasize that wages across the board have increased in recent years. An analysis from the KFF and Peterson Center evaluated changes in hospital employment data, including wage data, from February 2020 at the start of the COVID-19 pandemic through early 2024. This analysis found that the average weekly earnings for healthcare employees had gone up 20.8 percent from \$1,038 to \$1,254 weekly in January 2024. Even more specific to IPPS, the report found that hospital workers wages saw a 20.3% increase between February 2020 to January 2024, going from \$1,269 to \$1,527 per week.⁴⁵ CMS also observed this shift in wages as outlined in the agency's analysis of audited wage data for FY 2020 to 2021 in the proposed rule, which saw larger increases in average hourly wages and wage indexes than compared to years prior. CMS notes that there are several challenges related to determining the cause of these changes including uncertainty around the impact of the COVID-

⁴¹ *Supra*, note 39.

⁴² AAMC, [Comments to CMS on the FY 2020 IPPS Proposed Rule](#) (June 2019).

⁴³ *Bridgeport Hosp. v. Beccera*, 589 F. Supp. 3d 1 (D.D.C. 2022)

⁴⁴ *Kaweah Delta Health Care Dist. v. Becerra*, 1:21-cv-01422 AWI SKO (E.D. Cal. Sep. 22, 2021)

⁴⁵ "What are the recent trends in health sector employment?" Peterson-KFF Health System Tracker, March 27, 2024. <https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-health-sector-employment/#Cumulative%20%20change%20in%20average%20weekly%20earnings.%20since%20February%202020%20-%20January%202024>

19 PHE. (P. 36151). However, we are concerned that this observed change in wages may involve additional factors that affect low wage index hospitals, such as inflation and other market forces due to the effects of the PHE, that are not clearly accounted for or represented in the current low wage index policy.

Lastly, if CMS finalizes the continuation of the low wage index policy for an additional three years beginning in FY 2025, CMS should be definitive in establishing a clear end date to evaluate the effectiveness of the low wage policy. For a variety of reasons, including the COVID-19 PHE and other factors impacting wages, it is likely that changes observed in employee compensation may not be directly related to the low wage index policy. Although AAMC supports CMS' goal to address difficulties faced by low wage index hospitals, we urge CMS to tackle these issues in a more thoughtful and comprehensive manner that improves the standing of low wage index hospitals without impairing the standing of high wage index hospitals. Additionally, should CMS continue the low wage index policy, it should do so in a non-budget neutral manner.

SEPARATE PAYMENT FOR ESSENTIAL MEDICINE "BUFFER STOCK"

Evaluate Impact of Add-On Payment for Small, Independent Hospitals and Address Other Factors Contributing to Drug Shortages

In the CY 2024 Outpatient Prospective Payment System (OPPS), CMS requested information related to drug shortages and the idea of establishing an add-on payment for hospitals to establish an essential medicines buffer stock. As a follow up to this RFI, for FY 2025 CMS is proposing to establish a separate add-on payment under the IPPS for small, independent hospitals for the cost of establishing and maintaining a 6-month buffer stock of essential medicines. (P. 36232). Within this proposal, CMS defines a small hospital as having 100 or fewer beds and independent as a hospital that is not part of a chain organization as defined for purposes of hospital cost reporting. (P. 36234). It is CMS' intention that limiting this proposal to only small, independent hospitals will limit potential demand shocks to the pharmaceutical supply chain. (P.36234). In response to several concerns raised in the RFI responses, CMS is also proposing provisions within this policy to mitigate hoarding and other practices so as not to exacerbate drug shortages. CMS is proposing that if an essential medicine is listed as 'currently in shortage' on the FDA's drug shortage list, the hospital that establishes a new buffer stock of that medication, would be ineligible for the additional payment for the duration of the shortage. Hospitals would also be allowed to draw down from their buffer stock supply while in shortage and receive payment even if they dip below a six-month supply. Additionally, CMS requests comment on whether the size of the buffer stock should be phased in so that hospitals would be eligible for payment the first year for only a three-month supply and then for a six-month supply for subsequent years. (P. 36236). The AAMC thanks CMS for listening to comments concerning potential demand shocks and agrees that CMS should allow for a phased in approach to further minimize initial demands. This policy would not only help to address investment concerns related to the infrastructure needed to store and maintain the buffer stock but would also minimize initial demand. We urge CMS to evaluate additional policies that aim to mitigate potential demand shocks to the supply chain or practices that exacerbate drug shortages.

Overall, the AAMC supports CMS' efforts to ensure hospitals, providers and patients have access to needed medicines. Drug shortages negatively impact patients by adversely affecting drug therapy and potentially causing delays in medical treatments. However, we also urge CMS to further investigate root causes of drug shortages and implement changes that support the entire supply chain beyond the add-on payment for an essential medicine buffer stock. The AAMC shared additional potential policy changes in

response to an RFI from the Federal Trade Commission (FTC) and the U.S. Department of Health and Human Services (HHS) earlier this year.⁴⁶ Within this response, we urged policymakers to explore options that focus on quality and resiliency needs such as bolstering efforts around further developing a quality rating system for manufacturers, developing payment adjustments for generic essential medications frequently in shortage, and increasing supply chain transparency. Specifically, we urged CMS to consider payment adjustments to providers for generic essential medications frequently in shortage, when contracting with manufacturers that agree to supply chain mitigation and resiliency requirements, such as participation in the quality management maturity (QMM) rating system. Providing payment adjustments to providers that contract with manufacturers participating in supply chain mitigation and comply with resiliency requirements would incentivize providers to select contracts with manufacturers that are more reliable and are more likely to produce a quality supply of products. In turn this will ensure providers contract with reliable, quality manufacturers and reduce the risk of shortages arising from issues related to manufacturing quality, delays, or discontinuations. Ultimately, this will protect patients' safety and access to needed care while directly targeting some of the root causes of shortages in a way that does not exacerbate shortages.

CONDITIONS OF PARTICIPATION REQUIREMENTS FOR HOSPITALS AND CRITICAL ACCESS HOSPITALS TO REPORT ACUTE RESPIRATORY ILLNESSES

During the COVID-19 PHE, CMS began requiring hospitals to collect and report data on COVID-19 hospitalizations and hospital capacity through the Centers for Disease Control & Prevention (CDC) National Healthcare Safety Network (NHSN) "with a frequency, and in a standardized format, as specified by the Secretary."⁴⁷ The agency incorporated this requirement into the Medicare conditions of participation (CoPs) for infection prevention and control and antibiotic stewardship programs.⁴⁸ CMS' stated purpose for collecting this data was to leverage surveillance information to understand health care system stress, capacity, capabilities, and the number of patients hospitalized due to COVID-19.⁴⁹ Subsequently, in the FY 2023 IPPS rule, CMS finalized a policy to revise the CoPs to continue requiring that hospitals report on a subset of data elements related to COVID-19 from the end of the COVID-19 PHE through April 30, 2024, as well as data elements on acute respiratory illness, including seasonal influenza virus, influenza-like illness, and severe acute respiratory infection.⁵⁰

CMS is now proposing to amend the infection prevention and control and antibiotic stewardship programs CoPs once again to require, beginning on October 1, 2024, the weekly reporting of data on:

- confirmed infections of respiratory illness (defined more broadly to include COVID-19, influenza, and RSV) among new and hospitalized patients;
- hospital bed census and capacity, both overall and by hospital setting and population group; and
- limited patient demographic information, including age. CMS also requests feedback on collecting race and other demographic information. (p. 36505)

⁴⁶ AAMC, [Comments to FTC and HHS on Ownership and Consolidation in Health Care](#) (June 2024)

⁴⁷ Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. 85 FR 54820.

⁴⁸ 42 CFR § 482.42.

⁴⁹ [Guidance for Hospitals and Acute Care Facilities Reporting of Respiratory Pathogen, Bed Capacity, and Supply Data to CDC's National Healthcare Safety Network \(NHSN\)](#). Nov. 17, 2023.

⁵⁰ FY 2023 IPPS Final Rule. 87 FR 48780.

These new reporting requirements would apply outside of a declared PHE. CMS also proposes to require hospitals to report this data, as well as additional data elements as designated by the Secretary, up to a daily frequency, without notice and comment rulemaking when there is a declared federal, state, or local PHE. The agency also proposes that the Secretary could require reporting on these data elements if the Secretary determines that “an event is significantly likely to become a PHE for an infectious disease” (p. 36507). The AAMC supports the need for a data-driven approach to responding to future PHEs, but as we outline below, we do not believe the CoPs are the appropriate mechanism for balancing these goals with reducing excessive burden on providers.

Respiratory Illness Reporting Requirements Should Not be Part of the Hospital CoPs

The Medicare CoPs set minimum health and safety standards for hospitals participating in Medicare. Compliance with CoPs allows hospitals to maintain their CMS certification and continue to receive reimbursement for services furnished to Medicare and Medicaid beneficiaries. CMS has the authority to terminate a hospital’s certification if it deems a hospital is noncompliant with the CoPs.

Traditionally, CMS has used the threat of non-compliance with CoPs, which would result in potential hospital termination from the Medicare and Medicaid programs, as a mechanism to address significant breaches of quality and safety that may threaten patient care. The AAMC is concerned that CMS has increasingly begun to use COPs as an enforcement mechanism for data reporting requirements, and that this approach could have significant impacts on the nation’s health care system. As noted above, during the PHE, CMS used the CoPs as a means to increase compliance with daily coronavirus reporting, at a time when the hospital systems were most stretched. Nevertheless, CMS maintained that hospitals must use their scarce resources and allocate limited staff to onerous reporting rather than care for patients or face termination. Hospitals and health systems recognize the value of reporting this critical data voluntarily, which is an approach preferable to CMS’ mandated reporting requirements. We urge CMS to utilize the consequences of termination for only the most dire concerns of patient safety and quality.

In this proposed rule, CMS would continue to tie COVID-19 and other respiratory illness reporting to compliance with hospital CoPs. If hospitals do not comply with reporting requirements, they will be in violation of CoPs and could be subject to termination from Medicare and Medicaid. We believe that tying reporting to CoPs that involve removal from the Medicare and Medicaid programs as a potential consequence is inappropriate. Throughout much of the PHE, hospitals reported these data elements voluntarily and worked with federal and state governments to assist with surveillance. Requiring data collection, some of which is duplicative and redundant, does not improve the data collection; it just adds to the burden of those required to report it.

Furthermore, aside from the punitive nature of failure to comply with the CoPs, the CoPs are not the logical medium for the addition of respiratory illness-related reporting. The CoPs are intended to ensure hospitals adhere to Medicare quality and safety standards. CMS specifically proposes to add the requirements to the infection prevention and control and antibiotic stewardship program CoPs. These CoPs relate to best practices for improving antibiotic use and reducing the development and transmission of healthcare-associated infections (HAIs) and antibiotic-resistant organisms.⁵¹ Reporting requirements related to respiratory illness do not fit under the framework and broader purpose of these CoPs, which are focused on best practices, standards of care, and leadership and organizational responsibilities.

⁵¹ 42 CFR § 482.42.

CMS Should Not Extend Mandatory Data Reporting Outside of a Declared PHE

Although hospitals voluntarily reported data at the beginning of the COVID-19 PHE, CMS tied mandatory reporting of COVID-19 data and subsequently seasonal influenza data to the CoPs.⁵² Throughout the PHE, hospitals reported COVID-19 data on a daily basis. CMS proposes that hospitals would continue reporting a subset of data, beginning on October 1, 2024, even when there is no ongoing PHE declaration. While we appreciate that CMS has limited the number of required data elements that would be required when there is no ongoing PHE, the AAMC and its members continue to oppose mandating the reporting of these data elements. CMS could better meet its goals by working with other agencies, stakeholders, and hospitals to encourage voluntary reporting and to develop the infrastructure to support more automated data collection that would reduce the burden associated with manual data entry.

The AAMC recognizes the value of data reporting but does not believe that mandatory reporting is the appropriate mechanism for doing so. Ultimately, the value of limited data on respiratory illnesses collected through mandatory reporting outside of a PHE is outweighed by the burden it will impose on health systems. Despite a multitude of other challenges faced during the COVID-19 PHE, hospitals continued to report daily the required data elements and redirecting scarce resources from other settings to comply with the reporting. It remains unclear, however, how federal agencies utilized this mountain of information. We urge CMS to end mandatory data reporting since the COVID-19 PHE declaration has elapsed. CMS and other federal agencies should provide hospitals with a detailed analysis of the data collected, how it was used during the PHE, and solicit stakeholder input as to the value of continuing to collect this data, as well as identifying best reporting practices for future pandemics.

CMS Should Not Finalize Mandatory Reporting Requirements for COVID-19 and other Respiratory Illness Reporting During a PHE

As noted above, in addition to requiring reporting on a subset of data elements beginning October 1, 2024, CMS proposes to require more granular reporting in the case of a local, state, and national PHEs as declared by the HHS Secretary. The AAMC is aligned with CMS in its goal of ensuring the federal government is prepared to respond to future PHEs with comprehensive data on hospitalizations and hospital capacity. This data in theory would help the federal government determine its response to a PHE, including by directing appropriate resources to those hospitals most in need. However, the disjointed nature of the reporting infrastructure during COVID-19 underscores the need for improvements to reporting processes and clarity from CMS on required data elements before any requirements are finalized.

The AAMC appreciates the need for data to understand the impact of public health emergencies; however, during the pandemic, hospitals submitted an enormous amount of data without knowing how, or whether, it was used by the federal government. Data reporting, particularly when it does not have a targeted purpose, is very burdensome, forcing hospitals to redirect scarce resources in order to comply with reporting requirements. Once automated data is available, we urge CMS to work with stakeholders to determine the type of reporting that would be valuable.

Increase transparency of data. Hospitals agree with the need for transparency in COVID-19 data reporting. However, despite multiple inquiries as to the purpose and use of COVID-19 and seasonal influenza data collection, it is still unclear how this data is being used to guide the federal government's response to the pandemic. Throughout the PHE, hospitals provided an overwhelming amount of

⁵² CMS-3401-IFC.

information, but the government has not been transparent regarding its usefulness. We call on the Administration to be explicit about the reasons for collecting the current extensive amount of information, inform hospitals about how the data are being used, and discuss future plans for use of the data before adding additional data reporting requirements. In addition, this data must be available under proper HIPAA controls to be analyzed and studied to make important recommendations for future data collection, use of data and appropriateness of the types of data which were or can be most useful

Currently, state and local public health agencies have limited access to certain National Healthcare Safety Network (NHSN) data via their NHSN accounts. However, providing more access to the data will allow stakeholders to better understand how the PHE impacts them and their communities and allow for more detailed feedback on how the federal government can collect data that is informative and actionable.

Reduce data submission redundancy; simplify data elements; make definitions consistent. CMS should ensure that data reporting is streamlined, including making definitions consistent across federal, state, and local reporting platforms. Federal reporting requirements are often in addition to reporting hospitals are required to do at the state and local levels. Increased reporting combined with inconsistent requirements adds to the confusion on what and to whom to report. These inconsistencies are burdensome and have resulted in hospitals reporting the same or similar information to state and local governments and the federal government to ensure compliance.

For example, the CDC collects, compiles, and analyzes information on influenza activity year-round in the U.S. FluView⁵³ is a weekly influenza report that tracks seasonal influenza activity in the U.S. The Influenza Hospitalization Surveillance Network⁴ (FluSurv-NET) collects laboratory-confirmed influenza-associated hospitalizations among children and adults from a network of acute care hospitals to track influenza infections. Therefore, requiring hospitals to also report this information as part of hospital CoP data requirements is unnecessary.

Future Reporting Should Not be Required When an Event is “Significantly Likely” to Become a PHE

The AAMC has serious concerns about CMS being able to mandate more onerous reporting requirements, as well as increased frequency of reporting, in circumstances that are “significantly likely” to become a PHE, without notice and comment rulemaking. We believe that this provision vests incredible discretion in the Secretary without any associated guidelines or guardrails around what would constitute an event likely to become a PHE. This requirement would introduce tremendous uncertainty for hospitals, who would be in the untenable position of having to allocate additional resources and staff to report at an increased frequency and on additional data elements without sufficient notice. CMS has also not stated what the benefit would be of collecting data when there is not a declared PHE but when CMS determines events are “significantly likely” to become a PHE. Under section 319 of the Public Health Service Act, the HHS Secretary may declare a PHE after consultation with public health officials and must notify Congress within 48 hours of the declaration. These procedures are essential to ensuring that HHS follows appropriate procedures in declaring a PHE and allowing the Secretary to bypass this process would undermine the intent of PHSA in implementing these checks and balances. Therefore, CMS should not finalize the proposal that would allow the Secretary to require additional reporting when an event is “significantly likely” to become a PHE.

⁵³ <https://www.cdc.gov/flu/weekly/overview.htm>

CMS Should Delay Consideration of Requirements to Collect Data by Race and Ethnicity Until After HHS Completes its Action Plan on Race and Ethnicity Data for the OMB's Revised Standards

CMS seeks stakeholder input on whether to require hospital reporting of race/ethnicity demographic information beginning October 1, 2024. CMS believes expanding the scope of demographic information collection through respiratory illness reporting would further support improvements in clinical outcomes. (p. 36506) CMS notes that there are evolving data collection standards for race and ethnicity data, referencing the Office of Management and Budget (OMB) proposals in 2023 to revise the Statistical Policy Directive No. 15 on Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD No. 15). (p. 36506; referencing the proposed rulemaking in footnote 834). The OMB has recently finalized those changes to SPD No. 15, notably combining race and ethnicity into a single question and requiring government agencies to meet certain deadlines to implement these Government-wide principles, policies, standards, and guidelines for developing, presenting, and disseminating race and ethnicity statistical information.⁵⁴ The new standards are effective immediately for all new record keeping or reporting requirements that include race and ethnicity data, and require agencies to submit no later than September 29, 2025 to OMB a publicly available Action Plan on Race and Ethnicity Data describing how the agency intends to bring their collections and publications into compliance with the new standards by March 28, 2029.⁵⁵

The AAMC is aligned with CMS on the importance of race and ethnicity data to support health equity and clinical delivery improvements.⁵⁶ However, we urge CMS to not require reporting of race and ethnicity as part of a CoP for reporting respiratory illness at this time, and instead focus on contributions to a whole HHS approach to devising its Action Plan on Race and Ethnicity Data due in September 2025.

The OMB's changes to federal race and ethnicity data collection are significant and will require significant policy changes to fully implement. CMS has a vital role in working across HHS to ensure that policy change is consistent across the Department, considering its interactions with the CDC, Food & Drug Administration, and the Office of the National Coordinator for Health Information Technology (ONC). Hospital systems for collecting and reporting race and ethnicity are simply not yet configured to the new standards and will rely on the agencies across HHS to provide clear guidance and technical assistance to adopt these changes on the ground. The AAMC believes that implementing the OMB's changes to race and ethnicity data collection will meaningfully improve the data that agencies, healthcare providers, and communities all rely on to impact change and reduce health inequities. We ask CMS to pause any new race and ethnicity data collection policies to instead focus on ensuring a seamless implementation of the revised standards that sets healthcare delivery up for real success.

⁵⁴ 89 FR 22182 (March 29, 2024)

⁵⁵ *Id.*, at 22196.

⁵⁶ See, AAMC, [Comments to the Interagency Technical Working Group on Race and Ethnicity Standards](#) (April 2023), specifically referencing the challenges during the COVID-19 pandemic with federal data to best identify and address health inequities experienced by racial and ethnic minorities and the importance of improved national standards to accurately capture race and ethnicity data.

Consider Potential for Future Incentives for Health Care Reporting to the National Syndromic Surveillance Program (NSSP)

CMS asks for feedback on potential policy proposals to further advance hospital participation in CDC's NSSP, including through a condition of participation or as a modification to current requirements under the Promoting Interoperability (PI) Program. (p. 36508)

The AAMC cautions against requiring hospitals to report data through the NSSP through the CoPs or the PI Program. CMS notes that “CDC receives data from 78 percent of non-federal emergency departments across the 50 states, Washington DC, and Guam” and that this data tends to flow from the hospital's EHR to the local or state public health agency [PHA] and then from the PHA to the CDC. (p. 36508) This suggests that optional reporting to the NSSP is robust. CMS notes in its questions that not all state and local PHAs are participating in exchange with the CDC's NSSP, which critically highlights that additional participation may not be in the direct control of the hospital. As noted in our comments to the RFI on public health reporting and data exchange under the PI Program, not all state and local PHAs are well-funded or have robust data reporting and exchange capabilities. These factors in turn influence a state or local PHA's ability to presently exchange with the CDC's NSSP. Requiring hospitals in such locations to report to the NSSP puts hospitals in the untenable position of not being able to meet a CMS requirement for reasons over which they have no control. CMS should instead first work with CDC to identify and resolve issues preventing state and local PHAs' capabilities and incentives for participating in exchange with the CDC's NSSP. **When all state and local PHAs participate in the CDC's NSSP, CMS could reconsider the potential policies to incentivize hospitals to report data through the NSSP.**

MATERNITY CARE REQUEST FOR INFORMATION

Within this year's proposed rule, CMS included an RFI related to maternity care aimed at seeking feedback on the differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients compared to non-Medicare patients. In addition, the agency is interested in understanding how payment practices may impact maternal health outcomes as well as understanding additional policy options that could aid in driving improvements in maternal health outcomes. (P.36496). The AAMC appreciates and supports the administration's interest and commitment to maternal health and improving health outcomes. AAMC-member medical schools, teaching health systems and hospitals, and faculty physicians play a critical role in the maternal health care delivery system, offering highly specialized services that are often unavailable in other settings. As compared to only 12 percent of hospitals nationwide, 70 percent of AAMC-member health systems and hospitals provide level III obstetrics and gynecology services, which includes the management and treatment of complex maternal medical conditions, obstetric complications, and fetal abnormalities.⁵⁷ This care highlights the important role that academic medical centers, faculty physicians, learners, and other providers in academic medical centers play in addressing maternal health outcomes. Our members are committed to improving maternal health outcomes through investing in several factors affecting maternity care, including workforce, clinical care, research, and fostering relationships with patients, families, and communities.⁵⁸

⁵⁷ 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 September 2023.

⁵⁸ AAMC, [Medical Schools' and Teaching Hospitals' Efforts to Address the Maternal Health Crisis](#) (June 2021)

Ensure Adequate Payment for Hospital Services, Including Maternal Health Services

When considering the resources needed for hospitals to provide services to patients, it is imperative to ensure adequate payment rates. As noted throughout this letter, health systems and hospitals continue to grapple with financial challenges associated with increased costs, workforce shortages, and insufficient reimbursement as they try to maintain access to needed services, such as labor and delivery. Within Medicare, the market basket for Medicare base rates over recent years has failed to keep up with the increased costs and the rate of inflation as detailed earlier in this letter and in prior comment letters.⁵⁹ While CMS notes that only about 13% of Medicare beneficiaries are under 65 and potential users of maternal health services (P.36496), collectively adequate payment for all Medicare services has the potential to impact a hospital's financial viability and ability to continue operating a variety of service lines, including those related to maternal health care. CMS highlighted research from the March of Dimes and other relevant stakeholders within its obstetric service RFI on the trends in obstetric unit closures and decreased access to maternal care in part due to these financial challenges. (P. 36498). As hospital-based maternity wards continue to face closures, we have seen an emergence of "maternity care deserts," defined as counties without a hospital or birth center offering obstetric care. In 2022, over 2.2 million women of childbearing age lived in a maternity care desert.⁶⁰ This challenge is expected to worsen in the coming years due to the profound financial pressures facing health systems, affecting access for all patients, especially for those in rural and historically under-resourced communities. **The AAMC encourages CMS to ensure adequate payments rates for all Medicare services inclusive of accurate market basket updates for hospitals to maintain access to needed services.**

Ensure Adequate Payment for Hospital Services, Including Maternal Health Services, under Medicaid

As noted above, a fraction of Medicare beneficiaries are under 65 and potentially in need of maternal health services under Medicare. The agency also noted that the Medicare beneficiary population has specific characteristics that should be considered when evaluating IPPS payment rates and DRGs. (P.36496). These differences in the Medicare population may not accurately capture the resources needed by non-Medicare populations, and therefore IPPS payment rates and DRGs may not be viable benchmarks for other payers to use as a reference. However, as noted adequate payment rates in Medicare are necessary to ensure access, even for lower utilized services such as those related to maternal care. It would also be remiss not to mention the change in complexity in the maternal patient population as more individuals who previously were unable to become pregnant due to age or other disease states are able to. Based on US census data, the median age for birthing persons has shifted from 27 in 1990 to 30 in 2019.⁶¹ Additionally, in a report from Blue Cross Blue Shield, the number of women entering pregnancy with pre-existing conditions such as hypertension, type II diabetes, obesity, and behavioral health conditions had increased.⁶² These complexities may come with additional care needs during pregnancy and delivery which should be reflected in the payment for services provided.

⁵⁹ *Supra*, note 39.

⁶⁰ Brigance, C., Lucas R., Jones, E., Davis, A., Oinuma, M., Mishkin, K. and Henderson, Z. (2022). [Nowhere to Go: Maternity Care Deserts Across the U.S.](#) (Report No. 3). March of Dimes.

⁶¹ Morse, Ann. US Census. [Stable Fertility Rates 1990-2019 Mask Distinct Variations by Age.](#) (2022)

⁶² Blue Cross Blue Shield. [Trends in Pregnancy and Childbirth Complications in the U.S.](#) (2019)

Additionally, while Medicare covered births are a smaller fraction of births in the US, 41 percent of births in the United States are financed by Medicaid with four states exceeding 50 percent.⁶³ **Therefore, as CMS considers the effects of Medicare IPPS rates on maternal health, the agency should also evaluate the impact of Medicaid rates as this population is more likely to utilize maternal health services and more closely represent a majority in the population of patients utilizing maternal health care services.** The AAMC has previously submitted comments to CMS highlighting the need for sufficient Medicaid payment rates to maintain beneficiaries' access to care.⁶⁴ Specifically, the AAMC remains concerned that payments by both Medicaid FFS and MCOs continue to be below the cost of providing care, which has a negative impact on providers serving as safety-net providers for Medicaid beneficiaries and may significantly impede beneficiaries' access to care. Ensuring that Medicaid reimbursement is adequate to maintain coverage must be a priority to achieve CMS' goal of improving access to care and addressing health equity in maternal health care.

Perverse Incentives Do Not Affect Clinical Decision Making for Maternal Health Care

Within the RFI, CMS also seeks additional information on use of IPPS MS-DRGs relative weights in state Medicaid programs and how this may be influencing the number of low-risk cesarean delivery for the Medicaid population. This inquiry alludes to the idea that payment rates may be creating perverse incentives that dictate clinical decision making. (P.36496). The AAMC strongly disagrees with this idea. Clinicians make clinical decisions about the type of treatment or services a patient may need based on relevant clinical information and do not utilize health plans or payment rates to inform their decision. Clinicians undergo extensive training to refine their clinical decision-making skills so that treatment options are based on what is most clinically appropriate for their patient. Specifically in the context of maternal health, there may also be unexpected changes in a patient's risk level in the final stages of pregnancy or adverse events during the intrapartum period that impact clinical decisions around a patient's delivery method. These rapid changes are not always clearly represented in data or quality metrics, making it difficult to accurately evaluate the number of low-risk cesarean deliveries versus vaginal births.

Include Focus on Perinatal Services to Improve Maternal Health Outcomes

Additionally, CMS requests feedback on how to support hospitals in improving maternal health outcomes. The AAMC believes that hospitals and health systems play an important role in improvements to maternal health outcomes; however, the inpatient maternal health services explored within this RFI are just one piece in the broad range of maternal health care services necessary to support the health and safety of birthing persons. The payment for inpatient maternal health services is not inclusive of pre or postpartum services that serve a critical role in improving health outcomes for maternal care. Further, as it relates to bundled payments under Medicaid and other non-Medicare payers, this payment mechanism is rigid in the fact that there is little to no flexibility to address additional patient needs, especially those that may occur postpartum. For example, bundles under non-Medicare payers often do not include services such as vaccines or implants (e.g., IUDs) so if these services are needed the health system is faced with providing them without payment or the additional burden of having to prove why these services are needed. Both options are costly for providers and may not be sustainable in the long term. This is also

⁶³ KFF analysis of Centers for Disease Control and Prevention, National Center for Health Statistics. [National Vital Statistics System, Natality on CDC WONDER Online Database](#). Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

⁶⁴ AAMC, [Comments to CMS on the Medicaid and CHIP Managed Care, Access, Finance, and Quality Proposed Rule](#) (June 2023).

observed in cases where patients may be more complex and require additional visits pre/post-partum or require a higher level of care to ensure patient safety. Ensuring adequate and flexible payment models for the full suite of perinatal services across all healthcare settings where these services are offered is essential for improving maternal health outcomes and maintaining access. When evaluating payment rates related to maternal health care, CMS must also take these services into consideration.

In addition to payment adequacy for perinatal services, the AAMC has previously urged the administration to continue to advance policies that promote universal access to postpartum coverage.⁶⁵ In addition to payment, access to coverage is a critical component to improving outcomes for maternal care. One of the most common complications of pregnancy and childbirth are mental health conditions, which affect 1 in 5 mothers every year in the United States⁶⁶ with less than 15 percent of those receiving treatment.⁶⁷ Suicide and overdose are the leading causes of death in the first year postpartum, of which many of these deaths are preventable. **We appreciate CMS' work in extending postpartum coverage⁶⁸, and urge the agency to continue building on this momentum.** The AAMC believes that behavioral health integration is an effective strategy to improve pregnant and postpartum patients' access to mental health and substance use disorder services and encourages CMS to explore policy options within their authority that incentivize same-day care and ensure the long-term financial viability of behavioral health integration.⁶⁹ Integrated behavioral health (IBH) models involve a multidisciplinary team of medical and behavioral health providers working together to address the medical, behavioral, and social factors that affect a patient's health and well-being. These models, which can be embedded into both primary and specialty care settings, are a proven strategy to reduce the stigma surrounding mental health services and expand access to care, particularly for historically under-resourced patients.

Coverage alone does not guarantee access to care for pregnant patients. Barriers imposed by insurers, including administratively burdensome prior authorization requirements, can reduce patients' access to care and place additional strain on providers due to added costs and labor needs. This is particularly concerning in the context of maternity care, as prior authorization requirements can limit patients' access to time-sensitive diagnostic and treatment procedures, such as genetic testing. **To address this challenge, the AAMC continues to urge CMS to prohibit prior authorization for maternal care during the prenatal and one-year postpartum period.**⁷⁰ To support continuity of care during this critical window, the AAMC also recommends requiring payers to honor prior authorization approvals issued by a previous payer during pregnancy and for one-year postpartum. This policy would ensure that pregnant and

⁶⁵ AAMC, [From Crisis to a Call to Action: The AAMC's Recommendations to Address the Maternal Health Crisis and Advance Birthing Equity](#).

⁶⁶ Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period: A Multivariate Bayesian Meta-Analysis. *J Clin Psychiatry*. 2019 Jul 23;80(4):18r12527. <https://pubmed.ncbi.nlm.nih.gov/31347796/>

⁶⁷ Puspitasari AJ, Heredia D, Weber E, Betcher HK, Coombs BJ, Brodrick EM, Skinner SM, Tomlinson AL, Salik SS, Allen SV, O'Grady JS, Johnson EK, L'amoureux TM, Moore KM. *Perinatal Mood and Anxiety Disorder Management in Multicenter Community Practices: Clinicians' Training, Current Practices and Perceived Strategies to Improve Future Implementation*. *J Prim Care Community Health*.

⁶⁸Centers for Medicare and Medicaid. (2021). Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP) (SHO# 21-007).

⁶⁹ AAMC, [Focusing on Mental and Behavioral Health Care](#) (2022).

⁷⁰ AAMC, [Comments to CMS on the Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule](#) (March 2023)

postpartum patients have continued access to medically necessary care, regardless of whether their source of coverage has changed.

Enhance Maternal Health Workforce Capacity

Lastly, when considering access to care for maternal health services, we would be remiss to not discuss the projected physician shortage. According to AAMC data, the United States faces a projected physician shortage of up to 86,000 doctors by 2036, with demand rapidly outpacing supply.⁵ If all populations enjoyed the same access to care as white, insured patients living in suburban areas, then this shortage would surge to over 200,000 doctors.⁷¹ Health care workforce shortages significantly impact pregnant patients' access to maternity care including access to appropriate preventive, prenatal, and postpartum care, which can lead to worse health outcomes and profound disparities especially for those in rural and underserved areas. **The AAMC supports policies to enhance current workforce capacity and help providers efficiently respond to patients' care needs and urges CMS to collaborate with policymakers to develop policies that support the current workforce as well as advance long-term investments.**

REQUEST FOR INFORMATION ON OBSTETRICAL SERVICE STANDARDS FOR HOSPITALS, CAHS, AND REHS

Medicare CoPs are Not the Right Vehicle to Advance Maternal Health Outcomes

In addition to CMS' maternity care RFI, the agency included a second RFI focused on obstetrical service standards, specifically exploring options for health and safety requirements related to obstetrical services through Medicare CoPs. (P.36499). CMS began collecting feedback on the idea of advancing maternal health through CoPs in the FY 2023 IPPS proposed rule, which the AAMC previously shared comments on.⁷² **While the AAMC agrees that maternal healthcare outcomes are a critical issue facing the United States that must be addressed, the AAMC does not support changes to the CoPs to address this issue.** As stated previously, due to the significant consequences for failure to comply, CoPs are not the right vehicle for advancing these standards. There are alternative policy levers that CMS can utilize, such as its quality reporting and performance programs, to incentivize improvements for maternal health care. The AAMC also encourages CMS to explore policy options that incentivize and bolster providers ability to meet standards rather than penalizing them. Furthermore, as it relates to maternal health care equity, CMS must acknowledge the broader role of the full range of maternal care providers and services (e.g., physicians, certified nurse midwives, mental health providers) who provide prenatal and postpartum maternal care largely outside of the hospital inpatient setting. High quality care throughout pregnancy and following delivery are essential elements to achieving positive outcomes for babies and birthing persons. Hospitals do have a critical role in improving maternal health care equity, especially for labor and delivery outcomes, but cannot be held solely responsible for implementing much needed improvements and solutions. CMS should focus maternal health policy approaches in a way that addresses the full spectrum of perinatal care including care taking place outside of the inpatient setting.

Building on this idea, as outlined above in our response to the maternal care RFI, there is significant concern with the reduction of labor and delivery units in hospitals and the impact this has on access to

⁷¹ Dall, Tim, et al. [The Complexities of Physician Supply and Demand: Projections From 2021 to 2036](#). Association of American Medical Colleges (AAMC), 2024.

⁷² *Supra*, note 36.

care. As of 2019, 1,775 counties in the United States were devoid of hospitals or birthing centers.⁷³ Additional CoPs and requirements for operating would increase the risk for offering obstetrical care services and have the unintended consequence in becoming a factor in a hospital's ability to continue to maintain such services. Providers may already feel uncertain about the care they are able to provide to pregnant patients and additional requirements may exacerbate this. If hospitals feel they are not adequately equipped to meet these standards or that additional investments must be made to do so, providers that are struggling to operate these services due to financial hardship or workforce issues may ultimately make the decision to eliminate these services, to avoid the potential for significant penalization for failing to meet CoP requirements. As a result, requiring additional CoPs for obstetrical services could have the unintended consequence of further reducing the number of hospitals with services available to treat pregnant patients and further exacerbate disparities in care.

While we oppose the addition of standards for obstetric services in the COPs, if CMS decides to establish these additional standards, the agency should do so in a way that allows hospitals to tailor programs to their needs and abilities, especially for obstetric services taking place outside of the labor and delivery unit such as the emergency department (ED). CMS highlighted the existing Joint Commission (TJC) standards as an example of what may be implemented as it relates to standards for training for obstetric services, including education on hospitals' evidence-based severe hypertension/preeclampsia and hemorrhage procedures. (P. 36501). It is our understanding that it is common practice for hospitals to have protocols in place for severe hypertension/preeclampsia and hemorrhage procedures that allow hospitals and staff to be prepared in the event of an emergency. The standards from TJC allow for education around these procedures to be implemented while considering the differences between hospitals and their capabilities without being overly prescriptive. This approach is more feasible for providers to implement rather than applying a one size fits all approach. We urge CMS to consider this approach if the agency feels it must propose additional standards.

Training Requirements Related to Obstetric Services and the Impact of EMTALA

Continuing the idea of TJC standards related to training and education, the agency is seeking feedback on additional training, protocols, or equipment requirements in hospitals related to obstetrical services. Specifically, the agency is considering additional training requirements for hospital staff including non-obstetric, emergency department, and other staff that treat pregnant and postpartum patients. (P.36500). The AAMC supports CMS' effort to ensure proper training and urges the agency to continue to adopt policies that support and ensure the proper credentialing of providers to ensure patient safety. As noted above, this applies beyond traditional maternal health units as other units within the hospital may encounter pregnant patients and need to address patient needs, especially in an emergency. As described in the Emergency Medical Treatment and Labor Act (EMTALA), hospitals are required to offer the treatment necessary to stabilize patients in emergencies. Hospitals must also stabilize patients before transferring. Therefore, it does make sense for hospitals to have procedures and standards in place related to maternal health emergencies; however, as noted earlier in our comments, CoPs are not the appropriate vehicle for these requirements due to the severity of consequences in the event of missing the mark on these standards.

⁷³ U.S. Health Resources and Services Administration (HRSA), Area Resources Files, 2021; American Association of Birth Centers, 2022.

Along these lines, the AAMC is also concerned with barriers to providing training for health care providers as it relates to maternal care as well as access to clinically appropriate protocols needed for emergency maternal care in certain states. Since the United States Supreme Court issued a final decision on the *Dobbs v. Jackson Women's Health Organization*⁷⁴ case and reversed federal abortion protections, the AAMC has observed a noticeable change in residency applications in states that have issued restrictions on women's health care, affecting where physicians plan to practice.⁷⁵ This shift in applications has notably affected not only specialties most likely to treat pregnant patients but also residency applications in other specialties.⁷⁶ In the long term, this shift has the potential to further exacerbate provider shortages in states with restrictive practice environments and negatively impact access to care and maternal health outcomes.

Restrictions on Women's Health Care May Impact Medical Education and Access to Care for Maternal Health

As noted previously, there is concern that state laws that restrict women's health care may negatively impact the ability for health systems and hospitals to adequately provide the education and care needed for these services. As noted above, under EMTALA hospitals receiving Medicare funding must provide treatment necessary to stabilize patients in emergencies. Under EMTALA, on rare occasions, providers may be required to carry out the termination of a pregnancy to stabilize a patient's emergency condition. The question of whether EMTALA preempts state laws that prohibit abortions is pending a final decision from the United States Supreme Court. Specifically, in *Moyle v. United States*⁷⁷, Idaho is being challenged on whether its state law that criminalize providing an abortion, except in a few narrow circumstances, is preempted by EMTALA. Without EMTALA protections, patients may be faced with longer travel, greater barriers to access pregnancy-related care, and increased risk for negative maternal health outcomes especially for historically under-resourced patients.⁷⁸ **The AAMC remains concerned that restrictions on women's health care may impact patients safety and access to care and adequate training for residents in states with restrictive practice environments and urges CMS to work with relevant policymakers and stakeholders on policies that offer protections for training and access to care for all maternal health related services.**

Standards for Inpatient-to-Inpatient Hospital Transfers Related to Obstetric Services

Additionally, within this RFI, CMS is interested in understanding whether a hospital obstetrics CoP should include requirements for transfer protocols related to inpatient-to-inpatient transfers when a patient needs care that exceeds the capability of the hospital, outside of what is required under EMTALA. (P.36500). The AAMC appreciates CMS' interest in better understanding inpatient to inpatient transfers for maternal health care and agrees that standards around patient transfers would be beneficial to patient care; however, these should not be implemented through CoPs which have significant consequences for failure to comply. In an analysis of the 2011 Nationwide Inpatient Sample (NIS), an estimated 18,082 patients were transferred to an acute care hospital for maternal hospitalization with 81 percent of these

⁷⁴ *Dobbs v. Jackson Women's Health Organization*, 597 U.S. ____ (2022)

⁷⁵ Orgera, Kendal, Grover, Atul. [States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants](#). AAMC. 2024.

⁷⁶ *Id.*

⁷⁷ *Moyle v. United States*, No. (23A469), 2024 WL 61828 (U.S. Jan. 5, 2024)

⁷⁸ Kidd, Camille, Goodman, Shaina, Robbins, Katherine Goodman. [State Abortion Bans Threaten Nearly 7 million Black Women, Exacerbate the Existing Black Maternal Mortality Crisis](#). National Partnership for Women & Families. 2024.

transfers occurring prior to childbirth delivery.⁷⁹ These transfers were found to be towards hospitals with higher levels of obstetrical and neonatal care.⁸⁰ Additionally, inpatient-to-inpatient transfers are often more complex and costly to treat.⁸¹ To ensure patient safety, hospitals that are transferring out patients should follow evidence based guidelines and ensure adequate and appropriate staffing related to for patient transfers. As mentioned above, CMS should explore other policy levers outside of CoPs to accomplish the goal of improving service standards while maintaining flexibility for providers and without jeopardizing access to care.

Additionally, transfers often take patients out of their communities and away from their families due to the decrease in access to maternity care due to obstetrical service closures. This trend may also require patients to travel further distances to receive more routine maternal health care, which may place additional strain on birthing persons and their families related to social determinants of health. The AAMC recognizes that in addition to access, non-clinical factors, including access to safe and affordable housing, reliable transportation, nutritious food, and access to childcare, play a vital role in a person's maternal health care. **We encourage CMS to also consider social drivers of maternal and child health inequity when developing policies to improve maternal health outcomes.** The AAMC has also previously supported polices and legislation, such as the Connected Maternal Online Monitoring (MOM) Act⁸², to expand access to highly specialized maternal care services by utilizing innovative strategies such as the use of technology-enabled interprofessional consults ("e-consults") and remote physiological monitoring devices.⁸³ The use of these types of innovation in care allow patients to access specialized care without traveling outside of their community. **The AAMC urges CMS to consider creative policies that increase access to specialized care while keeping patients in their communities to boost health outcomes.**

Training for Providing Respectful Care, Implicit Bias, and Trauma-Informed Care

Within the RFI, CMS also expresses interest in training related to providing respectful care as well as training around implicit bias and trauma-informed care. (p. 36502). We agree with CMS that this training would be beneficial, even outside of the context of maternal care as this type of training could have a positive impact on care for all patients. If a requirement is implemented, the agency should do so in a way that adds maternal health specific information to baseline training on providing respectful care, implicit bias, and trauma-informed care for all patients rather than creating a separate training specific to just maternal health care.

Evaluate and Leverage Existing Data Collection Efforts for Obstetric Services and Maternal Health

Lastly, CMS is interested in understanding if and how it could incorporate data collection requirements into a maternal services CoP related to submitting data focused on maternal morbidity and mortality. The

⁷⁹ Morriss FH Jr. Interhospital Transfers of Maternal Patients: Cohort Analysis of Nationwide Inpatient Sample, 2011. *Am J Perinatol.* 2018 Jan;35(1):65-77. doi: 10.1055/s-0037-1606099. Epub 2017 Aug 14. PMID: 28806847.

⁸⁰ *Id.*

⁸¹ Baker MC, Koopman CJ, Landman JH, et al. Financial and clinical impact of transfer patients at major teaching hospitals [published online ahead of print June 25, 2019]. *Acad Med.* doi:10.1097/ACM.0000000000002855.

⁸² S.712 - 118th Congress (2023-2024): Connected MOM Act, S.712, 118th Cong. (2023), <https://www.congress.gov/bill/118th-congress/senate-bill/712>.

⁸³ *Supra*, note 65.

agency is also exploring data reporting to Maternal Mortality Review Committees (MMRC), focusing on the voluntary nature of reporting by healthcare facilities and collecting information on whether hospitals should be required to directly report to MMCs. (p.36502). MMRCs are committees made up of representatives from public health, medicine, and the community, to comprehensively review available data to identify and categorize pregnancy-related deaths that occur during or within 1 year of the end of pregnancy. These committees also recommend prevention measures and assist stakeholders in understanding and addressing key drivers of maternal deaths and outcomes. However, as noted by the RFI not every state has an MMRC. Further, each states' MMRC functions at various capacities where some states have a broader scope of work than others.⁸⁴ Additionally, MMRCs may receive federal support through programs such as the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program.⁸⁵ However, without congressional action federal support for these programs is set to expire at the end of FY 2024, creating uncertainty in funding for some of these programs.

Given the various functionality and existence of MMRCs between states, it is important to consider that data reporting to MMRCs may not be available for every state. Additionally, any data reporting requirements would be contingent on state readiness, and for those states without existing MMRCs or MMRCs with a narrow scope of work, meeting additional CoP requirements related to submitting data to MMRCs may not be possible. As noted above, the AAMC does not support utilizing CoPs to address this issue. CoPs are not the right vehicle for advancing data reporting initiatives due to the significant consequences for failure to comply.

Finally, the AAMC urges CMS to explore already established data collection efforts around maternal health care and evaluate what is currently being collected at the federal, state, and local levels to limit duplications in reporting and leverage data that is already available to tap into.

Utilizing currently available data rather than creating additional reporting requirements reduces the potential for duplications in data collection efforts. This also applies to quality reporting and patient experience. Rather than creating additional reporting mechanisms for providers, CMS should evaluate whether the information the agency is seeking to obtain is already being collected by providers or other community groups. Coordination in data collection, or at the very least maintaining consistency in the types of data collected and how it is reported to each stakeholder, will allow a reduction in redundancy and burden for providers.

HOSPITAL QUALITY PROPOSALS

IQR PROGRAM

Adoption of New Measures

CMS proposes to adopt seven new measures into the IQR, the pay-for-reporting program that hospitals must meet to receive 25 percent of the annual payment update.

⁸⁴ Guttmacher Institute. [Maternal Mortality Review Committee](#). 2023.

⁸⁵ Centers for Disease Control and Prevention. [Enhancing Reviews and Surveillance to Eliminate Maternal Mortality](#) 2023.

Structural Measures (2): Patient Safety (measure not endorsed) and Age Friendly Hospital (measure not endorsed)

CMS proposes to adopt two new structural measures beginning with CY2025 reporting (impacting FY2027 payment determinations) under the IQR: a Patient Safety measure (p. 36284) and an Age Friendly Hospital measure. (p. 36307) As structural measures, both measures require a hospital to attest yes/no to statement(s) across five measure domains. (pp. 36289-92 for the Patient Safety measure and p. 36309 for the Age Friendly Hospital measure) Neither measure is endorsed by a consensus-based entity.

The AAMC has long held that measures proposed for adoption into CMS quality programs should be endorsed prior to proposal, but understands that importance of measurement may, in some cases, supersede that policy principle. Additionally, the AAMC believes measures should focus on outcomes where possible. In this case, the AAMC agrees with CMS on the importance of measurement and supports adoption of these two measures. **We encourage CMS to work with patients and their families to better understand how they interpret these structural measures and might utilize publicly reported measure performance to make care decisions.** We believe there is potential for misunderstanding of what these measures assess (hospital structures and policies for safety and age friendly care) as compared to patients' and families' reading of publicly reported information as compared to their own experiences. **Additionally, we ask that CMS track measure performance for each measure and examine correlation with improved (or consistently high) performance on related patient safety and experience outcome measures, as well as monitor the measures for topped out measure performance.** CMS should retire the measures if they do not meet patients' and families' expectations for measuring these critical topics, performance does not meaningfully correlate with improved patient outcomes, or performance remains consistently high with little to no variation across hospitals.

NHSN Measures Stratified to Oncology Wards (2): Catheter-Associated Urinary Tract Infections (CAUTIs, #0138 – measure specific to oncology not currently endorsed) and Central Line-Associated Blood Stream Infections (CLABSIs, #0139 - measure specific to oncology not currently endorsed)

CMS proposes to adopt two healthcare-associated infection measures, CAUTI and CLABSI, specific to oncology wards to the IQR beginning with CY2026 reporting (impacting FY2028 payment determinations). Currently, both measures are included in the Hospital-Acquired Condition Reduction Program and the Hospital Value-Based Purchasing Program, though neither measure includes a risk-adjusted standardized infection ratio (SIR) inclusive of inpatient care in oncology wards. CMS believes that stratifying these two measures specific to oncology locations in the IQR would supplement, and not duplicate, measurement in the pay-for-performance programs and would improve patient safety for cancer patients. (p. 36312)

The AAMC supports the inclusion of these measures in the IQR to bolster measurement to improve patient safety. Currently, the measures are not endorsed specific to oncology only measurement. Concerns were raised during the pre-rulemaking measure review process about the potential for low reliability of the measures for some hospitals, as well as the potential for low case volumes for some hospitals to distort measurement.⁸⁶ Additionally, CMS notes that “[a] facility’s SIR is not meant to be compared

⁸⁶ Partnership for Quality Measurement, [Pre-Rulemaking Measure Review Measures Under Consideration 2023 Recommendations Report](#) (February 2024), p. 39.

directly to that of another facility.” (p. 36314 and p. 36317). **The AAMC urges CMS to monitor these measures for their reliability and validity through the measure endorsement process, as well as monitor for any unintended consequences, including misuses of public-reported SIR information to make inappropriate comparisons between facilities.**

Hospital Harm eCQMs (2): Falls with Injury (#4120e) and Postoperative Respiratory Failure (#4130e)

CMS proposes to adopt two Hospital Harm electronic clinical quality measures (eCQMs): Falls with Injury (p. 36317) and Postoperative Respiratory Failure (p. 36320), with optional reporting as part of the Program’s eCQM measure set beginning CY 2026 (impacting FY2028 payment determinations). The AAMC agrees that each measure represents an important measurement area and supports inclusion in the eCQM measure set from which hospitals may opt to report. We note that we have concerns about increased mandatory eCQM reporting, which we discuss elsewhere in these comments.

Thirty-Day Risk-Standardized Death Rate Among Surgical Inpatients With Complications [Failure-To-Rescue] (#4125– conditional endorsement)

CMS proposes to replace the existing CMS PSI-04 measure with the Thirty-Day Risk-Standardized Death Rate Among Surgical Inpatients With Complications, which CMS intends to refer to as the Failure-to-Rescue measure, beginning with the July 1, 2023 – June 30, 2025 reporting period (impacting FY 2027 payment determinations). (p. 36322) It measures death after a hospital-acquired complication for Medicare patients admitted for certain procedures in the General Surgery, Orthopedic, or Cardiovascular MS-DRGs (unlike CMS PSI-04, which includes very high-risk and very low-risk surgeries). The measure excludes patients whose relevant complication preceded their first inpatient operating room procedure (in recognition that in such cases the “rescue” might be the operation) and includes deaths 30 days following the date of the patient’s first operating room procedure, regardless of site of death.

The AAMC appreciates CMS’ efforts to address concerns with the CMS PSI-04 measure, including by limiting the scope of inpatient operations by recognizing complications preceding a procedure.

While we do not oppose the measure’s adoption in the IQR, we have a couple suggestions to improve the measure. First, we are concerned that the abbreviated name of the measure, Failure-to-Rescue, might not appropriately describe the underlying measure’s focus. We understand that medical literature can refer to adverse occurrences and death after surgery as “failure to rescue.” However, colloquially the name might evoke an image of wanton disregard for human suffering, and illicit feelings of distrust or avoidance of any hospital with a non-zero performance rate. Publicly reported quality performance should be communicated clearly and help build trust between patients and providers – and not inadvertently weaken it. We ask CMS to work with patients and communities to determine whether the measure’s name appropriately meets patients’ understanding of the measure’s underlying assessment of hospital care and how patients might use the measure to make determinations about where to seek inpatient surgical care. CMS should rename the measure if it finds the name does not adequately correlate to patients’ understanding of the measure.

Second, the AAMC agrees there is great need to better measure quality of care received by Medicare patients covered by MA plans, but we are concerned with potential data challenges to reliably do so. As noted in our recent comments in response to the agency’s RFI on MA Data, MedPAC has consistently noted challenges with the completeness and accuracy of MA encounter data, and that this frustrates

quality measurement.⁸⁷ We recommend that CMS consider policies to ensure that MA plans provide complete encounter data to the agency that can be relied on for quality measurement.

Measure Refinements

CMS proposes to refine two existing measures in the IQR.

Updates to HCAHPS Survey Measure Beginning with FY 2027

CMS proposes several changes to the HCAHPS Survey, including the introduction of three new sub-measures (Care Coordination, Restfulness of Hospital Environment, and Information about Symptoms), the removal of the Care Transition sub-measure, and the modification of the Responsiveness of Hospital Staff sub-measure, beginning with January 2025 inpatient discharges. (p. 36298) CMS also proposes changes to the “About You” section of HCAHPS, used in the patient case-mix adjustment, replacing the existing ‘Emergency Room Admission’ question with a new, ‘Hospital Stay Planned in Advance’ question, limiting responses to the question regarding “Language Spoken at Home,” as well as alphabetizing responses to race and ethnicity questions (p. 36300). CMS believes these changes will more appropriately capture hospital quality and patient-centered care, as well as create a fair comparison across providers. (p. 36299-36300)

The AAMC supports CMS’ decision to include new sub-measure categories for Care Coordination and Information about Symptoms, as these sub-measures account for staff coordination and patient or family/caregiver education. These aspects are shown to improve patient outcomes and should, therefore, be monitored and encouraged.^{88, 89} The AAMC also supports the removal of the Care Transition sub-measure in favor of the newly developed Care Coordination sub-measure, as it encompasses a broader range of questions on the same topic, again monitoring and supporting care coordination.

The AAMC recommends a more limited approach to the addition of the Restfulness of Hospital Environment sub-measure by instead including only one question on the topic of the hospital environment being conducive to restfulness. There are concerns that including repetitive questions may decrease survey completion. Recent CMS data has established that at best, only approximately 12% of eligible Medicare beneficiaries complete HCAHPS annually following an inpatient stay.^{90, 91} Additionally, studies demonstrate that response rates are lower for underserved patient populations and are often lower for longer surveys.^{92, 93} Adding repetitive questions to HCAHPS can limit the response rate and, given the low response rate already seen for underserved patients, this could further limit the

⁸⁷ AAMC, [Comments to CMS re: Medicare Program; Request for Information on Medicare Advantage Data](#), at 6-7 (May 2024).

⁸⁸ Agency for Healthcare Research and Quality, [Care Coordination](#).

⁸⁹ A. Johnson, A., et. al., [A Systematic Review of the Effectiveness of Patient Education through Patient Portals](#). *Journal of the American Medical Informatics Association*, 6 (1), (2023).

⁹⁰ See CMS, [Medicare Beneficiaries at a Glance](#), (2023), showing that there are 63.9M Medicare beneficiaries, with 213 inpatient hospital stays per 1,000 enrollees, which in turn would equate to roughly 16.2M Medicare beneficiaries with an inpatient hospital stay last year.

⁹¹ See, CMS, [Hospital CAHPS \(HCAHPS\)](#), (2024), stating that “nearly two million patients complete the survey each year.” If all patients who complete the survey are enrolled in Medicare, then, at maximum, roughly 12 percent of eligible Medicare beneficiaries complete the survey.

⁹² M. Elliot, et al., [Survey Protocols, Response Rates, and Representation of Underserved Patients A Randomized Clinical Trial](#), *The Journal of the American Medical Association*; 5 (1), (2024).

⁹³ B. Holtom, et al., [Survey Response Rates: Trends and a Validity Assessment Framework](#), *Human Relations*; 75 (8) (2022).

voice of these patient populations. Therefore, we urge CMS to limit the addition of new questions to those that provide meaningful and actionable data, and remove duplicate questions when appropriate.

Lastly, **the AAMC supports CMS' decision to incorporate 'Hospital Stay Planned in Advance,' as it more appropriately captures a patient's reason for hospital admission.** We also support CMS' decision to alphabetize responses for race and ethnicity questions. The AAMC, however, has concerns about limiting the available languages for the survey. While, overall, three languages (English, Spanish, and Chinese) account for 98.2% of respondents, there are regions of the country that have a higher prevalence of different languages, which may not be apparent in the overall data. According to 2019 census data, the United States also has high rates of Tagalog, Vietnamese, and Arabic speakers.⁹⁴ CMS should consider regional variances and offer additional languages.

Updates to Global Malnutrition Composite eCQM

CMS proposes to update the optional Global Malnutrition Composite eCQM by expanding the patient population from patients 65 and older to include all adults 18 or older, beginning with the 2026 reporting period. (p. 36327) **The AAMC supports the inclusion of beneficiaries 18 and older, as this expands the identification of malnutrition for patients seeking care.** This expansion could improve nutritional services for a wider range of patients.

Measure Removals

CMS proposes to remove the Death Among Surgical Inpatients With Serious Treatable Complications (CMS PSI-04) measure effective with FY 2027 payment determinations, with proposed removal contingent upon the adoption of the Failure-to-Rescue measure. (p. 36324) Additionally, CMS proposes to remove four hospital-level, risk-standardized 30-day episode-payment measures: acute myocardial infarction, heart failure, pneumonia, and total hip arthroplasty / total knee arthroplasty effective with FY 2026 payment determinations on the basis that another measure, the Hospital Medicare Spending per Beneficiary, is more broadly applicable. (p. 36326). **The AAMC supports these measure removal proposals.**

IQR Reporting Requirements

Increasing Mandatory eCQM Reporting Requirements

CMS proposes to increase the number of mandatory eCQMs hospitals report under the IQR, as part of the agency's re-commitment to better safety practices. Specifically, CMS would require hospitals to report the following five Hospital Harm eCQMs over two years: Severe Hypoglycemia, Severe Hyperglycemia, Opioid-Related Adverse Events, Pressure Injury, and Acute Kidney Injury. The first three would be required beginning with CY 2026 reporting (impacting FY 2028 payment), and the latter two would be required the following year with CY 2027 reporting (impacting FY 2029 payment). (p.36337) **The AAMC supports CMS' commitment to better safety practices for both patients and healthcare workers to save lives from preventable harm.**

CMS notes that in addition to supporting Patient Safety and Resiliency, these measures align with the agency's "Interoperability" goal within the National Quality Strategy and the agency's progression to using all digital quality measures (dQMs). **The AAMC strongly supports efforts to use standard, interoperable data for quality measurement to improve accuracy and reduce burden for reporting.**

⁹⁴ US Census Bureau, [Nearly 68 Million People Spoke a Language Other Than English at Home in 2019](#).

However, we ask CMS to provide greater clarity on its vision for digital quality measurement and where eCQM reporting fits within that vision. In prior rulemaking, CMS stated “[while] eCQMs meet the definition of dQMs in many respects, limitations in data standards, requirements, and technology have limited their interoperability.”⁹⁵ And that “[m]apping EHR data can be challenging and burdensome for providers as there is often novel data collection occurring to support quality measurement.”⁹⁶ Additionally, at CMS’ Annual Quality Conference this Spring, Dr. Brian Anderson, the co-founder and CEO of the Coalition for Health AI, noted in his keynote plenary remarks about artificial intelligence that he believed eCQMs would be obsolete in a few years.⁹⁷ The AAMC is concerned that increasing mandatory eCQM reporting may not be aligned with long-term goals for digital quality measurement, and thus the short-term burden to ramp up eCQM reporting capabilities might outweigh the benefits of reporting for CMS’ safety and interoperability goals.

AAMC Urges CMS to Delay Mandatory Hybrid EHR Measure Reporting in Recognition of Known Challenges with Matching Data Across Sources

Currently, there are two hybrid measures in the IQR that are currently under voluntary reporting, but that will soon become mandatory.⁹⁸ These measures are hybrid because they use data from multiple sources and must use linking variables to connect those sources for accurate reporting and measurement. For these measures, hospitals must link clinical data from the EHR (using quality reporting data logic used for eCQM reporting) to claims data. Claims billing coding logic is separate and distinct from quality reporting data logic, and these inconsistencies make it challenging for hospitals to successfully report these measures without practice and technical support. In addition, hospitals unfortunately experienced delays in actionable technical support from the agency during the voluntary reporting periods. The agency was delayed in issuing correct hospital-specific reporting feedback for the first voluntary reporting period, resulting in hospitals not receiving correct feedback, showing the challenges with patient matching across the EHR and claims data, for the first voluntary reporting period until *after* the second voluntary reporting period was due.⁹⁹ Hospitals are concerned that, due to the unforeseen challenges with patient matching coupled with delayed reporting and assistance, they will not be able to successfully report the first mandatory reporting period in Fall 2024. Failure to meet reporting requirements would result in a loss of 25 percent of the annual payment update in FY 2026. **The AAMC strongly urges CMS to consider delaying the mandatory reporting period for at least one additional year for these measures to ensure that hospitals, fully engaged with trying to successfully report these measures, are not penalized for challenges outside their control.**

Advancing Patient Safety and Outcomes Across Hospital Quality Programs – Request for Comment

CMS requests feedback from stakeholders on how pay-for-performance programs “could further encourage hospitals to improve discharge processes” by including measures reflective of post discharge

⁹⁵ 87 FR 28108, at 28487 (May 10, 2022).

⁹⁶ *Id.*

⁹⁷ Keynote Presentation Entitled “AI In Quality Measurements: Opportunities and Challenges in Health AI for a Resilient Health System,” CMS Quality Conference 2024 (April 8, 2024).

⁹⁸ The Hybrid Hospital-Wide All-Cause Readmissions and Mortality Measures will be required in the IQR beginning with the reporting period July 1, 2023 – June 30, 2024, with reporting due at the end of October 2024.

⁹⁹ Hospitals who voluntarily reported the measure in October 2022 received incorrect hospital-specific reports (HSRs) in June 2023. The CMS support contractor did not respond to July 2023 requests for technical assistance and corrected HSRs until November 2023 – acknowledging that there was an issue with the June 2023 HSRs and that corrected HSRs would be issued.

observation stays and visits to the ED. (p. 36306) **The AAMC is supportive of efforts to improve discharge processes, including using quality measurement. However, we urge CMS to ensure that any potential measures for use in the hospital pay-for-performance programs meet statutory requirements for these programs.** CMS notes four specific measures currently in pay-for-reporting programs in the RFI – the three Excess Days in Acute Care (EDAC) measures and the Hospital Visits Following Outpatient Surgery measure– that would not meet the requirements for the Hospital Readmissions Reduction Program (HRRP), the Value-Based Purchasing Program (VBP), or the Hospital-Acquired Condition Reduction Program (HACRP) as the measures are inclusive of follow-up admissions, observation stays, and ED visits. Specifically, CMS may *only* measure readmissions in the HRRP, which are defined in statute as “the case of an individual who is discharged from an applicable hospital, *the admission* of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge.”¹⁰⁰ [emphasis added] For the VBP, Congress excluded the use of readmission measures in the Program.¹⁰¹ And the HACRP is limited to measuring care during the inpatient stay, not care post discharge. To this end, we believe that the measures are appropriately included in the IQR and Outpatient Quality Reporting (OQR) Programs, where Congress has not set similar limits on their inclusion.

Additionally, we seek greater clarity from CMS on its broader vision for its hospital quality programs, as it appears the agency has conflicting views on the incentives for hospital improvement. Regarding the proposal to adopt the Patient Safety structural measure in the IQR, a pay-for-reporting program, CMS notes the various safety outcomes measures included in the VBP and HACRP, but notes, “[w]hile these metrics are important, they are not sufficient by themselves to measure and incentivize investment in a resilient safety culture or the infrastructure necessary for sustainable high performance within the broad and complex domain of patient safety.” (p. 36285) But then in this RFI, the agency states “[s]ince both the Hospital IQR and Hospital OQR Programs are quality reporting programs, a hospital’s performance on these measures is not tied to payment incentives,” yet also that public reporting of performance on these measures “encourages providers to engage in quality improvement activities to reduce unplanned follow-up visits.” (p. 36306) This appears to ignore that the complement of measures in pay-for-performance programs,¹⁰² coupled with the pursuit of mandatory episodic payment models for hospitals by the Innovation Center (p. 36381), are indeed significant direct payment incentives for hospitals to improve discharge processes. We ask CMS to clarify its broad vision for the hospital quality programs and the values that support maintaining robust pay-for-reporting programs.

VALUE-BASED PURCHASING (VBP) PROGRAM

Adoption of Modified HCAHPS Measure with a Transitional Scoring Period for the Person and Community Engagement Domain

CMS proposes to modify the scoring methodology in the VBP to accommodate the addition, removal, and modification of new HCAHPS sub-measures in the IQR for a three-year transition period FY 2027 – FY 2029. (p. 36300) This scoring methodology will only assess hospitals on the six unchanged domains until

¹⁰⁰ Section 1886(q)(5)(E) of the Social Security Act.

¹⁰¹ Section 1886(o)(2) of the Social Security Act states “The Secretary shall select measures *other than measures of readmissions*, for purposes of the Program.” [emphasis added].

¹⁰² VBP includes a cost measure that is inclusive of the costs associated with unplanned follow-up visits, as well as the inclusion of discharge related experience of care measures with the HCAHPS survey, which together control roughly 30-35 percent of a hospital’s total performance score in the program, and the measures in HRRP potentially reducing a hospital’s payments by up to 3 percent for poor performance.

a proposed new scoring methodology goes into effect in FY 2030 for the modified HCAHPS survey. (p. 36301) **The AAMC supports CMS’ proposal to only assess hospitals on the six original domains for a transition period as hospitals gain experience with the modified survey.** We appreciate CMS’ efforts to devise a policy solution that minimizes inconvenience to patients and providers by not requiring multiple versions of HCAHPS to be completed simultaneously.

PROMOTING INTEROPERABILITY (PI) PROGRAM

Increasing the Scoring Threshold for “Meaningful Use”

CMS proposes to change the scoring methodology beginning with CY 2025 EHR reporting to begin to require hospitals meet a minimum scoring threshold of 80 points for the scored objectives and measures of meaningful use. (p. 36369) CMS notes that in reviewing CY 2022 EHR reporting data, 99 percent of eligible hospitals met the existing 60-point threshold and 83 percent exceed the proposed 80-point threshold, suggesting that hospitals can successfully meet an increased scoring threshold. (p. 36369) **While the AAMC agrees that such performance would suggest likelihood of success for hospitals, we ask CMS to delay the proposal for one year as stakeholders cannot independently analyze the PI Program performance data CMS references.** CMS does not currently public report PI Program scores but will begin to do so for the CY 2023 EHR reporting period later this year.¹⁰³ The AAMC believes that stakeholders should have the ability to assess publicly reported data on the PI Program before the agency increases minimum scoring standards for hospitals.

RFI: Public Health Reporting and Data Exchange

CMS is seeking information on the Public Health and Clinical Data Exchange objective and ways to expand reporting. (p. 36377) **The AAMC supports CMS’ movement towards using the meaningful use program to support interoperable data exchange. However, we urge CMS to instead consider other policy options to support the expansion and interoperability of the public health agency (PHA) reporting systems, due to potential unintended consequences from increased public health reporting requirements.** CMS should focus on how it might partner with other federal agencies to expand PHAs’ capacity and infrastructure, as state- and local-level PHAs have varying degrees of investment. AAMC member hospitals have experienced difficulties in meeting the engagement metrics, due to limitations in their PHA partners’ reporting infrastructure to receive interoperable data. Tying additional public health reporting metrics to the annual payment update will unfairly penalize hospitals who have difficulty reporting due to PHA’s that do not have the adequate infrastructure in place for reporting. Additionally, increasing reporting thresholds will disproportionately affect safety net providers, rural hospitals, and other providers that have lower resources and staff, and further reduce the very resources needed to support both patient care and interoperable health IT solutions.

Additionally, the AAMC is concerned about balancing patient trust with increased public health reporting. Public trust is foundational to health information sharing.¹⁰⁴ Given the increased polarization (and potential criminalization) of certain health care services, particularly those related to sexual and reproductive health, many patients may not feel comfortable with the reporting of their health information and delay or even avoid obtaining much needed care. CMS should partner with the CDC and other federal

¹⁰³ 87 FR 48780, at 49347 (August 10, 2022).

¹⁰⁴ JE Platt, et al., [Public Trust in Health Information Sharing: A Measure of System Trust](#), Health Serv. Res. (April 2018).

partners to best devise data reporting policies that that build trust,¹⁰⁵ and do not put providers in the untenable position of meeting metrics tied to critical Medicare payments or maintaining the trust of their patients and communities.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

ELIGIBLE PARTICIPANTS

The AAMC understands that mandatory models are necessary to ensure CMS meets their goal of 100% of Medicare beneficiaries in accountable care relationships. Choosing to focus these initial mandatory programs on hospital-based episodes of care allows for a clearer delineation of accountability for providers. CMS should consider additional ways to include hospitals in TEAM on a voluntary basis.

Providers in States Participating in the AHEAD Model Should Not be Excluded from Participation in TEAM

Hospitals who are participating in AHEAD should not be required to participate but should be allowed to participate on a voluntary basis. The AAMC supports sharing TEAM-style summary episode data with AHEAD hospitals to encourage the integration of episodes of care into hospital global budgets. Hospitals who are in AHEAD states but decline to join should be part of the mandatory cohort in TEAM.

Physician Group Practices (PGPs) Should be Excluded from Participation in TEAM

CMS proposes to exclude PGPs from participation in the model. The AAMC agrees with the agency's rationale. Hospitals are better equipped to achieve integration with specialty groups by establishing a provider relations support team, leveraging available data on quality and cost, offering tools to improve communication between primary and specialty care, and in some cases, establishing gainsharing and other financial arrangements with specialists based on individual performance. PGPs also run the risk of having insufficient episode volume to reduce variability and create efficiencies in care redesign.

Additionally, constraining participation to one provider type eliminates the need for rules regarding precedence. The complex precedence rules in Bundled Payments for Care Improvement (BPCI) Classic made it more difficult to accurately forecast performance and created a sense of competition between institutions and physicians rather than fostering the kind of collaboration needed to provide coordinated care. In TEAM, the available financial arrangements can be used to facilitate collaboration between provider types across the care continuum.

Allow Acute Care Hospitals (ACHs) Outside the Participating CBSAs to Voluntarily Join TEAM

Allowing voluntary participation in Track 3 would encourage more ACHs to continue investing in value-based care programs and episodic payment models. It would further allow them to sustain quality improvement efforts longitudinally. It would also allow for meaningful evaluation comparing those in mandatory CBSAs with both voluntary participants and non-participants.

¹⁰⁵ F. Gille, et al., [Evidence-based guiding principles to build public trust in personal data use in health systems](#), Digit Health (Jan-Dec 2022).

Raise the Volume Threshold for Eligible Hospitals to No Fewer Than 30 Episodes per Episode Type in the Baseline Period

Using a higher number of episodes as a volume threshold helps reduce variability and ensures that programmatic performance is a better reflection of each hospital's efforts to improve care for their patients. The current low-volume threshold requiring at least 31 episodes across the 3-year baseline period for all included surgical procedures in total to require participation will force many providers into a position where they will not be able to control for the financial risks associated with random variation.

Other models such as the Comprehensive Care for Joint Replacement (CJR) and BPCI Advanced, have had low-volume thresholds of 10 episodes per year specific to the clinical episode category. Using historic models as precedence, CMS should adjust the low-volume threshold for TEAM to be at least 30 episodes per clinical episode category across the 3-year baseline period.

A combined minimum threshold also creates the possibility of a hospital having 25 of one type of procedure and extremely low volume in other episode types. The AAMC believes this introduces unnecessary and unreasonable risk for hospitals. CMS could make hospitals accountable only for those episodes that reach the 31-episode threshold in the baseline to ensure that hospitals are able to create efficiencies and reduce variability for those episodes at risk.

RISK ARRANGEMENTS

The risk arrangements proposed in TEAM do not create sufficient guardrails for safety net and other providers new to episodic payment and value-based care. The AAMC believes that one year is inadequate to allow for these providers to establish the infrastructure necessary to create systematic care redesign efficiencies.

Risk Arrangements Need Additional Guardrails for Safety Net Hospitals

Safety net hospitals have not been part of many of the Innovation Center's episode-based models. The AAMC is concerned that these providers do not have the established infrastructure for episodic models and lack the financial resources to build the infrastructure necessary to provide coordinated care under the program. Additional guardrails could include lower stop-loss thresholds or lower quality adjustment to ensure a better glide path to success in episodic care.

As an alternative to additional guardrails for safety net providers, CMS should allow safety net providers to remain in Track 1 for the duration of the model or create meaningful readiness metrics that would allow these providers to better understand their performance and give them adequate time for internal process improvement projects before being held accountable for these episodes of care.

Allow Track Choice for Participants in Year 1

Allowing all participants to join Track 1 for the first performance year creates opportunities to invest in quality improvement and infrastructure investments. These opportunities are especially important for less-experienced providers to create systematic care redesign efficiencies across episodes.

CLINICAL EPISODE SPECIFICATIONS

The AAMC believes that 30-day episodes limit financial opportunity and do not adequately incentivize coordinated care. If CMS expands the episodes in TEAM, those episodes should be previously tested in voluntary models and acute in nature.

The AAMC Supports the Selection of Individual Acute Surgical Episodes for TEAM

Individual acute clinical episodes are more easily understood and addressed by specialists and provider organizations. For example, providers report that it is helpful when episodes are easily identifiable on discharge, (e.g., a knee replacement).

Specifications for the Coronary Artery Bypass Graft (CABG) Episode Should Focus on Care Improvement for a Homogenous Patient Population

The AAMC agrees with excluding cases that involve percutaneous coronary interventions (PCI). Despite relatively low volume, episodes involving PCI create a high number of utilization outliers. Including such episodes also introduces additional specialists to the episode, complicating attribution, decision-making, and follow up. It is likewise appropriate to exclude episodes with acute myocardial infarction from reconciliation to ensure that the remaining CABG episodes are homogenous and more readily analyzed. This homogeneity ensures the impact of the model on cost is clear.

Seek Public Input on Future Acute Clinical Episodes to Include in the Model

Episodes based on acute issues are more akin to the proposed procedure-based conditions in TEAM. CMS should seek input on specific acute episodes to include in any future updates to the model to ensure they prioritize episodes that are acute, either surgical or acute medical. CMS should not include episodes that are chronic medical episodes, such as COPD or renal failure. These episodes require ongoing management over time. Therefore, chronic medical conditions are more appropriately cared for by Accountable Care Organizations (ACOs) and other population-based models, rather than within an episodic model, especially one which lasts only 30 days. The AAMC supports the inclusion of future acute clinical episodes in TEAM.

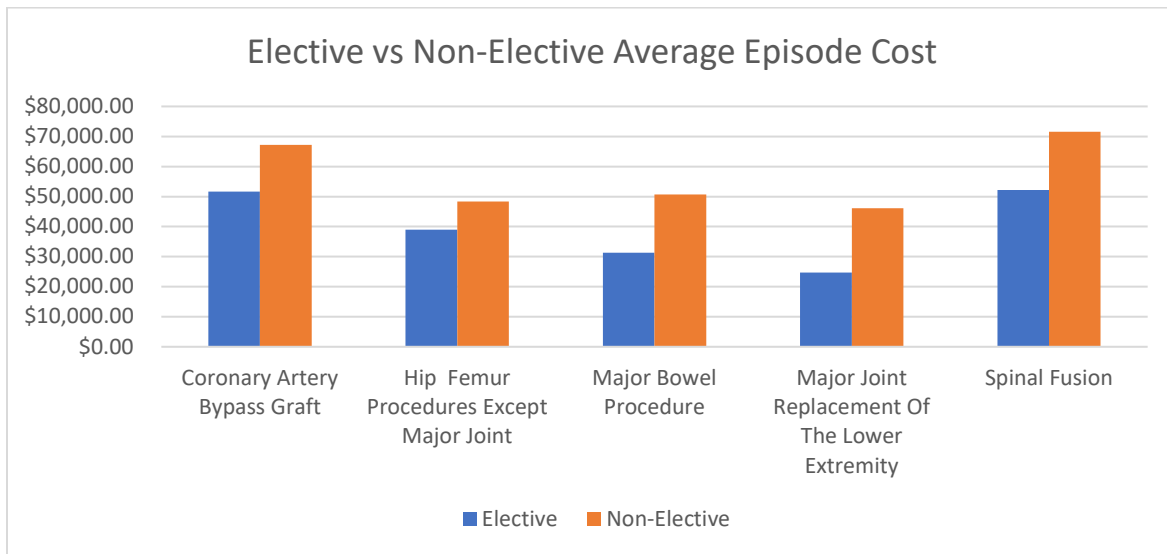
Do Not Test New Clinical Episode Categories in TEAM

As TEAM is a mandatory model, CMS should focus on episodes that already have a proven track record in voluntary models, like how CJR was able to build on BPCI Classic's success in joint replacement episodes. If new clinical episodes are to be tested in future iterations of TEAM, they should have an initial test period without downside risk to the participant until data is gathered to define the best approaches to establish value. The AAMC strongly opposes testing new clinical episodes in this mandatory model.

Stratify Episodes by Elective vs Non-elective Procedures

In analysis of the DRGs included in TEAM, the AAMC has found a significant difference in the average episode costs of elective vs non-elective procedures, demonstrated in Figure 2. Based on data from BPCI Classic and CJR, CMS identified fractures as an important factor in episode cost in Lower Extremity Joint Replacement (LEJR). The AAMC has found a similarly significant difference between elective and non-elective procedures. For our members who are referral centers, this presents the potential for regional targets that are artificially low for their patient population. Stratifying by elective status creates targets that are more equitable across hospital types.

Figure 2: Elective vs Non-Elective Average Episode Cost



Source: DataGen analysis of data from the CMS Standard analytic file, 2020 Q1-2022 Q3. 2024.

QUALITY MEASURES

The AAMC recommends that CMS include additional quality measures to create alignment across programs and allow for system-wide improvement efforts to better support high quality, person-centered care. Registry-based metrics are especially useful for engaging specialists and aligning value-based care programs across payers.

The CMS PSI 90 is an Inadequate Reflection of the Quality of Care in the Proposed Episodes

While the AAMC believes patient safety is a critical target for improvement, the component measures in the PSI 90 apply broadly to the hospital and not to the providers who are accountable for the care in TEAM episodes. Those teams will have limited opportunities to improve performance on these metrics as they are hospital wide.

Include Advance Care Plan (CBE #0326) in the Quality Strategy for TEAM

This metric creates opportunities for important conversations about goals of care across the care continuum. As it has been included in several CMS programs, it allows for alignment across the hospital and with primary care. When preparing for surgery, such conversations are a natural and necessary part of high-quality coordinated care.

Additionally, advance care planning (ACP) has implications for savings beyond the 30 days of these episodes. A study of ACOs found that patients in the ACP intervention group saved an overall adjusted average of \$10,433 per patient.¹⁰⁶ There was also a noted increase in health care power of attorney and Physician Orders for Life Sustaining Treatment (POLST) documentation in the intervention group.

¹⁰⁶ Bond WF, Kim M, Franciskovich CM, et al. [Advance Care Planning in an Accountable Care Organization Is Associated with Increased Advanced Directive Documentation and Decreased Costs](#). *Journal of Palliative Medicine*. 2018;21(4):489-502.

Implement a Consistent, Tested Set of Quality Metrics for the Duration of the Model

The AAMC strongly recommends against using untested quality metrics in this mandatory model. We also recommend keeping a consistent set of quality metrics for the purposes of evaluating the program and supporting continuity within the model.

Measure Performance Should not be Based solely on Survey Response Rates

The AAMC strongly supports the inclusion of more patient-centered metrics, including patient reported outcomes. However, we wish to advise against setting unrealistic expectations around longitudinal survey response, especially when those responses happen outside the episode window.

Set a Threshold for Reporting the THA/TKA PRO-PM for LEJR Episodes

The AAMC supports the inclusion of Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient Reported Outcome-Based Performance Measure (PRO-PM) for the LEJR episode but recommends the threshold for successful reporting be no greater than 50%, consistent with other implementations of this survey. Special consideration should be given to safety net hospitals to ensure they are able to successfully report this metric.

Utilize Registry-based Measures Where Possible in TEAM

The AAMC supports the use of registry-based measures as they create the opportunity for multi-payer alignment within value-based care programs. The most effective ways to create this alignment centers on quality measures. The clinical service lines for many TEAM episodes already participate in several registries that are currently used as measures in the BPCI Advanced Alternate Measure Sets. AAMC members have shared that the use of registry-based quality measures increased their specialists' engagement in the model.

Registries offer the opportunity to identify the exact causes of risk and address those risks more quickly. Registries can aid in model evaluation by giving more dimensions of care that are consistent across providers for the evaluators to analyze, along with demographic and patient reported outcome information. Finally, registries are national, clinically vetted, audited, and drive evidence-based practice.

For the CABG episode, the AAMC recommends using the Society of Thoracic Surgeons (STS) CABG Composite Score (CBE #0696) as this is a validated and well-researched metric that reflects many dimensions of care quality. The AAMC recommends using the Patient-Centered Surgical Risk Assessment and Communication (QPP #358) across all the TEAM episodes. This measure is currently used in BPCI Advanced for Spinal Fusion, SHFFT, and LEJR episodes. This measure is included in the American Academy of Orthopaedic Surgeons Registry, the STS registry and the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) Registry.

Surgical registries are designed with quality improvement and patient safety in mind. For example, the ACS NSQIP Registry is designed to improve hospital-wide quality across all surgical departments and helps surgical and quality teams make informed decisions about the improvement of quality of care while reducing complications and costs. CMS includes this registry in several MIPS specialty measure sets, allowing for hospital-wide quality improvement alignment across programs. According to data from the AAMC¹⁰⁷ and ACS¹⁰⁸, over 91% of general surgeons participate in the registry, making it an excellent

¹⁰⁷ [Active Physicians With a U.S. Doctor of Medicine \(U.S. MD\) Degree by Specialty](#), 2019. AAMC.

¹⁰⁸ [ACS NSQIP](#), ACS.

source for a well-tested, registry-based measure for Major Bowel and potential future related episodes. Over the first decade of its existence, this registry program has demonstrated positive effects on colorectal surgical outcomes.¹⁰⁹

PAYMENT METHODOLOGY

To establish the benchmark price, CMS proposes using three years of baseline data trended forward prospectively to the performance year. Targets will be based on a 100% regional benchmark rather than hospital-specific or a blend of regional and hospital-specific benchmarks. CMS will use the average standardized spending for each episode type in each region. Episode spending will be capped at the 99th percentile for each of the 24 proposed MS-DRG/HCPCS episode types and across nine regions.

Provide Detailed Methodology for how CMS Will Determine Benchmarks and Target Prices

The AAMC supports CMS' decision to set target prices prospectively as this approach will allow participants to better plan clinical transformation efforts and improve their performance. However, many additional details are necessary for participants to adequately plan and prepare for the model such as identifying clinical areas of risk and opportunity. For example, CMS has provided the average episode cost for the included episodes, but there are no details provided on how CMS will calculate the regional target pricing beyond the use of the nine census regions. Due to the size of the proposed census regions, the regions will contain extremely large differences in care patterns, payments, and other uncontrollable costs (i.e., wage indices). Some providers will be disadvantaged while others are advantaged by the regional target prices. The exact impact of the regional target prices for providers will be unclear until the detailed payment methodology is shared.

Calculate Historical Benchmarks or Regional Target Prices for Safety Net Hospitals

As shown by the literature cited in the proposed rule, research shows safety net hospitals in the CJR model were disproportionately disadvantaged by the 100% regional benchmark. Hospitals with limited experience in value-based payment models and those that care for more complex patients will not be able to compete against their peers in their region.

Use this Model as an Opportunity to Test an Administrative Trend

The AAMC appreciates CMS' steps in the proposed rule to develop benchmark and target price methodologies that address ratcheting effects and establish more predictable targets for providers. However, the proposed approach will continue to make it more difficult for providers to achieve significant improvements in efficiency and savings in the future. This is especially true for episodes like LEJR as many providers over the past decade have focused on reducing the cost of LEJR episodes. We recommend CMS test administratively set benchmarks as part of the TEAM payment methodology to address the problematic ratchet effect. Administratively set benchmarks avoid the ratchet effect as it is not directly linked to ongoing observed fee-for-service spending. CMS could set the benchmark to allow for spending to rise at a slower rate over time than projected FFS levels. This would not only allow for

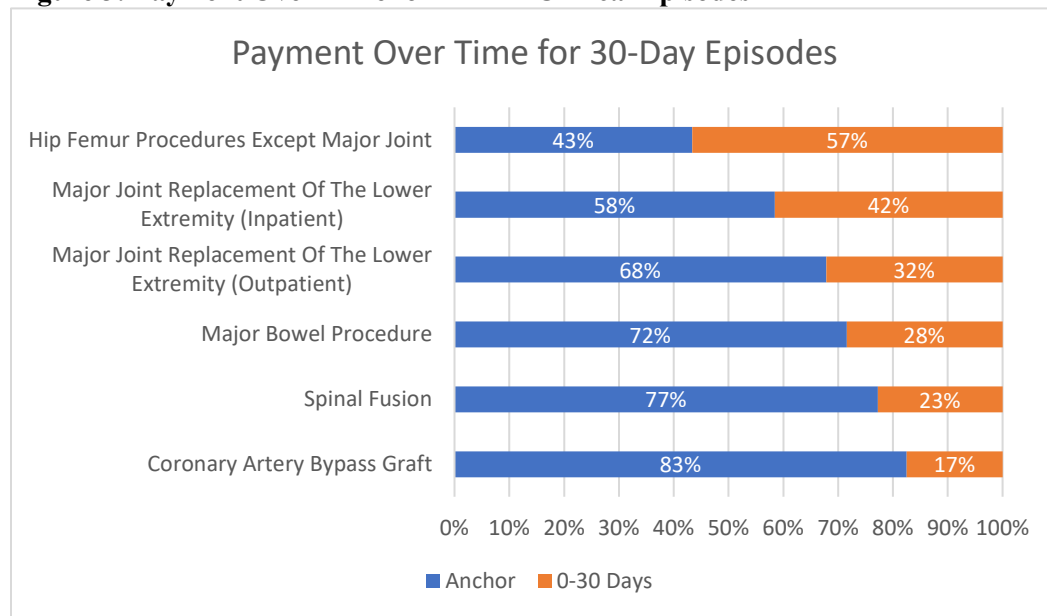
¹⁰⁹ Al-Mazrou AM, Haiqing Z, Guanying Y, Kiran RP. [Sustained positive impact of ACS-NSQIP program on outcomes after colorectal surgery over the last decade](#). The American Journal of Surgery. 219(1):197-205 (2022).

efficient providers to achieve savings but could support safety net hospitals and other providers new to episode-based payment models to be successful.¹¹⁰

Reduce the Discount Factor

CMS proposes to apply a 3% discount factor to the benchmark price to serve as Medicare’s portion of reduced expenditures from the episode. While this discount is the same as the one in the CJR model and for surgical episode target prices in the BPCI Advanced model, these models were based on 90-day episodes. When looking at the total Medicare spend for 30-day episodes in Figure 3, we can see that the anchor stay DRG/HCPCS is a large portion of the total spending for many of the proposed episodes. Due to the limited amount of post-acute care costs for many surgical episodes, a CMS discount of 3% translates to an extensive post-acute care cost reduction. Figure 4 demonstrates the amount of spending reduction in post-acute care required with the 3% target discount. For CABG, the index admission represented 83% of the total cost of care under a 30-day episode. The 3% discount factor would require up to a 17% reduction in post-anchor spending for a 30-day episode. In other words, a provider would need to reduce Medicare episode spend within the post-anchor period by up to 17% to break even. In comparison, when a 3% discount factor is applied to 90-day episodes of care, the percentage of post-anchor spending that needs to be reduced to break even is 1-3% lower for the same clinical episodes. The AAMC proposes CMS apply a discount factor of 1.5% to generate a more reasonable target price for providers to reach their goal.

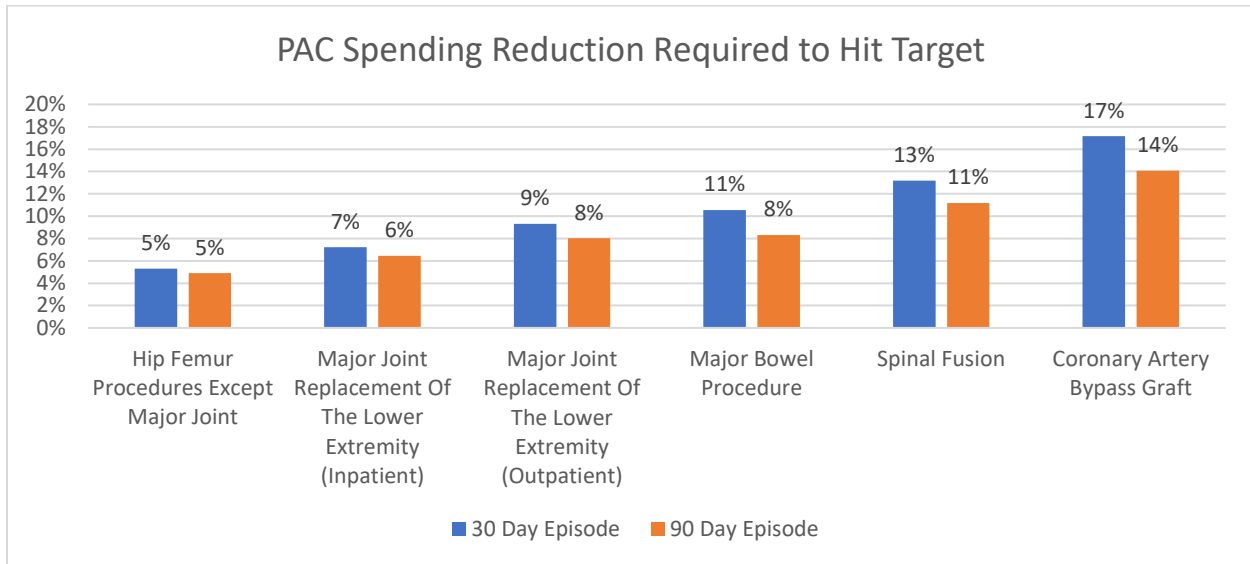
Figure 3: Payment Over Time for TEAM Clinical Episodes



Source: DataGen analysis of data from the CMS Standard analytic file, 2020 Q1-2022 Q3. 2024.

¹¹⁰ Chernew, M. E., Heath, J., & McWilliams, J. M., [The merits of administrative benchmarks for population-based payment programs](#). *The American Journal of Managed Care*, 28(7), e239–e243 (2022).

Figure 4: Post-Acute Spending Reduction Needed to Hit Target for TEAM Clinical Episodes



Source: DataGen analysis of data from the CMS Standard analytic file, 2020 Q1-2022 Q3. 2024.

Adjust the Low-volume Threshold to at Least 30 Episodes per Clinical Episode Category Across the 3-year Baseline Period

For the purposes of reconciliation, CMS proposes to have a low-volume threshold to apply to total episodes across all episode categories. If a participant does not meet a threshold of 31 total episodes in the baseline period for PY 1, then CMS will still reconcile their episodes, but the participant will be subject to Track 1 stop-loss and stop-gain limits. If a participant does not meet a threshold of 31 total episodes in the baseline period for PYs 2-5, then they would be subject to the Track 2 stop-loss and stop-gain limits for PYs 2-5. The proposed low-volume threshold will force many providers into a position where they will not be able to control financial risks associated with random variation. This low-volume threshold is the lowest that CMS has ever proposed. Other bundled-payment models such as CJR and BPCI Advanced, have had low-volume thresholds of about ten episodes per year for a given clinical episode. The AAMC recommends CMS raise the low-volume threshold to a minimum of 30 episodes in the baseline for each clinical episode.

Use Elements of the BPCI Advanced Target Price Methodology to Accurately Reflect the Population Served Instead of the National Normalization Factor

CMS proposes calculating a prospective normalization factor to ensure that risk adjustment does not inflate target prices overall. The prospective normalization factor would be applied to the benchmark price to calculate the preliminary target price for each MS-DRG/HCPCS episode type and region. Applying a national normalization factor effectively removes beneficiary-level risk adjustments and can disproportionately disadvantage hospitals with lower acuity patient case mixes. This can affect hospitals with patients with lower risk adjustments compared to the nation or affect hospitals with lower severity MS-DRGs compared to the nation.

The BPCI Advanced methodology risk adjusts on many beneficiary-level factors as well as hospital characteristics, resulting in more specific and fairer target prices. The AAMC recommends replacing the BPCI Advanced Standardized Baseline Spending (SBS) from hospital-specific baseline spending to

region-specific baseline spending, allowing for a regional target as intended for TEAM. In addition, the AAMC suggests using the BPCI Advanced Peer Group Trend (PGT) Factor Adjustment. As this is a mandatory model, there is concern for ratcheting target prices so low that they reach a level below what is clinically feasible, in particular for providers that have been actively engaged with reducing costs for in the past decade for episodes such as major joint replacement of the lower extremity. For TEAM, a PGT Factor Adjustment could be applied with an asymmetrical (-2%/+5%) cap so that target prices are not lowered too much due to improvements in care delivery at the time of the performance period reconciliation. Target prices would decrease over time due to annual baseline updates but that decrease would be experienced more gradually for providers.

Modify the Risk Adjustment Methodology to Include Adjustments Made in BPCI Advanced

CMS proposes calculating retrospective risk adjustment coefficients at the MS-DRG/HCC episode type level. Risk adjustment includes beneficiary age, Hierarchical Condition Categories (HCCs) with a 90-day look back, and a single, binary variable to capture multiple beneficiary markers of social risk. The social risk variable will be based on patients that are identified as dually eligible, low-income subsidy (LIS) recipients, or living in an area with a high area deprivation index (ADI) receiving a 1, and all other patients receiving a 0 for the adjustment. It is critical that CMS apply a sophisticated risk adjustment to ensure that providers are measured fairly based on the care they provide and on the patients' comorbidities/risk. The AAMC recommends that CMS include the following risk adjustments:

Hospital-level Risk Adjustments

The current adjustment does not appropriately capture the complexity of hospital settings. **CMS should include adjustment factors for rural/urban location, safety net status, size, and teaching status.** Providers in rural areas have a higher burden because of fewer resources and a smaller workforce. Safety net providers also have a higher burden because a large portion of their population are underserved, high-risk patients and teaching hospitals often provide care to the sickest and most medically complex patients. The inclusion of hospital characteristics will further improve the pricing accuracy for participants.

Patient-level Risk Adjustments

The AAMC strongly supports CMS' proposal to incorporate patient-level risk adjustments into the TEAM methodology, including age and HCCs. However, like BPCI Advanced, **CMS should account for both HCC weights and counts in the risk adjustment and use a 1-year look back for HCCs rather than 90-days, as Medicare patients are encouraged to see their primary care physicians on an annual basis.** In addition, the use of a single, binary social risk variable will not appropriately demonstrate a patient's social risk. Patients who identify with just one of the social risk categories will be seen as the same level risk as someone who identifies for all three of the adjustment components. Patients who identified as all three categories may need more resources as they may have more complex social issues that affect their ability to seek care. The risk adjustment methodologies of BPCI Advanced and CJR included additional risk categories that allowed for a better reflection of the patient populations being served. **The AAMC supports the use of the methodology in BPCI Advanced and CJR for the inclusion of dual eligibility status as well as expansion to LIS status, and state and national ADI for the TEAM risk adjustment methodology.** This methodology will more accurately capture the social risk faced by patients and the associated resource use for these patient populations. In prior comment letters, **AAMC has noted that dual eligibility is an imperfect proxy of social need and vulnerability, and requests CMS to investigate potential new indicators for assessing individual-level health related social needs (HRSN) correlated with negative health outcomes.** For example, CMS could

explore whether HRSN data reported in the Inpatient Quality Reporting (IQR) program can be correlated to health outcomes and evaluate the availability of ICD-10 Z-codes documenting HRSNs on inpatient claims. **The AAMC also recommends that CMS consider incorporating other patient-level variables for risk adjustment such as housing instability, food insecurity, financial needs, transportation problems, education, language, and interpersonal safety.** The use of robust risk adjustment is essential to ensuring that providers are fairly assessed on their performance, particularly those treating more complex patients.

Lastly, CMS introduced a new set of billing codes for screening for social determinants of health, community health integration (CHI) services, and Principal Illness Navigation (PIN) services, outlined in the calendar year 2024 Physician Fee Schedule. These services will not be appropriately captured in the historical benchmark for the target price methodology as they would not have been captured in historical spending trends. Therefore, **CMS should consider ways to account for the introduction of these new services around caregiver training, HRSNs assessment, CHI, and PIN.**

Conduct a Single Reconciliation

CMS proposes to conduct an annual reconciliation that would reconcile performance year spending against the target price to determine if a hospital is eligible for a reconciliation payment or repayment. CMS would conduct the reconciliation six months after the end of the performance year. The AAMC encourages CMS to release the reconciliation data on a consistent basis as defined in the participation agreement to ensure success in the model.

QUALITY ADJUSTMENT

The AAMC supports CMS' decision to use the quality adjustment methodology used in BPCI Advanced. As part of reconciliation, CMS proposes to adjust the difference between the participant's performance year spending and their reconciliation price by its composite quality score (CQS). Like BPCI Advanced, the quality measures would be weighted based on the volume of episodes and CMS would convert the raw score of each quality measure into a scaled score of zero to 100 by using the national performance percentiles. The percentiles would be determined using a fixed baseline period of CY 2025. The resulting CQS will be applied to the reconciliation amount, resulting in either increased savings or reduced losses for participants.

MODEL OVERLAP

The AAMC supports CMS' decision to allow overlap between TEAM and total cost of care models without recoupment. CMS proposes to allow overlap between TEAM and total cost of care and shared savings models, excluding the Maryland Total Cost of Care Model. This overlap would allow savings generated on an episode in TEAM, and any contribution to savings in the total cost of care model, be retained by each respective participant. The episode spending in TEAM would be accounted for in the total cost of care model's total expenditures, but TEAM's reconciliation payment amount or repayment amount would not be included in the total cost of care model's total expenditures. This means that participants can earn shared savings in TEAM and in another CMMI model without any recoupment requirement. This policy will encourage collaboration between specialists and ACOs and increase alignment across models.

FINANCIAL ARRANGEMENTS

The AAMC supports the options for gainsharing as it encourages collaboration between ACOs, specialists, and post-acute care providers. However, we encourage CMS to remove the 50% cap on gainsharing. While only TEAM participants can initiate an episode, CMS proposes to allow gainsharing of Medicare savings and costs between TEAM participants and other entities. Safe harbor regulations will apply, and CMS proposes an overall cap of 50% of shared losses, except for entities that are not ACOs, which would have a cap of 25%. across all entities. Removing the gainsharing cap would reduce the administrative burden for providers, strengthen integration between specialists and ACOs, and maintain consistency from other bundled-payment models such as CJR and BPCI Advanced.

HEALTH EQUITY

The AAMC agrees that health equity is a vital component of any new model that CMS implements. There are many dimensions of health equity that can be applied to quality measurement and risk adjustment methodologies. While health equity may require additional reporting requirements for participants, it is critically important to commit to consistent data collection across models to minimize provider burden and improve the evaluations.

Define Safety Net Providers by Matching the Methodology in the CMMI Strategy Refresh, with Consideration for the Possible Future Expansion

CMS has proposed the use of the safety net definition outlined in the Strategy Refresh, published in 2021. There are varying definitions surrounding safety net providers, with some studies indicating safety net status based on the level of charity care, facility characteristics, patient case-mix, or disproportionate share hospital status.¹¹¹ The Strategy Refresh outlines that safety net providers are those that fall into the 75th percentile for patients that are dually eligible or Part D LIS recipients. Given that CMS conducted extensive stakeholder roundtables to determine an appropriate definition and given that the definition aligns with CMS' work in other areas, we support the use of the outlined definition of safety net providers. In the future, CMS should consider incorporating disproportionate share hospitals into the definition of safety net providers, as well as other providers that see a large amount of underserved patients.

The AAMC, however, has significant concerns regarding the inclusion of safety net providers and other providers that care for a large portion of underserved populations, as a result of the low operating margins experienced by these providers. This leaves little room for investment in value-based care infrastructure and potentially jeopardizes the hospital's financial stability, especially considering many of these providers are new to downside risk arrangements. Given the inclusion of rural, safety net, and sole community providers, these facilities are often the only point of care for many patients in the community. If unintended consequences occur, such as limited funds or hospital closures, this could negatively impact patients in these communities who may lose their care providers. CMS should introduce further protections for safety net providers to negate any unexpected consequences.

¹¹¹ Hefner, J., Hogan, T., Opoku-Agyeman, W., and Menachemi, N., [Defining safety net hospitals in the health services research literature: a systematic review and critical appraisal](#). *BMC Health Services Research* (21) 278 (2021).

Include an Adjustment Factor for Rural Status to Account for the Unique Provider Type

CMS should include a factor in the risk adjustment methodology for rural status. CMS has indicated a higher burden on providers in rural areas, as a result of fewer resources and a smaller workforce, specified in the Advancing Health Equity in Rural, Tribal, and Geographically Isolated Communities resources developed by CMS. Rural providers are often not engaged with value-based care due to the high reporting burdens, the inability to take on risk, and the lack of a specialist workforce to support appropriate referrals.¹¹² Additionally, a recent study demonstrates that the risk adjustment methodology previously used in other CMS value-based care models does not appropriately capture rural patients' complexity, leading to underpayment of rural providers.¹¹³ Given the resource and staff deficits in rural communities, lower payments will only increase the burden on rural providers and could potentially lead to worse health outcomes for rural patient. Therefore, CMS should consider an adjustment factor for rural status in order to support rural providers in taking on risk and to acknowledge the disparities that exist in rural settings. CMS should also reevaluate the existing methodology regarding the adjustment for rural status, given that it does not appropriately capture the complexity of this setting.

Modify the Risk Adjustment to Include Health-related Social Needs (HRSNs) to Appropriately Capture Patient-level Social Risk

CMS has proposed the inclusion of a binary variable to capture social risk, with patients that are identified as dually eligible, LIS recipients, or living in an area with a high ADI receiving a 1, and all other patients receiving a 0 for the adjustment. The AAMC believes that this methodology would not appropriately demonstrate a patient's social risk. This methodology may not capture the extent of an individual's social risk, as patients who fall into one of the identified categories will be seen as having the same level risk as someone who qualifies for all three of the adjustment components. Patients who fall into all three categories will have higher resource use and may have more difficulties with social issues that affect their ability to seek care. Given that TEAM will include a whole new series of providers, such as safety net and rural providers, CMS needs to introduce a risk adjustment methodology that appropriately captures patient characteristics associated with high social risk. To qualify as a safety net provider in TEAM, a hospital must fall into the 75th percentile for dually eligible and LIS beneficiaries. Therefore, a high proportion of these providers' patients will have one or more of the identified high-risk characteristics.

The AAMC supports the use of the methodology previously established in BPCI Advanced and CJR for the inclusion of dual eligibility status in the regression model for patient case-mix. This model should be expanded to include the additional factors, LIS and ADI. This methodology will more accurately capture the social risk faced by patients and the associated resource use for these patient populations.

Furthermore, the AAMC has long flagged that dual eligibility is an imperfect proxy of social need and vulnerability. We ask CMS to commit to evaluating and sharing information on potential new indicators for assessing individual-level HRSN correlated with negative health outcomes to move away from the use of a blunt proxy indicator such as dual eligibility. CMS should do this by identifying a short list of the most essential social needs, collecting this data in a standardized manner across models, and using the data to create upside incentives to close gaps, while also risk adjusting financial measures. CMS should

¹¹² Meuller, K., McKinney, C., Lundblad, J., Weng, K., 2020. [How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report](#). Center for Rural Health Policy Analysis, Rural Value, and Stratis Health (2020).

¹¹³ Rogers, G., Smith, M., Gonzalez-Smith, J., and Saunders, R., [Bridging The Home-Based Primary Care Gap In Rural Areas](#). Health Affairs Forefront (2024).

explore whether HRSN data reported in the IQR program can be correlated to health outcomes, such as those measured in the Value-Based Purchasing program. 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 risk adjusting target prices to better support health equity.

Require Health Equity Plans Beginning in Performance Year 2

CMS should mandate the health equity plan starting in Performance Year 2 to allow time for providers new to value-based care the opportunity to build infrastructure necessary for addressing disparities in the hospital's service area and patient population. The delayed start will also assist safety net providers, who will likely need time and resources to create and address a health equity plan. At a minimum, the plan should be delayed for those in Tracks 1 and 2 of the model, as these participants are less likely to have the experience necessary to be fully invested in a new value-based care model, as well as additional requirements around health equity and population health. Delaying the onset of the plan could potentially lead to more investment in health equity from providers, as they will have had more time to initiate care interventions specific to the episodes included in the model and will, therefore, be more prepared to pivot to new initiatives in future performance years. Requiring the plan from the start may lead to a less thorough plan that is more easily addressed when taking on a new value-based care model.

CMS should include the proposed elements in the health equity plan around identifying disparities, as well as establishing goals, intervention strategies, and measurement methods. CMS, however, should consider providing data or technical assistance to safety net and rural providers, who may not have a built-in data analytics team to determine major gaps and disparities faced by the hospital's patient population. Analyses from these types of providers may be qualitative, based on experience with patients in the community, rather than extensive quantitative data.

CMS should also allow overlap of health equity plans across models. If a TEAM participant is also participating in a model that includes a health equity plan, CMS should pull the health equity plan from the other model in order to decrease burden on providers.

Align HRSN Data Collection with Screening Measure Used in the Hospital IQR Program

CMS should implement mandatory HRSNs data collection, based on voluntary reporting from patients, starting in Performance Year 2. CMS should implement model policies that align with measure reporting in the Hospital IQR program in order to create alignment between programs. The Hospital IQR program currently includes a measure of a hospital's rate of screening for five HRSNs, housing instability, food insecurity, transportation needs, utility difficulties, and interpersonal safety. TEAM should require the collection of the same five HRSNs to alleviate burden on providers and streamline reporting. Requiring the collection of the same HRSNs would create a more robust and standardized data set. CMS should still encourage the collection of additional HRSNs but only require the five HRSNs outlined in the Hospital IQR program. CMS should also commit to using or discontinuing the collection of each data element within 3 years (for the purposes of risk adjustment or quality measurement) to ensure that the data collection remains meaningful.

Investigate and Establish Processes for Closed-loop Referrals for Patients with Identified HRSNs

CMS should work with stakeholders to determine ways to create closed-loop referrals for patients experiencing HRSNs. Currently, there is a lack of consensus on how to approach this topic, given the

varying community resources available by service area. In addition, many Medicare beneficiaries travel for specialty care to AAMC members and other large tertiary and quaternary health systems, with no intention to remain in the area local to the health system. In such cases, it might be challenging for the health system to engage community service providers in the patient's local community on the patient's behalf.

CMS should consider a reporting mechanism that allows providers to indicate that no known resource is available. This would ensure that those providers who have access to robust community resources are encouraged to connect and close the loop for patients with an identified HRSN. This would also allow CMS to gain a better understanding of which communities are severely lacking in resources, without penalizing providers. This information can then be shared with other government agencies that can work both within government and with local partners to establish necessary resources for food, housing, employment, and other key areas. Specific to academic medicine, there is a potential for patients to travel to the health system for time-limited specialty care, with no intention to remain in the area local to the health system. In such cases, it might be challenging for the health system to engage community service providers in the patient's local community on the patient's behalf. This measure is likely more appropriate for providers who routinely have ongoing clinical relationships with patients.

Require the Collection of Demographic Data in Line with Timeline for Implementing New Race & Ethnicity Data Collection Standards

CMS should implement mandatory demographic data collection, based on voluntary reporting from patients, starting as early as Performance Year 2. The AAMC supports CMS' stance on making demographic data reporting voluntary in Performance Year 1 to allow time for providers new to value-based care to establish the necessary infrastructure and processes to appropriately collect this data. The AAMC encourages CMS to establish standardized demographic data collection methods, both in terms of the specific categories, as well as the patient responses. Standardized demographics would allow for more robust and reliable data.

Additionally, the OMB recently finalized long-awaited revisions to its Statistical Policy Directive No. 15 (SPD 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Hispanic and Latino categories would be combined into race and/or ethnicity, rather than maintaining separate questions.¹¹⁴ A category for Middle Eastern and North African was also added to standardized demographics for collection. These changes will be required immediately for new initiatives, starting in March 2024. The AAMC supports CMS' proposal to implement more inclusive demographic data categories. However, CMS should consider when and how they introduce these new demographic data elements to ensure continuity and validity of data, as there are no current agency plans for supporting the new OMB standards.

Provide an Upfront Infrastructure Investment Payment for Safety Net Providers Without a Requirement to Payback to CMS

CMS should provide an upfront infrastructure investment for safety net providers in Track 2. An upfront infrastructure investment would allow safety net providers to introduce the necessary technologies and staff needed to successfully participate in TEAM. If CMS wants to include new types of providers in value-based care in order to expand the reach to underserved patient populations, CMS needs to make

¹¹⁴ *Supra*, note 51.

accommodations to encourage active participation in TEAM from these providers that experience high burden, issues with staffing, and minimal resources.

CMS should not require a repayment of the upfront infrastructure investment payment. Currently, the ACO Primary Care Flex model has proposed an upfront infrastructure investment, however, CMS requires safety net providers to repay that amount. Requiring a payback could ultimately prevent safety net providers from seeking the investment. In general, safety net providers have not previously engaged with value-based care because of their narrow operating margins, which prevents them from investing in the appropriate electronic health record technology, additional staff, and other resources typically utilized in value-based care.¹¹⁵ Without the upfront infrastructure investment, many safety net providers will have the potential to fail under TEAM and requiring the amount be paid back may deter these providers from applying for it. CMS should introduce an upfront infrastructure investment; however, they should not require this amount be paid back by the safety net provider.

WAIVERS

The AAMC supports CMS' decision to include waivers in the model that would allow for easier access to post-acute care. Waivers are often underutilized due to concerns that the patient may not qualify as a model participant. **CMS could mitigate this concern by applying waivers to all FFS Medicare patients with billing codes that could trigger an anchor hospitalization or anchor procedure for TEAM at participating hospitals.**

Create a Post-discharge Home Visit Waiver to Match Waiver Available in BPCI Advanced

CMS should consider the addition of the post-discharge home visit waiver. CMS should match the methodology established in BPCI Advanced to ensure continuity and continuation of previous efforts. The "incident to" requirement is waived in BPCI Advanced, allowing auxiliary personnel to carry out the services to a patient in their home. While telemedicine has increased significantly since the pandemic, the post-discharge home visit waiver under BPCI Advanced provides a different type of services for higher risk patients that require more in person interaction. The types of services provided in the post-discharge home visit waiver differ from those provided under telehealth. Telehealth focuses more on consultation, management of chronic conditions, nutritional services, mental health, and more.¹¹⁶ Home visit services, however, provide more home health-based services, such as occupational, physical, and speech therapy, social services, injections, as well as other services. Limiting the scope of the post-discharge home visit services could limit the services provided to a beneficiary in the home. Given the orthopedic episodes included in TEAM, waiving the incident to provision in the post-discharge home visit waiver could allow for increased access to occupational and physical therapy services, ultimately leading to improved outcomes for patients in the model.

CMS should also waive the homebound requirement for home health services, to match the precedents established in BPCI Advanced. Again, this increases access to services in the home for those beneficiaries who may not be homebound but may still have ambulatory issues. Additionally, waiving the homebound requirement could assist beneficiaries that may have difficulties with social needs, such as transportation or the inability to take time off from work, and are unable to access services in person at the hospital. By

¹¹⁵ Cuellar, A., Dyer, M.B., and Matulis, R., [Value-Based Payment, the Safety Net, and Rethinking Risk](#). *American Journal of Managed Care* (28) 8 (2022).

¹¹⁶ [Telehealth for Providers: What You Need to Know](#), U.S. Department of Health and Human Services (2023).

providing home health services to these patients, there is an opportunity to increase outcomes, especially if patients would have missed follow up or physical therapy as a result of their social needs.

CMS should offer the Care Management Home Visit waiver offered under the Next Generation ACO Model and the Enhancing Oncology Model. This waiver would increase access to home health services by allowing additional personnel to provide care in a patient's home. CMS should also consider an environmental modifications waiver or beneficiary enhancement, similar to what is seen in the Guiding an Improved Dementia Experience Model. This would allow providers to get an understanding of a patient's home environment and determine if there are modifications needed to assist a patient in recovering at home, such as grab bars or other accommodations.

Telehealth Waiver

The AAMC supports CMS' inclusion of new home health telehealth G-codes for evaluation and management services to more appropriately capture these services when they occur.

The AAMC also supports CMS' decision to waive the geographic site requirement, as this will expand telehealth services to patients outside of rural locations, who may have difficulty accessing in person care due to mobility or social issues. The AAMC also supports CMS' decision to waive the originating site requirement to match the precedents established in BPCI Advanced and increase the locations at which telehealth can occur, expanding access to more beneficiaries.

3-Day SNF Waiver

The AAMC supports CMS' proposal to waive responsibility for denied claims in instances where the participating provider would have no way of knowing that a patient would not be captured in the model. This matches the precedents established in BPCI Advanced and encourages the use of the waiver by ensuring patients skilled nursing stays will be covered, should they fall out of eligibility for the model. The AAMC agrees with CMS' decision to not cover those uses of the waiver when a provider opts for a subpar skilled nursing facility that does not meet the three-star requirement.

The AAMC also supports CMS' proposal to include swing beds used for inpatient post-acute care in Critical Access Hospitals as part of the 3-day SNF waiver. As stated by CMS, this will increase access to post-acute care services for those living in rural areas or those areas with health care shortages, helping meet CMS' goals around health equity and improving access to care.

Adjust the In-kind Items and Services Beneficiary Enhancement to Reduce Burden on Providers

The AAMC supports CMS' proposal to implement an in-kind items and services beneficiary enhancement within TEAM. However, certain provisions regarding this inclusion are highly burdensome and may prevent utilization of this waiver. CMS currently requires any item exceeding \$75 to be returned upon the end of an episode. Providers are then responsible for tracking down those items that are not returned or stating the reason for why they were not returned. In-kind items and services waivers used in other models, such as BPCI Advanced and CJR, do not require the item to be returned. The AAMC urges CMS to match the requirements outlined in other models to prevent underutilization of this enhancement. Furthermore, CMS should increase the cost threshold for reporting. Currently, CMS will require participants to report all in-kind items and services exceeding \$25. The AAMC encourages CMS to raise the threshold to \$100, again to decrease burden on providers.

MONITORING

The AAMC supports CMS' proposal to monitor for inappropriate care patterns in TEAM, as well as provide transparency regarding costs and services provided to Medicare beneficiaries.

Monitor for Delayed Services or Referrals to Other Facilities to Ensure Providers are not Intentionally Avoiding Care for High-cost or High-risk Patients

The AAMC supports CMS' proposal to monitor care patterns to ensure patients receive timely and appropriate care.

Provide Post-acute Care Pricing Transparency to Patients upon Discharge

The AAMC supports CMS' proposal to provide pricing transparency on post-acute care services. This increases a patient's agency and engagement with their own care, as well as preparing them for any expected costs, allowing for opportunities for alternatives in care based on a patient's preferences or financial feasibility.

DATA SHARING

Provide Robust Monthly Claims-level Data

The AAMC recommends that the beneficiary-level data provided by CMS include data from all claim types, including inpatient, SNF, home health, inpatient rehab, inpatient psych, hospice, as well as data on any of the elements included in the risk adjustment or target price methodology.

CMS should update claims data monthly to ensure providers have the most up to date data on their patient population to assist with care planning and quality improvement initiatives. Model participants are often concerned with the long data lags that currently occur in many Innovation Center models. This is often a major area of concern for AAMC members who want actionable data in order to make real time improvements. It may be difficult to act when the data is further lagged. Therefore, CMS should work to provide timely data as soon as feasible.

Offer Claims Data to Both Participating Hospitals and Collaborators Upon the Receipt of a Data Attestation from the Collaborator

CMS should provide claims data to the participants with an option for also sharing claims data with collaborators. A data attestation could be used for those participating providers that maintain close care relationships with collaborators. This could be especially useful for safety net providers that may not have data analysts in house, who can then cut, analyze, and share the data with necessary providers. Allowing safety net or other providers new to value-based care to share data may relieve some of the burden they face, taking on a new model such as TEAM.

Provide Beneficiary-level Data for the THA/TKA Patient Reported Outcomes Measure

CMS should include beneficiary-level data for the patient reported outcomes measure included in TEAM. This would allow for increased quality improvement initiatives and targeted interventions. Given that there are pre- and post- components of the survey that require the results to be matched with a specific patient, the AAMC encourages CMS to provide these responses at a beneficiary-level to assist in quality improvement initiatives.

REFERRALS TO PRIMARY CARE PROVIDERS

The AAMC supports CMS' efforts to better align primary and specialty care to increase care coordination and improve outcomes. Referrals back to primary care providers are often associated with better patient outcomes. Therefore, CMS should consider incorporating referrals back to primary care providers, or referrals to new providers when appropriate.

Require Primary Care Referrals During Discharge from the Participating Hospital to Ensure Care Coordination and Better Outcomes

CMS should require referrals back to primary care providers (PCP) upon discharge to ensure better outcomes. Care coordination is a significant aspect of value-based care, as it improves patient outcomes.¹¹⁷ Timely follow up ensures that patients can ask necessary questions and address issues before they are exacerbated to the point of readmission. Studies show that patients that do not receive timely follow up are more likely to be readmitted, with some studies demonstrating a readmission rate ten times higher for those patients lacking follow up.¹¹⁸

By including a referral back to the PCP, the participating provider can also ensure that a patient has a PCP. If a patient lacks a PCP, the participating provider can work to connect a patient to a PCP to increase outcomes regarding the specific TEAM episode, but also to address preventable health issues overall. This would be of utmost importance for urgent CABG procedures, bowel obstructions, hemorrhage or perforations, as well as fracture episodes, where a patient may be admitted from the emergency department and not referred over for a specific procedure from the PCP. Therefore, the AAMC supports CMS' decision to include referrals back to the PCP upon hospital discharge to increase patient outcomes.

CMS should also consider the primary care shortages that are rampant nationwide, as well as the physician shortages in rural locations.¹¹⁹ Given TEAM incorporates a range of new types of providers, CMS should consider these providers' access to primary care services. Rural areas are expected to see a PCP shortage of 20,000 by 2025, therefore, CMS should consider allowing rural providers to report a lack of access to PCPs, rather than reporting a referral to PCPs.¹²⁰ If there is no PCP to refer a patient to, then providers should not be penalized.

TEAM should also include referrals to address mental, behavioral, or social needs when those needs are identified. While it is a patient's choice to pursue those referrals, CMS should include a mechanism to ensure that these are closed-loop referrals with warm hand-offs when possible.

¹¹⁷ [Care Coordination](#). Agency for Healthcare Research and Quality.

¹¹⁸ Misky, G., Wald, H., and Coleman, E., [Post-hospitalization transitions: Examining the effects of timing of primary care provider follow-up](#). *Journal of Hospital Medicine* (June 2010).

John, G., Payrard, L., and Donzé, J., [Associations between post-discharge medical consultations and 30-day unplanned hospital readmission: A prospective observational cohort study](#). *European Journal of Internal Medicine*, 99 (2022).

¹¹⁹ *Supra*, note 4.

¹²⁰ Nielsen, M., D'Agostino, D. and Gregory, P., [Addressing Rural Health Challenges Head On](#). *The Journal of the Missouri State Medical Association*; 114 (5) (2017).

INTEROPERABILITY

CMS Should Seek Information from Participants on their Plans for Engaging with Trusted Exchange Framework and Common Agreement (TEFCA)

The AAMC supports CMS' proposal to seek information on a participant's plans to engage with TEFCA. TEFCA can increase interoperability and connect providers, benefiting patients, as well as providers.

DECARBONIZATION

Utilize the Energy Star Score for Hospitals to Determine Building Emissions

CMS should use the Energy Star Score for hospitals as it is the most accurate and complete data available on a hospital's emissions. This score is already utilized by the Department of Health and Human Services and requires no additional reporting to CMS, limiting the burden on providers.

CMS Should Consider Tracking the use of Hydrofluorocarbon Metered Dose Inhalers (MDIs), While Also Encouraging the Use of Dry Powder Inhalers

CMS should be cautious about the way they approach tracking and decreasing MDIs. According to the American Lung Association, asthma is most prevalent in patients that are low income. Additionally, Black and American Indian/Alaska Native patients experience a significantly higher prevalence of asthma.¹²¹ Asthma is also more prevalent in low-income communities as a result of subpar housing and proximity to major roadways and highways.¹²² CMS should, therefore, consider partnerships with the Department of Housing and Urban Development, as well as the Department of Transportation, to ensure that the HRSNs that lead to increased rates of asthma are addressed in low-income and underserved patient populations, ultimately leading to a decrease in MDIs.

CMS should also consider promoting the use of powder-based inhalers, as these inhalers are significantly better for the environment. While hydrofluoroalkane is considered more environmentally friendly, when compared with hydrofluorocarbon, ultimately, it still contributes highly to global warming. Dry powder inhalers are considered significantly better than the alternatives listed in TEAM.¹²³ While tracking hydrofluorocarbons is a good step, CMS should consider promoting dry powder inhalers when appropriate, as well as additional initiatives with other government agencies to both promote the use of environmentally friendly inhalers, as well as address the leading causes of asthma.

CMS Should Provide an Incentive for Providers Voluntarily Reporting on Decarbonization

The AAMC supports CMS' proposal to incentivize the collection of specific data around decarbonization. We encourage CMS to implement a bonus payment, rather than an adjustment to the CQS. A bonus payment is likely to encourage providers more so than an adjustment to the CQS, as this is upfront cash that can be immediately reinvested back in value-based care and health equity. An adjustment to the CQS may not encourage providers' participation in the decarbonization effort, as the adjustment to quality

¹²¹ [Current Asthma Demographics](#). *The American Lung Association*.

¹²² Bryan-Stephens, T., Strane, D., Robinson, E., Bhambhani, S., and Kenyon, C., [Housing and asthma disparities](#). *The Journal of Allergy and Clinical Immunology*, (148) 5 (2021).
[Health and Equity](#). *The Department of Transportation*.

¹²³ Starup-Hansen, J., Dunne, H., Sadler, J., Jones, A., and Okorie, M., 2020. [Climate Change in Healthcare: Exploring the Potential Role of Inhaler Prescribing](#). *Pharmacology Research and Perspectives*, 8 (6) (2020).

often occurs over a year after the end of a performance period and may not provide the same incentive as a cash bonus.

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 – Shahid Zaman (szaman@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; Erin Hahn (ehahn@aamc.org) on the TEAM Model.

Sincerely,



Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief, Health Care Affairs

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