
**APRIL 28, 2023**

**RE: RFI: "Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals"; Document Number 2023-07389**

To the Centers for Medicare and Medicaid Services:

I write to you in response to your Request for Information on your proposal to modify the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. We are an organization of medical professionals devoted to keeping divisive and un-scientific identity politics out of the practice of medicine.

We are especially concerned with your proposal to force cancer hospitals to make a "commitment" to "health equity" beginning in FY 2026 and adjusting your funding formula accordingly. As most practicing physicians would attest to, one of the leading causes of poor health outcomes for patients is a delay in seeking healthcare treatment. Health equity, like many other terms used in political parlance, sounds wonderful until one examines what it means in practice.

The latest iteration of health equity is built on the false premise that our medical institutions are mired by bigotry, racism, and discrimination. It claims racism and discrimination are major problems in medical professions and the only solution is to implement radical and unsubstantiated policies as "solutions" to those problems. There is no evidence to support the position that America's doctors, nurses, hospitals, and other health care professionals and institutions are racist, sexist, or discriminatory.

I'll focus on a specific problem with your assumptions and methodology. In your rulemaking proposal, you assert (pages 1014-1015) that racial and ethnic minorities on Medicare with heart conditions have lower quality hospital care. One definition of hospital care quality is readmission rates. You conclude that because minorities have higher readmission rates, they are receiving lower quality care—perhaps because they're not being given good guidance on what behavioral changes may prevent readmission. This conclusion is absent any evidence that

doctors and healthcare providers are giving different discharge advice to patients from diverse racial demographics.

You go on to discuss complications from diabetes being more prevalent among minority Medicare patients than white Medicare patients. You use this disparity to justify the significant funding formula changes you propose. However, your assumption that these disparate health outcomes are a direct result of hospital quality of care ignores the possibility of behavioral, genetic, and other variables that are often more prevalent in one group than another.

Villainizing health care providers and making dramatic changes to CMS's hospital funding formulas may therefore be not only a misdiagnosis of public policy ills, but a cure that is worse than the disease. Your proposal moves us yet further in the direction of rationing resources more heavily among one group than another, for reasons completely unsupported by science but enthusiastically backed by political ideology.

It is time to back off from the precipice of disaster and return to the bedrock principles of medical practice: put science over ideology, assess information objectively, and most of all, *do no harm* to our most vulnerable patients.

**Dr. Stanley Goldfarb**
Chairman, Do No Harm