Leading for Better Health

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1809-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-1809-P. Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; etc.; Proposed Rule, July 22, 2024

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 235 member hospitals, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Outpatient Prospective Payment System proposed rule for calendar year (CY) 2025.

HAP and its member hospitals share the American Hospital Association's concerns regarding the payment updates proposed for outpatient hospital services for the upcoming year. Many hospitals in Pennsylvania continue to operate on negative or very thin margins. Failing to account for consistently high and rising operational costs poses significant risk to the viability of hospitals and patients' access to care.

We were encouraged to see CMS' consideration of the impact of the four walls requirement for Medicaid clinic services and are hopeful that if the agency's proposal is finalized, it will result in more robust treatment options for individuals in Pennsylvania.

In addition, we incorporate, by reference, all the comments provided in the American Hospital Association's response to the proposed rule.

Thank you for your consideration of HAP's comments regarding this proposed rule. If you have any questions, contact **me** at (717) 561-5317.

Sincerely,

Kate Slatt
Vice President, Innovative Payment and Care Delivery

Attachment

HAP Comments—Outpatient Prospective Payment System
Proposed Rule for Calendar Year 2025

OPPS UPDATE AND LINKAGE TO HOSPITAL QUALITY DATA REPORTING

The calendar year (CY) 2024 Outpatient Prospective Payment System (OPPS) conversion factor is $87.382. To calculate the proposed conversion factor for CY 2025, CMS adjusted the 2024 conversion factor by the fee schedule increase factor and made further adjustments for various budget neutrality factors. The fee schedule increase factor equals the proposed hospital market basket increase factor of 3.0 percent, reduced by a statutorily required productivity adjustment of 0.4 percentage points. Thus, CMS applies the resulting fee schedule increase factor of 2.6 percent for the CY 2025 OPPS proposed rule.

Hospitals that do not meet outpatient quality reporting (OQR) program requirements are subject to a reduction of 2.0 percentage points, resulting in a proposed fee schedule increase factor of 0.6 percent. Thus, the proposed CY 2025 OPPS conversion factor is $89.379 for hospitals meeting OQR requirements and $87.636 for hospitals not meeting OQR requirements. The increase in spending due only to changes in the 2025 OPPS proposed rule is estimated to be approximately $5.2 billion or 2.4 percent. CMS also estimates spending increases taking into account estimated changes in enrollment, utilization and case mix; for 2025, it estimates that such OPPS expenditures, including beneficiary cost-sharing, would be approximately $88.2 billion, which is also approximately $5.2 billion higher than estimated expenditures in 2024.

HAP is extremely disappointed that CMS has again proposed an inadequate update to hospital payments. The mere 2.6 percent increase for outpatient hospital services is simply not enough to help hospitals in Pennsylvania and across the country that continue to operate on negative or very thin margins. Providing quality care and investing in their workforce are only becoming more challenging and more costly; in many rural areas and other places hospitals' and health systems' ability to continue caring for patients and providing essential services for their communities is in jeopardy, and we strongly urge CMS to provide additional financial support in the final rule.

DATA PROPOSED FOR USE IN CY 2025 OPPS and ASC RATE SETTING

To set proposed OPPS and Ambulatory Surgical Center (ASC) payment rates, CMS is proposing to use the most updated cost reports and claims data available. Therefore, the agency proposes to use the CY 2023 claims data and the most updated cost report extract available from the Healthcare Cost Report Information System.

HAP applauds CMS' plan to use the most current data available, however we have significant concerns that while this data is available, it does not truly reflect the reality of what hospitals have been and still are currently experiencing. The proposed OPPS rates are based on CY 2023 claims data and CY 2022 cost data. It has been well documented that hospital operating expenses driven up during the COVID-19 pandemic have stayed inordinately high and are directly affecting hospital finances; these include high volume, high dollar items such as labor and

certain medical supplies. We encourage CMS to relook at these factors and make an adjustment to give them greater consideration in the final rule payment update.

MEDICARE'S SITE-NEUTRAL PAYMENT POLICIES

In this rule, CMS proposes to continue its payment cuts for non-grandfathered (non-excepted) off-campus provider-based departments (PBD) in CY 2025 identifying payment at 40 percent of the OPPS rate.

While CMS proposes to continue to pay for hospital outpatient clinic visit services furnished in grandfathered off-campus PBDs at 40 percent payment amount, it will continue to exempt excepted off-campus PBDs of rural sole community hospitals from this clinic visit payment policy.

We continue to strongly believe CMS has undermined clear Congressional intent and exceeded its legal authority, despite the U.S. Supreme Court declining to review the unfavorable ruling by the appeals court that deferred to the government's inaccurate interpretation of the law.

HAP reiterates its comments from the previous years' proposed rule and incorporates, by reference, all the comments provided in the American Hospital Association's response to the proposed rule. We continue to urge CMS to:

1. ***Immediately restore the higher payment rates for clinic visits furnished by excepted off-campus PBDs that existed before CMS adopted the unlawful payment cuts.***
2. ***Promptly repay hospitals the difference between the amounts they would have received under those higher rates and the amounts they were paid under the unlawful payment rates.***
3. ***Abandon the proposed continuation of the payment cut in 2025.***

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

In the proposed rule, CMS indicates that it would add four measures to the Hospital Outpatient Quality Reporting Program.

Proposed Adoption of the Hospital Commitment to Health Equity Measure

Beginning with the CY 2027 payment determination (data reporting in CY 2026 reflecting performance in CY 2025), CMS proposes to adopt this structural measure that assesses whether a hospital-based outpatient department (HOPD) demonstrates certain equity-focused organizational competencies.

Proposed Adoption of the Screening for Social Drivers of Health Measure

Beginning with voluntary reporting in CY 2026 of data collected in CY 2025 and required reporting in CY 2027 of data collected in CY 2026 data (to inform the CY 2028 payment determination), CMS proposes to adopt this structural measure that evaluates whether HOPDs are screening patients for certain health-related social needs (HRSN). CMS explains that HOPDs could use a self-selected screening tool to collect data.

Proposed Adoption of the Screen Positive Rate for Social Drivers of Health Measure

Beginning with voluntary reporting in CY 2025 of data collected in CY 2024 and required reporting in CY 2026 of data collected in CY 2025 data (to inform the CY 2028 payment determination), CMS proposes to adopt this measure that assesses the percent of patients 18 and older who were screened for the HRSNs and screened positive for (i.e., reported that they experienced) one or more.

HAP joins the AHA in its commitment to addressing the impact of social drivers on health. HAP supports hospitals across Pennsylvania through its Racial Health Equity Learning Action Network where hospitals are working collaboratively to advance efforts to capture and use data on social determinants of health.

REMOTE SERVICES

Outpatient Therapy, Diabetes Self-management Training, and Medical Nutrition Therapy

There are several important remote health care services that risk disruption without Congressional action. These services, which include outpatient therapy, diabetes self-management training, and medical nutrition therapy, were allowable remotely under CMS' Hospital Without Walls policy. During the COVID-19 Public Health Emergency (PHE), CMS created this policy to allow hospitals to reclassify patient's homes as temporary extension sites during the state of emergency.

In-person Visits for Mental Health Services Furnished by Telehealth Service

In the CY 2024 rule, CMS extended the policy through the duration of CY 2024. However, the statutory waivers enabling this extension will expire at the end of the year. CMS proposes to align policies with any Congressional action but proposes no other solution in the absence of it.

The end of statutory waivers is also quoted as an obstacle to continuing the waiver of the Consolidated Appropriations Act (CAA) 2021 requirements of an in-person visit six months prior to the administration of remote mental health services and annually thereafter.

HAP has significant concerns about a potential impact in the event that Congress fails to act to ensure these important services remain accessible to beneficiaries. HAP urges CMS to evaluate all possible avenues to maintain all current waivers that have benefited both patients, providers, insurers, and others significantly since the beginning of the PHE.

Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive CR (ICR), and Physical Rehabilitation (PR) Services and Diagnostic Services

CMS proposes to extend the currently virtual supervision flexibilities allowing for direct supervision to be furnished via two-way, audio/visual communication technology for CR, ICR, and PR services and diagnostic services in accordance with CAA 2023 through December 31, 2025.

HAP strongly urges CMS to permanently allow direct supervision via audio/video technology.

HAP is encouraged by CMS' continued efforts related to making telehealth services accessible to its beneficiaries. HAP urges CMS to continue to make broad, permanent adoption of any services that were acceptable during the pandemic, given that only services that did not pose significant patient safety concerns were added to the list during this time.

PROPOSED CHANGES TO MEDICAID CLINIC SERVICES FOUR WALLS EXCEPTIONS

CMS proposes to add three exceptions to the four walls requirements for Medicaid clinic services: a mandatory exception for Indian Health Service/Tribal clinics and optional exceptions for behavioral health clinics and clinics located in rural areas. These changes would revise the current policy, which only pays for Medicaid clinic services provided outside of the four walls of a clinic when provided to unhoused individuals. These changes could improve access to services for eligible individuals in certain settings. CMS is seeking input on defining rural areas, including whether to defer to states to define what areas are considered rural.

HAP appreciates the agency's proposal to add exceptions to the four walls requirements and expand access to behavioral health services and rural clinic services. This consideration is necessary in Pennsylvania and stands to support our most vulnerable populations. We encourage CMS to continue to think about how best to strike a balance between concerns regarding fraud, waste, and abuse and access to vital and cost-effective services.

PROPOSED CHANGES TO THE REVIEW TIMEFRAMES FOR THE HOPD PRIOR AUTHORIZATION PROCESS

CMS proposes to change the review timeframe for prior authorization (PA) requests for HOPD services covered by the OPPS prior authorization process from 10 business days to seven calendar days for standard reviews. For example, if a standard request is submitted on a Tuesday, June 2, under the new timeframe, a decision must be rendered by the next Monday, June 8, whereas under the old timeframe, the decision must be rendered by Monday, June 15.

The CMS Interoperability and Prior Authorization final rule shortened PA timeframes for certain payors, including Medicare Advantage organizations. It requires impacted payors to send PA decisions as expeditiously as the enrollee's health condition requires or as the beneficiary's health condition requires, but no later than 72 hours for expedited requests and seven calendar days for standard requests. Under the current OPPS PA program, providers must submit to the Medicare Administrative Contractor (MAC) a PA request for any service on the list of outpatient department services that require prior authorization. Upon receipt of the prior authorization request, the MAC should review it and issue a decision within specific timeframes, which are listed in the regulation text. While the OPPS is not an impacted payor under the CMS Interoperability and Prior Authorization final rule, CMS proposes to align its Medicare OPPS PA review timeframe for standard review requests for HOPD services with the timeframe in that final rule. CMS currently requires PA for: blepharoplasty, rhinoplasty, botulinum toxin injections, panniculectomy, vein ablation, cervical fusion with disc removal, implanted spinal neurostimulators, and facet joint interventions. This change would not only streamline the PA processes so that they are the same across payors but also would help to reduce provider burden by having the same timeframe and reducing the potential for delays in care by decreasing the time beneficiaries and providers wait for prior authorization decisions on standard requests in the OPPS.

HAP is supportive of CMS' efforts to standardize and shorten timeframes for payor responses to HOPD prior authorization requests. This change improves access to care for patients and reduces administrative burden for providers. We applaud this effort and encourage similar consideration of other opportunities to streamline payor practices.