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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS),
Department of Health and Human Service
P.O. Box 8013
Baltimore, MD 21244–8013

Attention: CMS–1808–P

Re: CMS’s proposed rule: Hospital Inpatient Prospective Payment
Systems for Acute Care Hospitals and the Long-Term Care Hospital
Prospective Payment System CMS-1808-P (RIN 0938–AV34)

Dear Administrator Brooks-LaSure:

On behalf of the over 16,000 members of the American Thoracic
Society (ATS), we appreciate the opportunity to submit comments
on CMS’s proposed rule: Hospital Inpatient Prospective Payment
Systems for Acute Care Hospitals and the Long-Term Care Hospital
Prospective Payment System CMS-1808-P (RIN 0938–AV34).
Specifically, The ATS would like to comment on the § 512.598
Decarbonization and Resilience initiative. ATS strongly supports
CMS’s efforts to solicit voluntary Transforming Episode
Accountability Model (TEAM) participant greenhouse gas (GHG)
emission metric reporting.

As background, the American Thoracic Society is a medical
professional society of physicians, scientists, nurses, respiratory
therapists and allied health professionals dedicated to prevention,
detection, treatment and cure of pulmonary disease, critical care
illness and sleep disordered breathing. In short, we are lung
experts. As lung experts, ATS members are acutely aware of GHG
and Environmental Protection Agency (EPA) criteria pollutant
emissions from the healthcare sector. The ATS supports CMS’s
regulatory efforts to utilize available reporting metrics and CMS
existing public reporting infrastructure to solicit TEAM participant
GHG emissions starting in fiscal year 2026-2030. As experts on lung
health, we offer the following comments:

**1. Healthcare systems are significant contributors to greenhouse
gas emissions.**

Human activities significantly contribute to climate change through
the burning of biomass fuels and the resulting greenhouse gas
emissions. Experts warn that a global temperature rise of 1.5°C
above pre-industrial levels will cause enduring and irreversible
damage to ecosystems and adversely affect human health.^{1,2} The

Intergovernmental Panel on Climate Change (IPCC) states that without immediate and substantial emission reductions across all sectors, limiting global warming to 1.5°C or even 2°C will not be feasible.³ As stated in the proposal,

healthcare delivery is a notable source of greenhouse gas emissions, encompassing direct emissions from healthcare operations (such as emissions from anesthetic gases and emissions from vehicles owned, leased, or operated by healthcare facilities), emissions from purchased energy, and emissions associated with the supply chain of healthcare services and products.^{4,5} In total, the U.S. health sector accounts for approximately 8.5% of the nation's GHG emissions, highlighting the need for effective strategies to significantly reduce these emissions from the healthcare sector.⁵ The generation of harmful EPA criteria air pollutants partly depends on greenhouse gas emissions. Increases in global temperatures from these emissions directly raise levels of criteria pollutants like ozone and fine particulate matter $\leq 2.5 \mu\text{m}$ (PM_{2.5}), due to accelerated atmospheric photochemical reactions that produce ozone and more frequent wildfires that release large quantities of PM_{2.5}.⁶ The healthcare sector is uniquely positioned at the crossroads of greenhouse gas and air pollutant production and the treatment of patients who are most vulnerable to the impacts of these emissions. With its public reporting infrastructure, CMS is well-placed to gather data on emissions related to healthcare and steer positive changes within the healthcare system.

2. Greenhouse gas and EPA criteria air pollutant emissions have significant adverse pulmonary health effects, and low-income, Black, Hispanic, and Native American communities are disproportionately affected.

Climate change poses a significant threat to human health and this threat is unequally distributed across low-income communities and Black, Hispanic, and Native American communities. As such, the climate crisis has also been described as an equity crisis.⁵ Individuals with respiratory diseases are particularly at risk from the adverse effects of climate change.⁷ As previously mentioned, GHG emissions contribute to increased levels of air pollutants like PM_{2.5} and ozone, which are associated with a rise in respiratory disease cases and severity.^{6,8,9} Nationally, PM_{2.5} exposures that exceed ATS recommendations are linked to approximately 20,400 deaths, 10,950 emergency room visits, and 1,760,000 lost workdays annually.¹⁰ Similarly, ozone levels above ATS recommendations are associated with an estimated 11,900 deaths, 64,210 emergency room visits, and 6,800,000 lost school days annually.¹⁰ Notably, emissions from wildland fires alone are estimated to cause around 40,673 deaths, 16,430 emergency room visits, 2,550,000 lost workdays, and 692,000 lost school days annually.¹⁰ Additionally, higher average temperatures and extreme weather events are likely to intensify and prolong wildfire and pollen seasons, posing significant risks in spring, summer, and fall, especially for those with respiratory conditions.⁷ The predicted rise in sea levels and flood frequency may also lead to increased mold exposure, further contributing to the respiratory disease burden.⁷

Globally, the majority of GHG emissions are sourced from those most able to afford climate adaptation strategies, exacerbating inequity and climate injustice. In the US, a higher percentage of Black, Hispanic, and non-White individuals reside in warmer areas with less vegetation resulting in higher ambient temperatures and often lack air conditioning as a climate adaptation strategy.¹¹ Moreover, lower income and non-white communities are frequently situated near roads with high levels of traffic-related air pollution, which climate change intensifies.¹¹ Consequently, Black, Hispanic, Native American, populations face a higher risk of diseases like temperature-related asthma and increased cardiorespiratory morbidity.^{11,12} Addressing health disparities is a critical goal of the TEAM initiative and the § 512.598 Decarbonization and Resilience plan will further help address these disparities.¹³

With the above information as context, the ATS offers the following policy recommendations for CMS to consider as it moves forward to finalize the § 512.598 Decarbonization and Resilience initiative:

1. ATS supports the CMS initiative to implement and help guide voluntary TEAM participant carbon emission metric reporting.

Experts have previously advanced the prospect of integrating decarbonization efforts into existing public reporting initiatives such as those administrated through CMS.¹⁴ The proposed initiative plans to collect standardized data for scope 1 and 2 emissions. Voluntary participants would report total GHG emissions from anesthetic gases normalized for anesthetic hours as measured by purchase records. They would also report transportation metrics including gallons of gasoline used for owned and leased vehicles. Building energy metrics would be reported based on ENERGY STAR[®] PortfolioManager[®] guidelines. This is an important first step for measuring and reporting healthcare-related scope 2 emissions through a program already used by 3500 US hospitals.¹⁴ Another highlight of the proposal is the collection of assessment questions based on key actions recommended for reducing scope 1 emissions as well as questions regarding TEAM participant sustainability team and sustainability activities. This along with individualized feedback reports comparing sites to aggregate TEAM participant facilities may help foster a culture of change and quality improvement within voluntary participant sites.

2. ATS urges developments in scope 3 emissions reporting and further incentivization for total GHG reporting.

It is estimated that 80% of GHG emissions from healthcare are from scope 3, supply chain related sources.¹⁵ Thus, there is a need for further collection of sophisticated metrics that reflect supply chain emissions.¹⁵ One particular strategy could be developing scope 3 emissions inventories by implementing elements of EPA's Practical Guide as promoted by Health and Humans Services Office of Climate Change and Health Equity.¹⁶ To this end, results of White House/HHS Health Sector Climate Pledge signatory reported inventories of scope 3 emissions planned for the end of 2024 may be further informative.¹⁶

ATS applauds CMS's proposed recognition for TEAM voluntary reporting through a hospital recognition badge to be publicly reported on a CMS website. Previous CMS managed programs such as the Hospital Value-Based Purchasing Program financially incentivizes quality healthcare. It can be argued that lowering GHG emissions should be viewed as a quality metric as it would likely improve population health and lower health care costs.¹⁵ However, we recognize that healthcare organizations grapple with competing priorities and added reporting may be onerous.¹⁴ Given that the reduction of GHG emissions is an urgent matter, innovation to further incentivize voluntary reporting is suggested to further the goals of this CMS proposal.

In summary, the ATS appreciates the opportunity to comment on this important rule to address climate change. The ATS urges CMS to finalize and implement the § 512.598 Decarbonization Resilience initiative. The health of our patients and our planet depends on it.

Sincerely,



Irina Petrache MD, ATS
President
American Thoracic Society



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