June 10, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services, Department of Health & Human Services
Attention: CMS-9895-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov.

RE: "FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule [CMS-1808-P]"

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit the following comments to the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule [CMS-1808-P]."

USofCare is a nonpartisan, non-profit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift voices of real people engaging with the health care system whose perspectives shape our advocacy work.

USofCare applauds CMS's efforts to promote transparent, affordable, equitable, and people-centered care through the 2025 IPPS proposed rule. A majority of our response focuses on the proposed Transforming Episode Accountability Model (TEAM), while also highlighting CMS's work to implement patient-first care (also known as value-based care), improve the standards for maternal health care delivery, and promote health equity across the board. Specifically, our comments focus on the following topics:

I. Centering Health Equity
II. Request for Information on the Use of the Medicare IPPS Payment Rates for Maternity Care by Other Payers
III. Shifting Toward Patient-First Care, Including Through TEAM

> "All inclusive, personalized, personable, and affordable health care would be great."
> *~ White woman, Georgia*

Centering Health Equity

USofCare appreciates CMS's continued commitment to improving health equity and reducing health disparities. **We support language found in the proposed rule to more fully account for the social determinants of health (SDoH), including access to housing,**

when calculating hospital payments and collecting patient data. For example, by elevating several ICD-10-CM diagnosis codes that describe various levels of housing instability, hospitals are better able to account for the social factors that shape people's care needs. We agree with the agency's rationale that this will improve data reliability and better reflect how people with housing instability experience care, just as new SDoH data collection requirements in the Long-Term Care Hospital Quality Reporting Program will better gauge whether Long-Term Care Hospitals (LTCHs) are meeting health equity standards.

> *"We've literally gone through four family doctors since we've been together for seven years because they just [health care providers] up and leave the community or the office… It seems like all of the sudden they're not as friendly as they were before as well or you can't find someone stable."*
> *~ White woman, Colorado*

Additionally, USofCare deeply appreciates CMS's focus on prioritizing the ongoing behavioral health crisis and on reducing disparities through its planned distribution of Graduate Medical Education (GME) residency slots. The COVID-19 pandemic emphasized the importance of mental health and having an adequate mental health care workforce. Addressing behavioral health workforce issues is critically important for those experiencing access issues, such as people living in rural areas, people of color, and people who identify as LGBTQ+. The proposed rule helps address that shortage by increasing the number of GME slots dedicated to psychiatry and related specialties, with a particular emphasis on improving access in areas with provider shortages. **While we understand that the proposed rule is limited to the additional GME slots allocated through the Consolidated Appropriations Act (CAA) of 2023, we urge CMS to adopt additional training requirements for GME slots to ensure that all trained physicians are able to provide culturally responsive care.** This aligns with USofCare's recent recommendations to advance culturally responsive care, which was developed from our work listening to people's unique needs for the health care system.

Request for Information on the Use of the Medicare IPPS Payment Rates for Maternity Care by Other Payers

USofCare appreciates CMS's efforts to set higher standards for maternal health care delivery through the use of hospital Conditions of Participation (CoPs). We know from existing literature and our listening research that the maternal health care experience varies widely: some pregnant women and people receive comprehensive, high-quality care, while others face gaps and mistreatment leading to adverse outcomes. Implementing maternal health-specific CoPs can enhance the quality and safety of care by establishing consistent standards and protocols. This ultimately improves health outcomes, addresses disparities, and promotes a better maternal health experience for all pregnant women and people.

Shifting Toward Patient-First Care, Including Through TEAM

Through our listening work, USofCare knows that in addition to care that is equitable, people want more time with their doctors, better communication between their providers, more personalized and customized care, and the ability to be treated as a whole person rather than a series of symptoms; collectively, a system grounded in patient-first care. Because of this, **USofCare supports the Transforming Episode Accountability Model (TEAM) included within the proposed rule, which will bring more hospitals into patient-first care initiatives.** Expanding the number of providers engaged in these models increases participating hospitals' incentives to coordinate care with other providers and invest in care quality improvements that may not otherwise be paid by the traditional fee schedule.

Additionally, the establishment of TEAM makes progress towards CMS's goal of having all Medicare beneficiaries enrolled in accountable care relationships by 2030.

Our own research shows that, by a 4:1 margin, when offered an alternative fee-for-service, people favor a system that prioritizes more personalized care. **Through TEAM, CMS is listening to patients' needs for payment models that incentivize greater care coordination between providers (including primary care providers) and shared decision-making with patients, while also improving patient health outcomes, lowering costs, and improving health equity.** We are excited that TEAM builds upon earlier bundled payment demonstrations, such as the Comprehensive Care for Joint Replacement (CCJR) model, which yielded greater interaction and communication between patients and providers. The mandatory nature of TEAM will allow for a more comprehensive understanding of its effectiveness which can be used to inform the development of future bundled payment models, as well as total cost of care models more generally.

> *"Better communication would make me trust my doctor more. I would talk to him more frequently and make sure that he's listening to me, and that I'm listening to him. I would make sure that we're communicating effectively. I've had experiences with doctors where we didn't get along with one another and it was not enjoyable. There is no way I'm not going to stay with that doctor; I don't trust them. It doesn't make sense. If I don't trust the doctor, I'm not staying with them."*
> *~ Black man, Illinois*

Far too often, care coordination declines or drops off entirely once a patient is discharged from a hospital. This significantly impacts a patient's recovery and potentially leads to otherwise avoidable care needs or further hospitalization, which can be both physically and financially taxing for patients and the health care system at large. TEAM promotes access to whole-person, coordinated care by establishing set reimbursement for five specific, commonly practiced surgical care episodes that should facilitate greater access to these procedures and benefit underserved patients who often find it difficult to access or afford needed care. **The model aligns incentives, encourages collaboration, and facilitates the transition of a patient back to their primary care provider following a surgical procedure in a way that serves patients, including those who may otherwise lack a primary care provider, and better aligns incentives for the system as a whole.**

Health Equity Considerations
Any successful model must center health equity as its primary goal. TEAM is the first bundled payment model to incorporate social risk – equally weighting three social risk indicators – in determining payments to participating hospitals. **We strongly support the inclusion of these adjustments to ensure that facilities that disproportionately serve underserved populations, such as communities of color and rural communities, aren't penalized given their higher investment needs.** We also support additional health equity-focused elements that require hospitals to submit health equity plans, collect socioeconomic data, and screen patients for health-related social needs, such as transportation and food insecurity, to understand the impacts non-clinical factors have on people's health.

> *"My doctor has helped me and does a lot to make sure I get better. She is one of a few doctors who I would trust with my health concerns. She shows a real interest in caring for my needs."*
> *~ Asian man, Oregon*

Wherever possible, we encourage CMS to think through how TEAM participants and contracted entities can facilitate access to culturally responsive care in primary care and other settings by incorporating and responding to the health needs and cultural beliefs of people with varied cultural origins and identities. Our recent report on culturally responsive care access discusses how lack of understanding about unique population-based needs affects people's access to care and may prevent them from accessing needed health care services, including primary care, due to language barriers or other cultural differences. Without taking these care needs into account, it may prove difficult to ensure that patients maintain a relationship with their primary care provider.

Requiring hospital participation, a concept supported by both the Medicare Payment Advisory Commission and the Congressional Budget Office, will also allow CMS to more fully understand its impact on different patient groups, especially underserved populations, ahead of any further model expansion. **We believe that mandatory participation in this model, as opposed to voluntary participation where adverse selection may limit the usefulness of any collected data, will paint a fuller picture of the model's successes, as well as any shortcomings that can be addressed prior to any potential expansion.**

We also believe that accommodations must be made to support model participants that disproportionately serve underserved populations and avoid the mistakes of previous bundled care models that inadvertently penalized safety-net participants. We are concerned about how two-sided financial risk beginning in year two of the model will affect safety net providers and people's access to care. **While we oppose efforts to carve these would-be participants out of TEAM entirely, we believe participants that meet all safety-net hospital criteria should not be subject to the same requirements as larger, well-resourced hospitals, such as exposure to downside risk, that may impact patient access.**

Beneficiary Engagement
The patient perspective should always play the central role in the transition away from fee-for-service toward patient-first care. It is critical that patients and their caregivers be incorporated before, during, and after a care episode through shared-decision making. We know that people want to be able to understand their health care, but patients are often included in various patient-first care models without their knowledge, complicating these models' effectiveness and failing to share the benefits of these models with patients.

To address this shortcoming, we applaud CMS for thinking comprehensively about how entities contracted with TEAM participants (i.e. accountable care organizations) can work with patients and their caregivers to engage in appropriate beneficiary notification and engagement efforts when "reasonably practical" as patients transition out of hospital care to their primary care provider. Beneficiary and caregiver notification materials that explain a model and how they affect a beneficiary's access to care will allow patients to be more engaged, ensure providers will be better able to gauge patient needs and preferences, and further overall model goals. We encourage CMS to require that beneficiary notification materials under its review be submitted in understandable language and consider offering translation services for English language learners or others for whom English is not their first language. **When developing future models, we also encourage CMS to consider similar engagement strategies with patients and their caregivers *before* a surgical procedure to underscore the importance of shared-decision between patients, their caregivers and providers from beginning to end of a care episode.**

Similarly, we realize that patient and caregiver engagement doesn't just begin and end with care delivery. **Through our research, we know that these valuable perspectives must guide the development, implementation, and evaluation of all care models, including TEAM, to ensure that patient perspectives and lived experiences are incorporated into every step of the process.** The proposed model incorporates patient-reported outcomes to measure TEAM performance and provides incentives, such as preventive care items that advance a clinical goal, for beneficiaries to encourage compliance in their own health care management, both of which help center people within the model.

Beyond the documentation requirements found in the proposed rule, **we encourage CMS to establish data collection requirements that test the effectiveness of these incentives on health care outcomes,** including hospital readmissions, and patient experience, such as beneficiary adherence to care plans. This data, when broken down by demographic group, could be used to inform the design of other beneficiary incentive programs, and in particular, guide the creation of incentives that may disproportionately increase patient engagement with and improve care outcomes for underserved populations.

Finally, we encourage CMS to continue to proactively engage with potentially-impacted people on the front end so their needs are heard and incorporated before a model is fully developed. CMS went to great lengths to engage with stakeholders, experts, and others in soliciting feedback through discussion roundtables and the Request for Information. While patients and their caregivers can respond to the Request for Information just as others can, we urge CMS to make this information more accessible to everyday people. We also encourage CMS to pursue approaches that effectively gather and incorporate beneficiary and caregiver perspectives into model designs, including through community-based partnerships and patient advisory councils.

Conclusion

We look forward to the successful rollout of TEAM and the remainder of the IPPS proposed rule. Pending successful implementation and evaluation, we are hopeful it forms a template for expanding patient-first care throughout the Medicare program as it continues its shift away from the traditional fee-for-service, volume-based payment system.

Thank you for the opportunity to respond to the proposed rule, which will build towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care if finalized. Please reach out to Eric Waskowicz, Senior Policy Manager, at ewaskowicz@usofcare.org, with any questions.

Sincerely,

Lisa Hunter (she/her)
Senior Director for Policy & External Affairs
United States of Care