



Kansas Hospital
ASSOCIATION

September 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: 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.

Submitted electronically via regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of its 123 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Hospital Outpatient Prospective Payment System for calendar year (CY) 2023. KHA would like to thank CMS for its ongoing support for our nation's hospitals, providers, and patients.

We support a number of the OPPTS proposed rule's provisions, including CMS' decision to end its policy to significantly cut reimbursement to 340B hospitals following the Supreme Court's unanimous ruling in American Hospital Association v. Becerra.

PROPOSED PAYMENT UPDATE CY 2023

A. Proposed Conversion Factor Update

KHA has significant concerns about the low payment update (2.7%), particularly given the inflationary environment and continued labor and supply cost pressures that Kansas hospitals



and health systems face. The most recent Consumer Price Index released by the Bureau of Labor Statistics shows an 8.3% increase over the past twelve months ending in August 2022.¹ Even if inflation subsides, prices are not decreasing to pre-2022 levels. Inflation rates may be lower in 2023, yet that rate is built upon the excessive growth in inflation during 2022. In light of this, CMS' proposed OPSS payment update is inadequate.

CMS uses the same market basket percentage update for the OPSS rate as in the Inpatient Prospective Payment System (IPPS), which CMS projected to be 3.1% in the FY 2023 IPPS proposed rule.² The final IPPS rule was published on August 10, 2022, and included an increase to the proposed market basket update using second quarter 2022 forecast data.³ CMS finalized a market basket update of 4.1%, the largest update in 25 years. KHA asks that CMS adopt a market basket update of no less than 4.1% in the final OPSS rule to increase payments to better reflect the current economic reality that hospitals are facing. Further, because Kansas hospitals provide a significant portion of outpatient services and are more reliant on Medicare payments, receiving the higher market basket update will be especially important to long-term Kansas hospital viability.

In addition, KHA asks that CMS work within its statutory authority to do more to improve the CY 2023 payment update. A market basket percentage change in the final rule would be significant, but more must be done to ensure hospitals' financial viability. While government intervention in the form of pandemic relief funds temporarily stabilized hospitals, the end of those funds coupled with 8.3% inflation,⁴ increased labor costs, and the statutorily required Medicare sequestration and Pay-As-You-Go (PAYGO) policies could be disastrous. To mitigate this, CMS must explore pathways to increase the FY 2023 payment update. Low OPSS payments and the aforementioned challenges means that many Kansas hospitals will struggle to stay financially viable and keep their doors open as an access point for beneficiaries.

¹ BUREAU OF LABOR STATISTICS, U.S. DEPARTMENT OF LABOR, *Consumer Price Index Summary* (Sept. 13, 2022) <https://www.bls.gov/news.release/cpi.nr0.htm>.

² Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates. 87 Fed. Reg. 28403 (May 10, 2022) (to be codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).

³ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates. 87 Fed. Reg. 49029 (Aug. 10, 2022) (to be codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).

⁴ BUREAU OF LABOR STATISTICS, *supra* note 1. ⁷
42 U.S.C. § 1395l(t)(2)(E) (2018).



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B. Proposed Wage Index Changes

KHA is pleased to see that CMS has proposed a 5% cap on any decrease to a hospital's wage index. External factors outside of a hospital's control, such as COVID-19 labor demands, can contribute to significant fluctuations in the wage index, and a cap on any decrease will help to mitigate those factors.

PROPOSED OPPTS PAYMENTS FOR DRUGS, BILOGICALS, AND RADIOPHARMACEUTICALS

KHA thanks CMS for proposing to reinstate the average sales price (ASP) plus 6% payment rate for 340B drugs in the final rule in light of the Supreme Court decision in *American Hospital Association v. Becerra*, 596 U.S. (2022).

In order to make hospitals whole, KHA encourages CMS to remedy the payment cuts by repaying hospitals the full amounts that were lost to the ASP – 22.5% policy from 2018 to 2022. Further, when CMS complies with the *AHA* decision to make hospitals whole, we urge CMS not to take funds from hospitals exempted from the payment cuts in order to achieve a budget neutral implementation. As discussed, Kansas hospitals face unique challenges and operate under financial strains such that any lost payments threaten viability and thus access to care for our residents.

NONRECURRING POLICY CHANGES

A. Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes

The COVID-19 pandemic worsened the overall mental health of Americans and Kansas communities were no exception. Compounding the effects of the pandemic, Kansas communities face a severe lack of access and availability of the full range of mental health care services.⁵ Over two-thirds of mental health HPSAs are in rural or partially rural counties.⁶ While other factors like

⁵ Brenda Mack, et al., *Mental health in rural areas*, NATIONAL RURAL HEALTH ASSOCIATION, 1 (Feb. 2022) https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Mentalhealth-in-rural-areas-policy-brief-2022.pdf.

⁶ BUREAU OF HEALTH WORKFORCE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, *Designated Health Professional Shortage Areas Statistics: Third Quarter of Fiscal Year 2022*, 3-4 (July 1, 2022) <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.



acceptability among rural communities may impact some rural residents' willingness to seek out mental health care, availability and access are substantial barriers as well.⁷

KHA thanks CMS for taking steps to help overcome the challenges that Americans face in obtaining mental health services. Covering mental health services furnished remotely by hospital staff to at-home patient's increases access and availability of options for Medicare beneficiaries requiring mental health care. It is critical that patients' continuation of care is not disrupted at the end of the COVID-19 Public Health Emergency (PHE) because remote options end. Over the course of the PHE, patients have built relationships and rapport with mental health practitioners via virtual care and returning to regular travel to receive in-person mental health care would be a burden for many patients. Retaining remote mental health services will encourage beneficiaries to continue care with their trusted practitioner. KHA also commends CMS for permitting Critical Access Hospitals to bill for these services even though they are not paid under OPSS.

KHA recommends that the clinical staff do not need to be "in" a hospital outpatient department to furnish mental health services to a remote beneficiary. We hold that 42 C.F.R. § 410.27(a) should be amended to include an exception for outpatient mental health services furnished to remote patients, particularly if reimbursement for these services will be under the lesser Physician Fee Schedule and not the OPSS rate because of the lesser hospital costs associated with remote care.

Moreover, KHA is troubled by the lesser reimbursement for outpatient remote mental health services. Hospitals may not accrue the same costs associated with an in-person service when providing remote care, but Kansas hospitals are not in a place financially to receive less reimbursement. We reiterate our comments above highlighting the importance of telehealth options for beneficiaries, especially because of the access challenges that they face. Considering the immense benefit of remote care for beneficiaries, a lower reimbursement rate may disproportionately disadvantage Kansas hospitals when providing remote mental health services.

The in-person requirements for continuation of remote mental health services provide adequate flexibility for beneficiaries. KHA appreciates that beneficiaries need only make an annual in-person visit, after an initial in-person visit, to continue to receive remote care. However, KHA requests clarification on the exceptions to the annual in-person visit proposed rule. CMS states that the 12-month visit may be excused if "the risks and burdens of an in-person service outweigh the benefits of it." KHA believes that in areas the travel time and distance are burdens and could

⁷ Mack, et al., *supra* note 8, at 1 ("Barriers to mental health care in rural areas can be grouped into availability, access, and acceptability").



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create undue hardship on some beneficiaries, and thus may outweigh the benefits of in-person service.

KHA supports CMS' proposal to continue the use of audio-only technology for mental health services post-PHE for beneficiaries that cannot use audio/video technology due to broadband limitations. Rural areas are more likely to have limited access to broadband and have benefitted greatly from audio-only telehealth.

B. Proposal to Exempt Rural Sole Community Hospitals from the Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

KHA thanks CMS for exempting rural Sole Community Hospitals (SCHs) from paying the site specific Medicare Physician Fee Schedule equivalent payments. By paying SCHs the full OPPTS rate when a clinic visit is furnished in an off-campus provider-based department, CMS ensures that rural communities retain access to care and that providers are appropriately compensated.

Accordingly, KHA believes that all hospitals, especially those with less than 100 beds including Medicare Dependent Hospitals, Low-Volume Hospitals, and Rural Referral Centers, should similarly be exempted from the site-specific payment cuts. The same reasoning that led CMS to propose to exempt SCHs also applies to all hospitals. Factors other than the payment differential can be attributed to the volume of services in provider-based clinics at hospitals. Off-campus provider-based departments are often the only point of access to care in communities. Continued cuts to hospital reimbursements for clinic visits are excessive and harmful, especially at a time of tremendous financial challenges.

Likewise, if rural hospitals with less than 100 beds are exempted from the site-specific policy, these hospitals should receive the rural SCH 7.1% payment increase. 42 C.F.R. § 419.43(g)(1) should be amended to add these hospitals as eligible for receiving additional payment for covered outpatient services. We urge CMS to reverse in entirety its harmful policy of reducing payment for outpatient clinic visits in excepted off-campus provider-based departments.

C. Prior Authorization process for facet joint interventions

KHA asks that CMS not impose new prior authorization processes on facet joint interventions. The current data reveals that utilization levels of these services have already recessed, and there are other oversight mechanisms available to CMS that do not inappropriately delay care that should be used, rather than prior authorization, to address improper Medicare payments. KHA



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urges CMS to require data-driven justifications by health plans over which it has oversight authority, including Medicare Advantage and plans on the Federal Exchange.

OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

CMS does not propose to adopt or remove any quality measure from the OQR, but does propose to modify the cataracts measure to allow for voluntary rather than mandatory reporting. KHA supports CMS's proposal to no longer require reporting this measure. However, KHA continues to encourage CMS to remove less effective measures that do not provide a valuable impact to patient outcomes. A reduction in overall provider reporting burden would be appreciated.

REQUEST FOR COMMENT: MEASURE FOR OUTPATIENT VOLUME

KHA does not support re-implementation of volume measures or the development of new volume measures for the OQR as methods to assess quality of care. Volume measures are inconsistent with the strategic goals of CMS's own Meaningful Measure framework to promote innovation and modernization of all aspects of quality.

ORGAN ACQUISITION PAYMENTS

The Medicare program reimburses transplant hospitals (THs) for organ acquisition costs, the transplant surgery and post-transplant costs for Medicare recipients. Currently, Medicare reimburses transplant hospitals for organ acquisition costs under a reasonable cost-based method using the hospital's ratio of Medicare usable organs to total usable organs. In the FY 2022 IPPS proposed rule, CMS proposed a number of policies to change, clarify, and codify Medicare's organ acquisition payment. However, due to the nature and volume of comments received by the agency, it did not finalize any of its proposed policies.

In this year's OPSS proposed rule, CMS proposed additional revisions and policies related to Medicare's organ acquisition payment policies. Specifically, the agency proposed to change how organs procured for research are counted for the purposes of calculating Medicare's share, requiring that THs and organ procurement organizations (OPOs) exclude organs used for research. The agency also clarified that organ acquisition costs would include certain hospital costs incurred for services provided to deceased donors. Additionally, CMS solicited a request of information (RFI) on an alternative methodology for counting organs used in the calculation of Medicare's share of organ acquisition costs.

KHA is concerned with CMS' proposals related to Medicare usable organs and organ acquisition payments to THs. Excluding research organs from the count of Medicare's share of organ



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acquisition costs would disincentivize innovative scientific organ research. In addition, CMS' alternative methodology for counting organs in the calculation of Medicare's share would jeopardize hospital transplant programs, which of course rely on these funds. Taken together, these proposals would entail payment cuts endangering transplant programs' ability to provide care and, subsequently, access to organ transplantations for vulnerable patients. We strongly urge CMS to withdraw these proposals.

In proposing these policies, CMS states that its rationale is to ensure that Medicare does not share in the cost of procuring organs that are not transplanted into Medicare beneficiaries. However, the proposals go too far in that they could actually result in Medicare not reimbursing for organ procurement costs that ultimately are transplanted into Medicare beneficiaries.

CMS' proposal to exclude research organs from THs count of Medicare's share of organ acquisition costs in particular is at odds with Medicare's commitment to cover routine costs in clinical trials as part of its national coverage policy. Doing so would negatively impact the affordability and availability of research organs and hinder the advancement of clinical research.

DIRECT SUPERVISION OF CARDIAC AND PULMONARY REHABILITATION SERVICES BY INTERACTIVE COMMUNICATIONS TECHNOLOGY

During the COVID-19 PHE, cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) and pulmonary rehabilitation (PR) services may be provided via telehealth with the services originating from a patient's home, and the physician supervision of these services permitted to take place virtually using audio/video real-time communications technology (excluding audio-only). However, once the PHE ends, CR, ICR and PR services must originate from a health care setting in a rural area to be paid via telehealth under the Physician Fee Schedule (PFS), but this only applies until December 31, 2023. After that date, CR, ICR and PR services will no longer qualify as Medicare telehealth services.

Under current OPSS policy, during the COVID-19 PHE, these services may be furnished in the Hospital Outpatient Departments (HOPD) with the virtual physician's direct supervision, but this policy will no longer apply when the

COVID-19 PHE ends. After that date, the physician will be required to be immediately available in a physical way for the direct supervision requirement to be met and for the hospital to be paid for these services. In the CY 2023 OPSS proposed rule, CMS requests comments on whether it should extend its deadline for allowing physician direct supervision to be provided virtually for CR, ICR and PR services in the HOPD setting through the end of CY 2023, to be consistent with the policy under the PFS.



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KHA appreciates and supports CMS' proposal. We believe it will improve access to these important hospital outpatient services for patients and reduce burden on providers as the impact of the pandemic gradually recedes and as CMS unwinds its waivers and flexibilities. We urge the agency to consider making this policy permanent, which we believe would do far more to improve access to these highly effective, yet underutilized services.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work. If you would like additional information, please contact Shannan Flach at sflach@kha-net.org or 785-276-3132.

Sincerely,

A handwritten signature in black ink that reads "Shannan Flach". The signature is written in a cursive, flowing style.

Shannan Flach
Vice President, Health Care Finance and Reimbursement
Kansas Hospital Association