September 13, 2022 ***e-comment submitted electronically***

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS 1772-P
7500 Security Boulevard
Baltimore, MD, 21244-1850

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating (CMS-1772-P)

Dear Administrator Brooks-LaSure:

The Tennessee Hospital Association (THA), on behalf of its over 140 healthcare facility members, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed calendar year (CY) 2023 Outpatient Prospective Payment System (OPPS) rule, CMS-1772-P.

Payment Update

For CY 2023, CMS proposes a market basket update of 3.1 percent, less a productivity adjustment of 0.4 percentage points resulting in a hospital outpatient update of 2.7 percent. Like many other CMS proposed rules, this update has not appropriately taken inflationary cost factors into account. With the continuation of the public health emergency (PHE), increased costs due to shifts in labor markets, disruptions to the vital supply chains, and with inflation recently reported as high as 8 percent, operating costs for our facilities have drastically increased.

The historical data used to estimate the market basket update has too much time-lag to adequately capture the unprecedented inflationary environment hospitals still are experiencing. Using more recent data, we see that the market basket for CY 2022 is trending toward 4.8 percent, well above the 2.7 percent OPPS update implemented in the CY 2022 final rule. Additionally, while CMS proposes a productivity cut of 0.4 percentage points, the latest data indicates decreases in productivity, not gains.

Tennessee hospitals continue to struggle with many challenges that threaten their ability to care for patients and provide essential services to their communities. These challenges include extraordinary inflation expenses hospitals are being forced to absorb related to supporting their workforce while experiencing severe staff shortages. According to a recent report from the American Hospital Association (AHA), nationally, hospital labor expenses per patient are up 19.1 percent from 2019 pre-pandemic levels. Labor expenses account for more than 50 percent of hospitals' total expenses. At the same time, drug expenses have increased 36.9 percent on a per patient basis and medical supplies have increased 20.6 percent.

In Tennessee, the demand for nurses has increased 74 percent since May 2022, and we are heading into the fall, where in the past two years, our hospitals have seen significant increases in COVID-19 cases, higher turnover, and higher demand for nurses. In order to maintain staffing levels to continue providing quality care, hospitals have invested significantly. One hospital reported investing over $7 million to retain the staff they have, and another has increased their average hourly wage over 26 percent since the start of the pandemic. Contract labor costs have increased over 100 percent, and in many cases have topped 200 percent. Increased costs in other areas, such as increases in drugs, fuel, and supplies only exacerbate hospital finance challenges. Hospitals are reporting inflationary increases in supplies from 3 percent to 10 percent. Freight costs are up 10-20 percent due to fuel costs.

Because this high rate of inflation is not projected to subside soon, it is critical to account for these challenges when considering hospital and health system financial stability in FY 2023 and beyond. **THA urges CMS to consider additional funding opportunities to account for these increased costs, reduce the productivity cut for CY 2023 to better align with actual losses in productivity during the PHE, and increase the market basket to match the experienced costs of hospitals more closely.**

Outpatient Clinic Visits in Excepted Off-Campus Provider-Based Departments (PBDs)

CY 2023 Site-neutral Payment in Non-grandfathered (Non-excepted) Off-campus PBDs.

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) requires that services, with the exception of dedicated emergency department (ED) services, furnished in off-campus provider-based departments (PBDs) that began billing under the OPPS on or after Nov. 2, 2015, or that cannot meet the 21st Century Cures "mid-build" exception, will no longer be paid under the OPPS but under another applicable Part B payment system.

For CY 2023, the agency continues to identify the Physician Fee Schedule (PFS) as the applicable payment system for most of these non-grandfathered (non-excepted) services and sets payment for most non-grandfathered (non-excepted) services at 40 percent of the OPPS rate. **By continuing the cut, CMS has undermined congressional intent and exceeded its legal authority, despite the U.S. Supreme Court, on June 28, declining to review the unfavorable ruling by the appeals court that deferred to the government's inaccurate interpretation of the law. We continue to urge the agency to withdraw this policy.**

Proposed Exemption of Rural SCHs from Site-Neutral Payment Reductions for Outpatient Clinic Visits in Grandfathered (Excepted) Off-campus PBDs.

In the CY 2023 proposed rule, CMS indicates that it has continued to assess how the site-neutral policy has been implemented and how it affects both the Medicare program itself and the beneficiaries. There are a number of special payment provisions designed to maintain access to care in rural sole community hospitals (SCHs) including the 7.1 percent increase in payment for all services and procedures to compensate them for their higher costs relative to other OPPS hospitals and their exemption from CMS' policy to reduce payment for 340B program drugs from ASP plus 6 percent to ASP minus 22.5 percent. Often rural providers, SCHs in particular, are the only source of care in their communities. The closure of inpatient departments of hospitals and the shortage of primary care providers in rural areas further drives utilization to off-campus PBDs in areas where rural SCHs are located.

For these and other reasons, CMS believes that exempting rural SCHs from being paid a PFS-equivalent rate for a clinic visit in an off-campus PBD would help to maintain access to care in rural areas. Therefore, for CY 2023, CMS proposes to pay the full OPPS payment rate, rather than 40 percent of the OPPS rate, when a clinic visit is furnished in a grandfathered (excepted) off-campus PBD of a rural SCH.

As we discuss above, THA continues to urge CMS to reverse its policy of reducing payment for clinic visits in excepted off-campus PBDs of *all* hospitals. **However, if CMS declines to do so, THA strongly supports CMS' proposal to exempt excepted off-campus PBDs of rural SCHs from the site-neutral payment reductions outpatient clinic visit services.** THA also supports the exclusion of off-campus PBDs of Medicare Dependent Hospitals, should Congress act to extend the program past Oct. 1, 2022. CMS would be supporting the ability of these critical providers to continue to maintain access to care in their rural communities.

Prior Authorization

Citing authority under section 1833(t)(2)(F) of the Social Security Act, in an effort to control unnecessary increases in the volume of covered OPD services, specifically blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation in the CY 2020 final rule, CMS adopted a prior authorization process when furnishing these services to ensure that Medicare is only paying for these services when medically necessary.

In the CY 2023 proposed rule, CMS is proposing to add a new service category to this policy: Facet Joint Interventions. The requirement for this service category would begin for dates of service on or after March 1, 2023. THA appreciates CMS' more researched justification for adding a new service category to its prior authorization process**. However, we oppose the application of prior authorization for facet joint intervention services, as:**

- **the increased utilization of these services has other appropriate yet underexplored, justifications;**

- **data reveal that utilization levels of these services have already recessed; and**
- **there are other oversight mechanisms available to CMS that do not inappropriately delay care.**

THA urges CMS not to finalize this policy and if CMS continues to believe additional controls are necessary, we recommend improving existing oversight mechanisms and enhancing education on Medicare payment policy for providers, physicians, and billing and coding teams. Doing so would be a more appropriate way to help ensure that medically necessary care is provided, without introducing avoidable delays in patient care.

We also urge CMS to require clear explanations for data-driven justifications by other healthcare plans that CMS has authority over, including Medicare Advantage and plans on the Federal Exchange.

Rural Emergency Hospital Proposals

Our rural community hospitals serve as anchors for their area's health services, even though they struggle with remote locations, limited workforce, and constrained resources. They provide essential acute services, prevention and wellness services, as well as community outreach and employment opportunities. Many of these hospitals are currently fighting to survive — especially in the high inflationary and workforce shortage environment hospitals have been operating under —leaving their communities at risk for losing vital access to local healthcare services. To support rural communities, Congress established a new Medicare provider type, the Rural Emergency Hospital (REH), which would allow a facility to maintain a medical presence by providing emergency hospital services for Medicare payment without the need to furnish acute care inpatient services. **THA appreciates CMS issuing several rules to implement this new designation as our hospitals are eager to evaluate the conversion. We urge CMS to provide further guidance on key issues in a timely manner so that rural hospitals have enough time and necessary information to formulate informed decisions.**

REH Payments

Under statute, REHs must be paid 105 percent of the OPPS rate for covered outpatient services, plus an additional facility payment. The agency proposes a monthly facility payment of $268,294 for CY 2023 – approximately $3.2 million annually – and is soliciting comments on the methodology used to determine the facility payment for CY 2023. The additional facility payment for 2023 is calculated as the excess of the actual total amount paid to all critical access hospitals (CAHs) in 2019 over what would have been paid had payments been made under the applicable prospective payment systems (i.e. the projected Medicare payment for inpatient, outpatient, and skilled nursing facilities PPS), divided by the total number of critical access hospitals in 2019. For 2024 and subsequent years, the facility payment would be increased by the hospital market basket percentage.

THA believes an important part of Medicare, Medicare Advantage (MA), was not included in the calculations and urges the agency to evaluate whether these payments should be, given the growing share of patients covered by MA plans.

THA strongly urges CMS to publish a more detailed methodology of its additional facility payment calculations. Without this information, stakeholders are not fully able to replicate and evaluate the agency's methodology. Specifically, we urge CMS to publish its calculations of CAH actual and projected Medicare spending for CY 2019 broken down by provider category (inpatient hospital, inpatient rehabilitation, inpatient psychiatric, outpatient hospital, and skilled nursing (hospital-based and swing bed)). While the agency provided the aggregate figures across all payment systems, stakeholders, especially those considering converting, need to understand the role each payment system plays in the calculation of actual and projected spending in order to properly evaluate and comment on the agency's proposed methodology.

REHs are required by statute to maintain information on how they have used their additional facility payments. CMS is proposing that this requirement be met using existing cost report requirements on outpatient services. **We agree with this proposal and believe that REHs should not be required to report new data and information to meet this requirement.**

REH and Covered Outpatient Department Services

The statute defines "REH services" as ED and observation services as well as, at the election of the REH, other medical and health services furnished on an outpatient basis as specified through rulemaking. In this rule, CMS is proposing to define REH services as all covered outpatient department services that would be paid under the OPPS; the agency would pay the applicable OPPS payment plus an additional 5 percent payments for these services. **We support this proposal.** The specific care needs in rural communities are diverse and the current proposal gives an opportunity for REHs to best serve the needs of their communities, allowing all services under the OPPS to be furnished, as well as to be paid for under the statutory rate.

In addition, we strongly agree with the agency's proposal to not apply Section 603 site-neutral rates to REHs. Under this policy, certain non-excepted off-campus PBDs are reimbursed a PFS-equivalent rate of 40 percent of the OPPS rate. CMS recognizes that if a CAH becomes an REH, and as a result becomes subject to the Section 603 amendments, it would experience a significant decrease in payment for items and services furnished by its off-campus PBDs. This would create a financial disincentive for CAHs to convert to REHs and would therefore be contrary to the congressional intent for creating this new provider type.

CMS proposes that outpatient services not covered under the OPPS could still be furnished by REHs, but they would not receive payment at the OPPS plus 5 percent rate. These include services such as laboratory services and outpatient rehabilitation therapy services, among others. Specifically, CMS proposes that any outpatient service furnished by an REH that is not

under covered OPPS would be paid under the same, applicable payment system as if it was performed in a hospital outpatient department (HOPD). For example, laboratory services provided at a REH would be paid under the Clinical Laboratory Fee Schedule, and ambulance services provided by REHs would be paid under the ambulance fee schedule.

We have heard from rural members that the change in reimbursement from pre-converted status to an REH would create difficulties in maintaining financially viable models. **Therefore, we ask that CMS work with Congress to improve reimbursements for these services, thereby helping to ensure the financial sustainability of REHs.**

THA also strongly urges CMS to work with Congress to allow REHs to maintain swing beds, as CAHs are allowed. Medicare has allowed CAHs to obtain swing bed reimbursement to help bolster rural communities and better serve patients. The pandemic has highlighted how important hospital bed capacity has been and allowing REHs to provide either acute or skilled nursing facility care in swing beds grants them additional flexibilities to meet the needs of their patient population, often keeping the patient in their home community while post-acute care is provided.

REH Quality Reporting

THA anticipates the mix of services provided at its member hospitals that convert to this designation will differ greatly by facility. For example, some REHs may see a high volume of diagnoses prevalent in its patient population that may not reflect common patient interactions at another REH. Even if CMS were to develop a broad set of measures, the variation in volumes — not just by procedure, but by year — would likely result in REHs across the nation reporting disparate combinations of these measures over time. We understand that CMS develops quality reporting to hold providers accountable, improve quality, and inform people as they decide where to seek care. **Given the expected variation among volumes and procedures and that patients who utilize an REH will not have much choice in alternative locations to seek care, THA will hold off on supporting or opposing the proposed measures until more information is known.**

Remote Outpatient Mental Health Services

During the COVID-19 PHE, many beneficiaries received mental health services in their homes using communications technology under the flexibilities adopted. In order to avoid negative impacts on access to care and to avoid potential disruptions to continuity of care for those beneficiaries, CMS proposes to designate certain behavioral health therapy services furnished remotely by clinical hospital staff using communications technology to beneficiaries in their homes as “covered OPD services” for which payment would be made under the OPPS.

THA appreciates and supports CMS’ efforts to ensure expanded access to remote mental health services by making these waivers permanent. These services have been vital to

address mental healthcare during a pandemic as well as providing essential flexibilities for stretched staff. Anything that continues to lessen the burden on a strained workforce is especially helpful for all of our hospitals, particularly those in our rural communities. We encourage the agency to continue to review other areas of the PHE waivers and make other remote care provisions permanent.

Conclusion

THA and our members appreciate CMS' consideration of these comments and welcome continued opportunities to work with the agency in improving the OPPS. Thank you for the opportunity to share our thoughts and concerns.

If you or your staff wish to discuss this letter, please contact me at anewell@tha.com.

Sincerely,

Amanda Newell
VP of Financial Policy
Tennessee Hospital Association