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June 9, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; the Long-Term Care Hospital Prospective Payment System (CMS-1785-P)

Dear Administrator Brooks-LaSure:

The Society of General Internal Medicine (SGIM) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for fiscal year (FY) 2024 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals. SGIM is a member-based internal medical association of more than 3,000 of the world's leading academic general internal medicine physicians, who are dedicated to improving the access to care for all populations, eliminating health care inequities, and enhancing medical education. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce.

Training in New Rural Emergency Hospitals (REH) Facility Type

To address the growing concern over closures of rural hospitals, Congress established rural emergency hospitals (REH) as a new Medicare provider type, effective January 1, 2023. In response to requests to designate REHs as GME eligible facilities, like the GME designation for critical access hospitals (CAHs), CMS is proposing to allow REHs to be designated as GME training sites.

SGIM strongly supports CMS' proposal to allow medical school residents to train in REHs. The first National Primary Care Report Card released this year has outlined the dire situation of primary care in this country, and this is especially true in rural areas.^{1,2} In order to achieve high quality primary care for every US citizen as outlined in the 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) report on

¹ <https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/>

² [https://www.gao.gov/products/gao-23-](https://www.gao.gov/products/gao-23-106651?utm_campaign=usgao_email&utm_content=topic_health&utm_medium=email&utm_source=govdel)

[106651?utm_campaign=usgao_email&utm_content=topic_health&utm_medium=email&utm_source=govdelivery](https://www.gao.gov/products/gao-23-106651?utm_campaign=usgao_email&utm_content=topic_health&utm_medium=email&utm_source=govdelivery)



“Implementing High-Quality Primary Care,” we must move towards training primary care teams where people live and work.³ SGIM supports allowing medical school residents to train in REHs as an important step to train more physicians in rural community settings. Residents that train in rural settings are far more likely to choose to practice in a rural community.⁴ Additionally, SGIM would support other initiatives to transform physician training programs from urban settings, currently representing the majority of programs, and having more robust training options in rural communities.

Moreover, SGIM recommends that the financial support and resources for such training programs be sustainable and allow residents to fully complete their training without the concern of funding gaps. We aim to ensure continuous financial support for training programs, avoiding any interruptions or breaks in funding as most rural hospitals are unable to financially support residency training positions independently, and thus will rely on federally funded GME resources.

Revise the Hospital Value Based Purchasing Program to Add a Health Equity Adjustment

In this proposed rule, the agency is proposing to add a health equity adjustment to the hospital Value Based Purchasing (VBP) program beginning in FY 2026. CMS believes adding bonus points to the VBP score will encourage hospitals to provide high quality care to dually eligible beneficiaries. **SGIM strongly supports the addition of a health equity adjustment to the VBP score. However, given the known limitations of using dual-eligible status as a marker for underserved patient populations, SGIM recommends that other markers be incorporated as well.** Specifically, similar to the changes to the Medicare Shared Savings Program (MSSP) in the CY 2023 Medicare Physician Fee Schedule (MPFS) final rule, which incorporated dual-eligible status, area deprivation index, and Part D low income subsidy, SGIM recommends that until the evidence base has identified the optimal methods to identify underserved populations, CMS use multidimensional approaches to account for social risk in order to be most sensitive in capturing at-risk beneficiaries. Therefore, SGIM suggests an alternative approach. Rather than basing the health equity adjustment on the ratio of dual eligible

³ <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>

⁴ <https://meridian.allenpress.com/jgme/article/14/4/441/484914/Family-Medicine-Residencies-How-Rural-Training>



inpatient stays out of the total Medicare inpatient stays, we propose it be based on the ratio of inpatient stays for beneficiaries who are either dual-eligible, receive the Part D low-income subsidy, or have an ADI above the 85th percentile out of the total Medicare inpatient stays.

SGIM also supports the methodology being used in the ACO Realizing Equity, Access, and Community Health (REACH) Model, where not only hospitals caring for the highest proportion of underserved patients receive a bonus, but those caring for the lowest proportion of underserved patients receive a penalty. This provides some incentive to care for underserved patients and to avoid “cherry picking.”

Proposed Changes to the Severity of Level Designation for Z Codes Describing Homelessness

CMS is proposing to change the severity level designation for social determinants of health (SDOH) diagnosis codes describing homelessness (Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness)) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC) for FY 2024. Through this change, CMS will recognize homelessness as an indicator of increased resource utilization in the acute inpatient hospital setting. **Consequently, SGIM strongly supports elevating the severity level of homelessness-related diagnosis codes from non-CCs to CCs.**

Homelessness has long been shown to be an independent predictor of increased morbidity and mortality.^{5,6,7} Elevating the severity level of homelessness Z codes thus reflects a crucial step towards ensuring higher quality care for patients facing homelessness and co-occurring health-related social risk factors (HRSRs). If accompanied by an appropriate increase in reimbursement, this change will also confer enhanced financial resources to safety net hospitals, which care for a disproportionate number of patients impacted by HRSRs. Further, more adequate reimbursement should, in concert with recent inpatient quality reporting (IQR) reporting requirements related to SDOH⁸,

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803132/>

⁶ <https://pubmed.ncbi.nlm.nih.gov/29124292/>

⁷ <https://academic.oup.com/ije/article/38/3/877/686657>

⁸ https://qualitynet.cms.gov/files/6206c355c26e150016d4e53e?filename=COVID-19_HCP_Meas_FAQs.pdf



incentivize improved utilization of homelessness-related Z codes, which have been heavily underutilized.^{9,10}

Increased use of these Z codes can help drive meaningful evaluation of the association between these Z codes and outcomes to further refine their appropriate status classifications as CCs, non-CCs, or major complication or comorbidity (MCCs). **Therefore, SGIM believes that any increases in reimbursement tied to the elevation of homelessness Z codes to CC classification must be sufficiently substantial to meaningfully support overstretched and under-resourced safety net institutions and drive enhanced Z code utilization.** Elevating the severity level of homelessness Z codes with only marginal increases in reimbursement will do little to contribute to progress in these domains and be inadequate to support the realization of CMS's stated health equity mission.

Correspondingly, SGIM reiterates the call made in its response to the FY 2023 IPPS proposed rule calling for increased investment in safety net hospitals to support the development of the infrastructure necessary for SDOH data collection and reporting. Ultimately, SGIM believes homelessness-related diagnosis codes are most appropriately classified as MCCs. This view stems from decades of research data documenting associations between homelessness and markedly higher age-adjusted mortality.^{11,12,13} Studies have also linked homelessness to significantly higher rates of hospital utilization and, by extension, substantial excess healthcare costs.¹⁴ Nevertheless, we recognize that the elevation of these codes from non-CC to CC status is a logical and necessary step. **SGIM recommends CMS continue to study the spectrum of Z codes related to homelessness and other HRSRs and urges CMS to continue to consider the appropriateness of MCC designation for these codes.**

⁹ <https://pubmed.ncbi.nlm.nih.gov/32925453/>

¹⁰ <https://pubmed.ncbi.nlm.nih.gov/33350768/>

¹¹ <https://pubmed.ncbi.nlm.nih.gov/8022442/>

¹² <https://pubmed.ncbi.nlm.nih.gov/10191796/>

¹³ <https://doi-org.offcampus.lib.washington.edu/10.1353/hpu.2022.0035>

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/21368678/>



Safety Net Hospitals – Request for Information (RFI)

SGIM appreciates that CMS has made advancing health equity the first pillar in its Strategic Plan. As part of this pillar, the agency is exploring how CMS can support safety net providers, including acute care hospitals that deliver essential services to the uninsured, underinsured, and other populations that face barriers to care. SGIM highly values the opportunity to contribute to the discussion and provide our insights on this important topic. As such, we developed comprehensive responses to address the questions posed in this RFI.

How should safety net hospitals be identified or defined? What factors should not be considered when identifying or defining a safety net hospital and why? What are the different types of safety net hospitals?

SGIM agrees with calls to standardize definitions of safety net hospitals as there is currently a heterogeneous approach that limits generalizability of research and analysis to inform policy making. One of the more widely accepted definitions comes from the National Academy of Medicine, which states that safety net providers are those that “(1) either by legal mandate or explicitly adopted mission they maintain an ‘open door,’ offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.”¹⁵

Before exploring the practical aspects of putting this or other definitions into action, SGIM encourages CMS to dive into a deeper interrogation of the underlying premises and identify opportunities for alignment with the agency’s stated goals of health equity. SGIM is troubled that not all hospitals maintain an “open door” to all patients as this is an inequitable practice. While the opportunity to define safety net hospitals more specifically is important, we would advocate that all hospitals operate with a baseline expectation of non-discrimination. Title VI of the Civil Rights Act prohibits discrimination by any program financed by the federal government including not only intentional discrimination but also disparate-impact discrimination.¹⁶ The presence of safety net

¹⁵ America’s Health Care Safety Net: Intact but Endangered; 2000

¹⁶ <https://www.dol.gov/agencies/oasam/regulatory/statutes/title-vi-civil-rights-act-of-1964#:~:text=No%20person%20in%20the%20United,activity%20receiving%20Federal%20financial%20assistance>



hospitals and the overrepresentation of individuals from racial and ethnic minority backgrounds¹⁷ is evidence of ongoing racial segregation of care.

Defining safety net hospitals can have significant implications. For example, three different definitions, including uncompensated care burden, Medicaid caseload, and facility characteristics, reveal significant differences in hospital demographics and quality outcomes.¹⁸ For this reason, we agree with the analysis provided by Powell et al¹⁹ in a large systematic review of safety net hospital status and definition. The authors argue that unidimensional definitions are “problematic... and not in alignment with modern health equity theory.” They also argue for a framework that includes employment of measures that are independently captured outside of health systems, that is, measures that do not solely rely on Medicaid coverage, uncompensated care, or other hospital characteristics. They also call for a comprehensive definition of disadvantage based on health equity theory, incorporating a multidimensional approach that includes public health measures, contextual-level factors, and individual-level factors aggregated at the hospital level. Moreover, neighborhood-level indices of social risk, such as the ADI, are already in use in various CMS programs, and these indices can be incorporated into safety net hospital definitions to improve measurement precision.

Additionally, safety net hospital definitions should not be binary – there is importance to identifying safety net services rather than safety net hospitals. A “sliding scale” measure of safety net status could prove more valuable.²⁰ **As CMS continues to explore definitions of safety net hospitals, we encourage a multifaceted approach using a breadth of data sources as well as innovative ways to capture the complexity of safety net candidacy. Before implementation, we also support robust analysis of any unintended downstream consequences.**

What are the different types of safety net hospitals? How helpful is it to have multiple types or definitions of safety net hospitals that may be used for different purposes or to help address specific challenges?

¹⁷ Essential Data 2022: Our Hospitals, Our Patients. America’s Essential Hospitals

¹⁸ McHugh et al, Medical Care Research and Review 2009;66(5):590-605

¹⁹ Powell et al, Health Equity 2022;6(1):298-306

²⁰ Chatterjee et al, NEJM 2020;383:2593-2595



SGIM recommends that CMS investigate developing a set of typologies for safety net hospitals. Describing a small, rural hospital and a large, urban county/trauma hospital with the same notation lacks precision, as the needs of their patients are quite different. Therefore, a broader definition of safety net hospitals and the creation of a branching definitional framework would be useful to better compare and understand the needs of different types of hospitals in a more nuanced fashion. For example, the American Hospital Association proposed a designation of “Metropolitan Anchor Hospitals” (MAH) to identify urban centers that provide critical services to low-income community members.²¹ It would be conceivable for this type of designation to fall under the safety net umbrella, alongside something like a critical access hospital (CAH).

Below we have provided several examples of several types of safety net hospitals.²² It is important to note that a given hospital can fall into multiple categories simultaneously, as its classification is not limited to a single category.

- Those that serve a population geographically restricted from other sites of care, such as rural or CAHs;
- Those that serve a population financially restricted from other sites of care, such as uninsured, Medicaid, etc.;
- Those that provide specialty services that are restricted in some way, such as trauma care, burns, psychiatry/behavioral health, etc.; and
- Those that provide essential training services, such as GME programs.

What are the main challenges facing safety net hospitals?

Workforce shortages: While this issue is impacting all sectors of health care, it has an outsized impact on safety net hospitals, which have limited financial resources to successfully recruit from the limited health care workforce pool.

Aligning financial incentives in value-based care programs: Hospital value-based payment programs have historically led to higher financial penalties to safety net hospitals. Such programs must be modified to account for SDOH and factors outside

²¹ <https://www.aha.org/lettercomment/2022-12-01-aha-urges-medpac-consider-current-financial-challenges-faced-hospitals-and-health-systems>

²² Hefner et al. *BMC Health Serv Res* 2021;21 (278).

hospital control, to improve health equity rather than worsen it through penalization of safety net hospitals.²³

Community resources and impact on hospital capacity: Hospital capacity is one of the most straining issues currently impacting safety net hospitals. A key underlying driver of this phenomenon is prolonged patient length of stay (LOS), which has both functional effects on patient access and quality of care as well as financial effects, such as hospitals losing money on an individual case and losing the ability to admit other patients into that bed. In a US nationwide study between 2001-2012, prolonged hospitalizations, defined as longer than 21 days, represented 2% of hospitalizations and 14% of hospital days.²⁴ Prolonged hospitalizations were represented by increasingly younger, male, and minority status patients, and these hospitalizations occurred more frequently in urban, academic hospitals.

While prolonged LOS may be related to increased medical acuity, there is growing evidence that much of this time is spent while the patient is medically ready for discharge.²⁵ Also, safety net hospitals may struggle with securing appropriate post-discharge support to meet the needs of their patients. For example, a retrospective sample from one safety net hospital reported that 28.3% of all hospital days were classified as “alternate level of care” (i.e., did not meet utilization management criteria for inpatient level of care). Patients with prolonged alternate level of care days were more likely to be publicly insured, experience homelessness, and have substance use or psychiatric comorbidities. They were also less likely to be discharged to the community.²⁶

In another safety net hospital, a retrospective study compared successful versus unsuccessful skilled nursing facility (SNF) placement for its patient population. Presence of substance use disorder, Medicaid or uninsured, and homelessness independently predicted SNF referral failure and these patient populations spent significantly more days in the hospital awaiting discharge.²⁷ The underlying reasons for this phenomenon are multifactorial, including insufficiency of local post-acute care sites and staff, SNF-

²³ doi: 10.1007/s11606-022-07698-9

²⁴ Doctoroff L, Hsu D, Mukamal. Am J Med 2017;130(4):483.

²⁵ Bann M, Rosenthal M, Meo N. JHM 2022;17(12):1021-1024

²⁶ Rosenthal M, et al. J Hosp Med 2023; 18(4):294-301

²⁷ Waters K, et al. JGIM 2022 37(13):3506-3508



level fiscal constraints, regulatory complexity, and stigmatization.²⁸ However, safety net hospitals are increasingly called upon to bear the burden of these deficiencies. For example, caring for patients throughout lengthy guardianship processes, housing patients when SNFs turn away patients with stable and medically treated substance use disorders, and keeping patients in the hospital when they could be discharged home if adequate resources for caregiver support were available in the community. Safety net hospitals do this all while receiving egregiously little financial reimbursement for patients with lengthy hospitalizations. For these reasons, hospitals are incredibly dependent on surrounding community-level resources. While funding models aim to increase efficiency and reduce costs, safety net hospitals cannot succeed when patients require community resources beyond the scope of what hospitals can control, and when hospitals are not reimbursed adequately for the daily care for such lengthy hospitalizations.

Is MedPAC's SNI an appropriate basis for identifying safety net hospitals for Medicare purposes? How might it be improved? Should there be a threshold for identifying safety net hospitals using the SNI? Should an area-level index, such as the ADI, be part of an appropriate basis for identifying safety-net hospitals? ++ Would it be appropriate to adapt the risk-factors based scores used in the Shared Savings Program to the identification of safety net hospitals? ++ How might it be adapted?

The MedPAC SNI incorporates three metrics: (1) a hospital's share of low-income Medicare beneficiaries; (2) the share of the hospital's revenue spent on uncompensated care; and (3) the hospital's Medicare share. As discussed above, a unidimensional approach to safety net designation, based on hospital characteristics driven by insurance status, but not accounting for community and patient factors, is inadequate. An area level index, such as ADI, should be incorporated into safety net definitions, incorporating multidimensional approaches to identifying underserved patients and communities. Further, a research and evidence base must be developed to determine optimal methods. **Until that evidence base is established, SGIM continues to recommend using multiple modalities to achieve the most sensitive identification of underserved patients.**

²⁸ Wakeman S and Rich J. *JGIM* 2017;32(1):17-9
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Are there social determinants data collected by hospitals that could be used to inform an approach to identify safety net hospitals? Are there HHS or CMS policies that could support that data collection?

While SDOH screening is important to better understand patient challenges and needs, collecting individual patient-level social determinant data and using it for administrative purposes such as safety net determination is problematic. First, it could increase the mandatory reporting burden on already over-stretched safety net hospitals. Second, such data collection is likely to be incomplete, due to the low uptake of Z codes. The imposition of reporting responsibilities on hospitals, coupled with the establishment of safety net status based on such reporting, could trigger a detrimental cycle that penalizes safety net hospitals. These penalties may arise from difficulties faced by such hospitals in risk adjustment or quality measure reporting, resulting in financial punishment. For these reasons, using area-level indices may prove to be a better approach to prevent additional data collection burden on hospitals.

Should safety net hospitals' reporting burden and compensation be different than other hospitals? If so, how?

Reporting burden is a substantial issue for safety net hospitals, given limited resources. Additionally, current mandatory reporting can be disconnected from the mission of safety net hospitals and the needs of the communities they serve. SGIM has previously advocated for increased standards for safety net and non-profit hospitals in conducting meaningful community needs assessments and acting on the results of such assessments. Quality measures and financial incentives should be tied to the needs identified by the community. Reporting should follow similar requirements. Such assessments, done in partnership with communities and trained staff skilled in qualitative interviews and thematic analysis, can lead to more meaningful quality measures and compensation models that can truly incentivize improving health equity and meeting the needs of communities. Furthermore, patient and community voices must be better represented in the leadership of safety net hospitals. While Federally Qualified Health Center boards must have more than 50% patient representation, safety net hospitals have no such requirements, despite a similar mission to serve patients and communities.



While safety net hospitals remain beholden to traditional quality measures and value-based care arrangements, SGIM continues to advocate that payment models have level playing fields such that safety net hospitals are not unfairly penalized for failing to achieve the same level of reporting and quality measure performance as well-resourced hospitals caring for the affluent and well-insured. The health equity adjustment for the hospital value-based purchasing program in this proposed rule is a welcome start, but more must be done, as outlined in SGIM’s position statement on equity in value-based care.²⁹

SGIM thanks CMS for the opportunity to provide these comments and welcomes the opportunity to discuss these issues further. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

A handwritten signature in black ink that reads 'Martha L. Gerrity'. The signature is written in a cursive, flowing style.

Martha Gerrity, MD, MPH, PhD, FACP
President, Society of General Internal Medicine

²⁹ <https://doi-org.offcampus.lib.washington.edu/10.1007/s11606-022-07698-9>