Minnesota Hospital Association

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September 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

Submitted electronically through www.regulations.gov

RE: Comments on Proposed Rule CMS-1772-P, 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

Dear Administrator Brooks-LaSure,

On behalf of our 127 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the 2023 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center Payment Systems.

MHA generally supports the recommendations and detailed comments submitted by the American Hospital Association (AHA). Rather than duplicating AHA's analysis and suggestions, MHA's comments will focus on the topics of most concern to Minnesota's hospitals and health systems.

Specifically, we are providing comments and recommendations in the following areas:

1. Payment Update
2. 340B Drug Discount Program
3. Rural Emergency Hospitals
4. Telehealth
5. Other Miscellaneous Provisions

1. Payment Update

MHA is concerned with CMS' proposed payment update of only 2.7% given the historic financial challenges facing Minnesota hospitals and health systems due to the ongoing COVID-19 public health emergency (PHE), inflation, supply chain delays, and severe workforce shortages.

In calculating the payment update, CMS used a 3.1% market basket percentage update, which is the same rate included in the Inpatient Prospective Payment System (IPPS) proposed rule. However, the final IPPS rule was published on Aug. 10, 2022, and increased the market basket update to 4.1% by using second-quarter 2022 forecast data. CMS should similarly adopt this market basket update in the final OPPS rule to increase payments to better reflect the current economic reality that Minnesota hospitals and health systems are facing.

CMS also proposes to adopt a permanent policy to place a 5% cap on any wage index decreases each year. As stated in previous comments, MHA supports this policy to reduce wage index volatility, especially during an ongoing PHE. However, this stability should not come at the expense of other health care providers. CMS should consider unintended consequences since the net benefit may be minimal. While we appreciate the limits for losses of the 5% cap, CMS should instead find a non-punitive way to implement wage index fairness without penalizing states like Minnesota that are low-cost, high-quality Medicare providers.

2. 340B Drug Discount Program

As a result of the recent Supreme Court decision in *American Hospital Association vs. Becerra*, we support CMS' intent to revert to its prior policy of paying Average Sales Price (ASP) plus 6% for 340B-acquired drugs in 2023. We also strongly encourage CMS to promptly repay 340B hospitals the difference between ASP plus 6% and what they were actually paid for drug claims from 2018 through 2022.

To rectify this underpayment, CMS should not retrospectively recoup funds from other hospitals to achieve budget neutrality. Not only would retrospective recoupment be illegal, but it would also be practically impossible. Most hospitals have spent those funds during the pandemic, and they continue to face significant financial challenges. Clawing back those funds would only further put patients and Minnesota communities at risk. Therefore, we urge CMS to correct the proposed adjustment to ensure that the appropriate amount is added back into the 2023 OPPS conversion factor and no hospital is underpaid. Given the importance of the 340B Drug Pricing Program, we also encourage CMS to consider alternative regulatory mechanisms to administer the program so it would not be subject to budget neutrality. These drug savings are key for important community resources across the state of Minnesota and should not be funded at the expense of other necessary payments.

3. Rural Emergency Hospitals

MHA supports CMS' Rural Emergency Hospital (REH) payment policy proposals to include all outpatient department services paid under OPPS as REH services and provide an additional monthly payment to support emergency care and infrastructure. Robust payments for REHs will ensure that facilities are financially feasible and could continue to provide essential services to the surrounding rural communities in Minnesota. MHA appreciates the proposed broad definition of covered services defined as an "REH service."

To better support long-term financial stability, REHs should also continue to be eligible for drug savings under the 340B Drug Pricing Program. We reiterate our previous comments to the agency and encourage CMS to work alongside Congress and be an advocate to ensure this important change is made. Without 340B eligibility, far fewer hospitals will consider converting to

an REH since the program savings are key to maintaining the financial viability of rural hospitals.

MHA also provides comments and requests clarification from CMS on these additional REH policies:

- Consistent with legislative intent, CMS must provide guidelines for payment to REH provider based rural health clinics (RHCs). CMS must allow REHs to maintain operation of existing provider based RHCs grandfathered by April 1, 2021, that meet the qualifications in section 1833(f)(3)(B) of the Social Security Act for the special payment rules that establish non-capped rates instead of the national statutory payment limit.

- Overall, we support the proposed monthly facility payment for REHs, adjusted annually for the market basket. We also support using the existing cost reporting process to document information on how the monthly facility payment is being used to support patient care in their communities. We greatly appreciate CMS seeking existing processes and efficiency for helping eligible hospitals enroll in this program.

- We support a process for a hospital that is enrolled as an REH to be able to revert to its original designation using the CMS-855A Change of Enrollment application. If the REH designation does not meet needs or expectations for any reason, CMS should allow the REH to revert to a previous designation with the ability to recoup the same number of inpatient beds. We note that CMS discusses REH-CAH conversion in the proposed rule (Part 424, Subpart P, p. 44788). We appreciate that CMS aligned with the statute to explicitly state that an REH can convert back to its prior designation. It is important that REHs have the ability to revert to a CAH if the REH program does not best fit their community needs.

- CMS should adopt a policy that directs states to allow participation as an REH while maintaining the number of licensed inpatient beds within an organization. For instance, if a current CAH becomes an REH, the number of beds should be allowed to be transferred within an organization (same Taxpayer Identification Number) indefinitely. This will ensure that if an REH needs to revert to a CAH or other designation, the facility will not need to seek new licensed beds from the state. We ask CMS to adopt a policy and providing guidance to states pertaining to acute hospital licensed beds and the ability to retain those as an REH. In addition, existing CAHs that were deemed necessary provider status and exempt from the 35 miles distance rule from another hospital that enrolls as an REH, should be allowed to revert to a CAH with the existing grandfathered status. We ask CMS to clarify this in the final rule in the provider enrollment section.

- CMS intends to adopt a rural emergency hospital quality reporting program (REHQR). The agency notes that the REHQR program measure set should consist of measures that are important, impactful, reliable, accurate, and clinically relevant for REHs. Overall, we support a thoughtful approach to creating a quality reporting program for REHs. Measures should be relevant to rural providers and comparable as well to CAHs if applicable to outpatient or emergency department settings. Measures should be meaningful and endorsed by a governing body such as the National Quality Forum (NQF) prior to inclusion. The purpose should be value over volume—measures that add value to patient care and are understood by consumers while minimizing administrative burden. We urge caution in publicly displaying performance, ensuring that small samples

are accounted for by establishing minimum thresholds that exist in other quality reporting programs. CMS should propose a small, but meaningful measure set in the early years of the program while hospitals get acclimated to providing care under this new model.

4. Telehealth

Throughout the pandemic, health care providers have demonstrated that medical care services can be delivered safely and effectively via telehealth services. CMS needs to consider ways to maximize access for patients, especially those residing in rural and underserved areas. Currently during the PHE, CMS has allowed hospitals to provide and bill for remote outpatient mental health services. MHA supports CMS' proposal to make this change permanent using OPPS-specific coding and allowing these remote services to be furnished to beneficiaries when in their homes beyond the end of the PHE. We also appreciate the flexibility in allowing CAHs to bill for these services even though they are not paid under OPPS.

However, CMS is also proposing to require an in-person service within six months prior to a beneficiary receiving a remote mental health service. This unnecessary guardrail deters vulnerable populations from entering the mental health care system and accessing care. MHA encourages CMS to exercise flexibility and appreciates the proposed exceptions to these requirements if hospital clinical staff and the beneficiary agree and provide appropriate documentation that the risks and burdens of in-person care outweigh its benefits. The most appropriate site of care should rely on patient needs, clinical judgement, and physician discretion.

MHA also supports CMS' proposal to continue coverage of audio-only technology for these mental health services for beneficiaries who cannot use audio/video technology due to broadband limitation, lack of access to video devices, or other limitations outside of a provider's control. In many cases, where two-way telehealth audio/visual technology has been attempted and failed, audio-only has been a good substitute.

While we appreciate CMS' commitment to increasing access to mental health services, we are concerned with requiring clinical staff of the hospital be physically at the hospital outpatient department during the service. Minnesota's psychiatric health care providers should have the flexibility to be at their home or another location when treating a patient.

5. Other Miscellaneous Provisions

We support the ability of nonphysician practitioners to practice at the top of their license and clinical training. We thank CMS for proposing that nonphysician practitioners may provide general, direct, and personal supervision of outpatient diagnostic services, per state scope of practice laws. Workforce flexibilities are crucial for Minnesota hospitals and health systems that face enduring challenges in recruiting and retaining an adequate workforce.

MHA also supports increased payments for services furnished under the partial hospitalization program, which allows Minnesota hospitals and health systems to provide intensive mental health services without requiring an inpatient psychiatric hospitalization. Some commercial payers have reduced coverage for this program, despite its importance within the mental health care continuum. CMS should continue strengthening its commitment to the partial

hospitalization program, which should include providing payment for remote mental health services.

While we also appreciate the CMS proposal to make payment adjustments for the additional cost that hospitals face in procuring domestic NIOSH-approved surgical N95 respirators, we seek additional clarification on long-term expectations. CMS should provide this payment update in a non-budget neutral manner and monitor utilization and cost data to ensure there are no unintended consequences within the health care supply chain.

As always, we appreciate the opportunity to comment on CMS' proposed rules. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
Vice President, Finance Policy & Analytics