Do No Harm

September 8, 2023

Public Comment Re: "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program"

To the Centers for Medicare and Medicaid Services:

This comment is respectfully submitted regarding the proposed rule CMS–1784–P, which proposes many changes to Payment Policies Under the Physician Fee Schedule in the Medicare and Medicaid programs. We submit this comment as an organization of medical professionals devoted to keeping divisive and un-scientific identity politics out of the practice of medicine.

The proposed rule gives our group of experienced medical professionals great concern in several areas. What should be straightforward updating of various payment policies has instead become just the latest effort by the Biden administration to use critical government services as a carrier for its alleged "health equity" goals.[1] These goals and this proposed rule continue the theme of past rule changes by CMS that abandon sound medical science in favor of dubious political science.[2]

These programs are critical to tens of millions of Americans, including our nation's most vulnerable populations – the elderly, disabled, and poor children.[3] They also cost hundreds of billions of taxpayer dollars each year. They are not programs where wholesale changes in payment should be made without careful consideration for the impact on vulnerable populations.

These safety net programs should never be treated as a playground for political ideology. Physician payment structure is a leading issue when it comes to whether participants in the program receive care.[4] Changes to these structures must be focused one thing – what

[1] https://www.whitehouse.gov/briefing-room/statements-releases/2023/03/09/fact-sheet-president-bidens-budget-advances-equity/
[2] https://donoharmmedicine.org/2023/05/10/do-no-harm-responds-to-the-centers-for-medicare-and-medicaid-services-reimbursement-proposal-to-force-cancer-hospitals-to-commit-to-health-equity/
[3] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet
[4] https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t

is best for patients and not just the furtherance of political "pillars" like "diversity, equity and inclusion."[5–6]

It is very telling, and disturbing, that the CMS press release announcing the rule led with the title, "CMS Physician Payment Rule Advances Health Equity."[7] The focus on this particular aspect underscores the political nature of the proposed rule. The release goes on to mention more important and fundamental changes to the program within the proposed rule, such as increased primary care rates or dental support for cancer patients. However, the administration's focus on the "healthy equity" aspect in the title emphasizes the real reason for the rule – to promote a political goal instead of patient outcomes.

We have several specific issues with the latest proposed rule that governs the Medicaid and Medicare programs. The bottom line is this – the Biden administration has ignored an oath that dates back hundreds of years in the medical field, to "first, do no harm." Instead, the focus on race and equity further perpetuates the tired untruth of the Biden administration that medical institutions are mired by bigotry, racism, and discrimination that need to be "fixed" through market manipulation and social engineering.[8]

Specifically, the rule:

1) Establishes new billing codes for which the express purpose is to fulfill the CMS "pillars," or goals, of diversity, equity and inclusion;

2) Includes enhanced payments for certain populations, based on factors other than health alone, likely in violation of the Civil Rights Act;

3) Creates a "health equity adjustment" that only has an upside;

4) Institutes variable payments based solely on "race and ethnicity."[9]

Each one of these problems represents a significant departure from where medical practice and public policy should be centered. Instead of putting each patient as the focus, this proposed rule would twist payment methodology to incentive and reward providers for providing services to one population over another on factors outside of health. This is wrong.

One of the new codes created within this proposed rule seems to be in violation of the Social Security Act. One of the clear tenets of the Act is that:

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[5] https://www.cms.gov/cms-strategic-plan
[6] https://www.cms.gov/files/document/dei-strategic-plan-external-strategy.pdf
[7] https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-advances-health-equity#:~:text=%E2%80%9CCMS'%20proposals%20in%20the%20proposed,performed%20by%20community%20health%20workers.%E2%80%9D
[8] https://donoharmmedicine.org/2023/05/10/do-no-harm-responds-to-the-centers-for-medicare-and-medicaid-services-reimbursement-proposal-to-force-cancer-hospitals-to-commit-to-health-equity/
[9] https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

> *"No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."*

However, the proposed rule seeks to establish a brand-new billing code for "social determinants of health" that will undoubtedly cost taxpayers significantly and is designed for a dubious reason.[10] As CMS states in the proposal, this new code is meant to, "support HHS's Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity, as well as the CMS Framework for Health Equity." CMS should stick to the law and spend tax dollars solely to diagnose or treat illness or injury, not deputize the medical community to also become race-obsessed social workers in the exam room.

The proposed rule also doubles down on bad policy from an earlier rule.[11] The rule proposes to give Accountable Care Organizations an increased payment for providing more service to a "higher proportion of underserved beneficiaries."[12] So the quality performance score, which means more money for ACOs, would be "upwardly adjusted" if they are "serving a high proportion of underserved beneficiaries."[13] Who are the "underserved beneficiaries?" According to Biden's executive order in 2021, "underserved communities are:

> *"Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."*[14]

In plain language, this proposal would directly financially incentivize ACOs (providers) to provide more services to people of certain races, sexualities, and religions, which is in direct violation of the Civil Rights Act of 1964.[15] Especially for providers who are already stretched thin and seeing every patient they can, pushing individuals to the front of the line based on any factor other than health is morally wrong, on top of being illegal.

This proposed rule continues a recent trend by CMS to reward value and quality by increasing payments to ACOs and specifically for the "underserved population."[16] Recent rules have threaded this strategy throughout various programs and payment methodologies, including nursing homes.[17] There is nothing wrong with paying for quality

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[10] https://www.federalregister.gov/d/2023-14624/p-659
[11] https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other
[12] https://www.federalregister.gov/d/2023-14624/p-1520
[13] https://www.federalregister.gov/d/2023-14624/p-3831
[14] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/
[15] https://www.dol.gov/agencies/oasam/civil-rights-center/statutes/civil-rights-act-of-1964#:~:text=The%20Civil%20Rights%20Act%20of%201964%20prohibits%20discrimination%20on%20the,hiring%2C%20promoting%2C%20and%20firing.
[16] https://www.federalregister.gov/d/2023-14624/p-2916
[17] https://www.federalregister.gov/documents/2023/08/07/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

results for patients. However, to prioritize certain populations based on race, sexuality, or religion is wrong. Despite being one of the largest budget items in the country at a time of significant debt, we are not opposed to paying for quality care. We are opposed to paying providers more to serve a certain race. And so would the Supreme Court be should a case present itself to them. The Biden administration should shelve this ill-fated proposal before it meets its end through litigation.

The final issue we take with this rule is maybe the most egregious. The rule contemplates variable payments for factors such as "race/ethnicity" to further the health equity goals of the Biden administration. This particular proposal takes the insanity to another level, proposing to populate quality and payment data with lunacy such as "Surname Geocoding" to determine metrics.[18]

While it's unclear exactly what this data would produce for change in payments, it's clear that CMS means to use the data to produce a payment based on billing or outcomes. This method is derived by taking data from a "set of six racial and ethnic probabilities" to estimate "the percentage of discharges for each specified racial/ethnic category for each hospital by taking, the sum of the probabilities for that category for that hospital and dividing by the hospital's total number of discharges."[19] Under no scenario should our nation's largest health care programs be divvying up quality payments or billing based on "racial and ethnic probabilities." But that is exactly what is being proposed.

As a group of medical professionals, we are appalled by data and criteria that promote certain races and ethnicities over certain risk groups or ailments. Just as Lady Justice is supposed to be blind to the accused, medicine is supposed to look only to helping and healing. The Biden administration's proposals, this proposed rule included, to elevate one race over another is a travesty and counter to the oath we took to "do no harm." We ask that this payment rule be reconsidered with a blind eye towards race, and with a renewed focus on the health and wellness of **all Americans**, no matter what "population" or "community" they are from.

Respectfully submitted,

Stanley Goldfarb, M.D.

Chairman

[18] https://www.federalregister.gov/d/2023-14624/p-3834