



A Passionate Voice for Compassionate Care

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program: 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1786-P)

Dear Administrator Brooks-LaSure:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the calendar year 2024 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment rates. This proposed rule updates OPPS payment policies that apply to outpatient services provided to Medicare beneficiaries, the hospital outpatient quality reporting program and implements statutory provisions that create a new benefit category for "Intensive Outpatient Program Services (IOP) among other issues. We appreciate your staff's ongoing efforts to administer and improve the payment systems for outpatient hospital and ambulatory surgical services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **OPPS Payment Update**

CMS is proposing to update hospital OPPS rates by 2.8 percent for calendar year (CY) 2024. This rate update equals the hospital market basket of 3.0 percent less 0.2 percentage points for total factor productivity and is the same update that was proposed for the FY 2024 IPPS.¹

As CMS has already finalized an update of 3.1 percent for the FY 2024 IPPS², it is likely that CMS will be adopting a CY 2024 final rule OPPS update of 3.1 percent (3.3 percent market basket less 0.2 percentage points for total factor productivity). This increase was insufficient.

¹ 88 FR 27004

² See page 982 of the display copy of the FY 2024 IPPS final rule at: [2023-16252.pdf \(federalregister.gov\)](https://www.federalregister.gov/documents/2023/10/28/2023-16252) (scheduled to be published in the Federal Register October 28, 2023).

CHA reiterates our FY 2024 IPPS proposed rule comments and requests that CMS reconsider that it has adopted a market basket that does not fully recognize the increase in hospital costs over the last several years.

As we indicated in our FY 2024 IPPS proposed rule comments, upward pressure on hospital costs occurring throughout the pandemic has not been well represented in past year hospital market baskets, particularly for CY 2022. CMS finalized a CY 2022 market basket update of 2.7 percent, but the hospital market basket based on later after-the-fact data was 5.7 percent—a difference of 3.0 percentage points. These figures were 0.6 and 0.5 percentage points respectively for CYs 2021 and 2023 making the update over three years for CYs 2021 through CY 2023 a combined 4.1 percentage points less than the rate of inflation. Repeated below-inflation updates result in a permanent understatement of OPSS rates. In our FY 2024 IPPS proposed rule public comments, we requested that CMS consider a forecast error correction when the increase in the actual market basket based on after-the-fact data differs from the estimated increase applied to IPPS and OPSS rates by more than a threshold percentage.

CMS has established such a policy for the skilled nursing facility (SNF) prospective payment system (PPS) and the capital PPS. Above a difference of 0.5 percentage points for the SNF PPS and 0.25 percentage points for the capital PPS, CMS applies a prospective adjustment for prior year forecast error correction. If CMS were to adopt such a policy, we recognize that it would be applied as either an upward downward adjustment to the market basket but would have the advantage of not making permanent large differences between the market basket update based on a projection and its actual increase based on later information.

Given recent history and the large difference between the forecasted market basket and the actual market basket, CHA believes the CY 2024 update would be the ideal time to adopt such a policy.

Furthermore, it is our understanding that the data source CMS uses to determine labor cost changes, the U.S. Bureau of Labor Statistics' Employment Cost Index (ECI), may be underestimating the growth in labor costs over the last several years because it does not accurately reflect changes in costs driven by shifts in categories of labor, such as the significant increase in the use of contract labor. Contract hours as a percentage of worked hours rose 133% in 2022 compared to 2019 and contract FTEs grew in all clinical departments, ranging from surgical, imaging, emergency to nursing. The largest growth was in nursing where contract FTEs grew 180% from 2019 to 2022.

We urge CMS to find ways to compensate for the inadequate market basket update, such as adopting a forecast error correction policy for the OPSS update, and reconsider its data sources in light of how the health care industry staffing model has shifted since the pandemic.

- **Intensive Outpatient Program (IOP) Services**

Effective for items and services furnished on or after January 1, 2024, Congress established a new Medicare benefit for IOP services that may be furnished by hospital outpatient departments, CMHCs, FQHCs, and RHCs. An IOP is similar to a partial hospitalization program (PHP). It is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, including depression, schizophrenia or substance use disorders. However, it is considered to be less intensive than PHP and is not required to be provided in lieu of inpatient hospitalization.

CMS proposes to cover IOP services for patients who require at least nine hours per week of therapeutic services (per the plan of care), are likely to benefit from a coordinated program of services, require more than isolated sessions of outpatient treatment, do not require 24-hour care, have an adequate support system while not actively engaged in the program, have a mental health diagnosis, are not judged to be dangerous to self or others, have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the intensive outpatient program. Mental health diagnosis includes substance abuse disorder and behavioral health diagnoses generally for both partial hospitalization services and intensive outpatient services.

CMS proposes four separate rates for PHP and IOP services provided by a hospital-based PHP program. These rates range from \$96.49 to \$364.04 and would be based on hospital mental health claims data—not just those claims used from hospital-based PHP program—to determine the payment amounts for the hospital-based PHP programs. CMS would calculate the PHP rates for CMHCs and hospital-based programs separately. CMS also proposes to establish payment under Part B for IOP services furnished by outpatient treatment programs for the treatment opioid use disorder (OUD) beginning CY 2024.

CHA agrees with all of CMS' proposals and appreciates the agency's expeditious implementation of these important programs to treat Medicare patient mental health conditions.

CMS solicited comments on including caregiver-focused services in the list of recognized services for PHP and IOP. **CHA would support CMS including additional codes for caregiver and peer services as part of an IOP.** Caregivers experience a heavy physical and emotional toll from taking care of a mentally ill loved one. Family caregivers provide needed day-to-day support and services and manage complex care tasks. Providing reimbursement for caregiver services can ease some of the financial burden on both the beneficiary and the caregiver in order to allow the caregiver to be more attentive and provide better assistance to the loved one in their care.

- **Remote Services**

Periodic In-Person Visits

In the 2023 OPPS final rule, CMS adopted a policy to allow OPPS payment for remote mental health services when a hospital outpatient is receiving these services in their home. CMS requires an in-person visit within six months prior to the initial remote mental health service and within 12 months after each such encounter. CMS is proposing a delay on the application of these requirements for remote outpatient mental health services provided by hospitals and CAHs until January 1, 2025. **CHA supports delaying this requirement.**

Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT)

During the COVID-19 PHE, CMS allowed outpatient therapy services (including physical therapy, occupational therapy and speech language pathology), DSMT and MNT to be furnished by hospital-employed staff to patients in their homes through the use of real-time interactive telecommunications technology. CMS initially ended this flexibility after the declared end of the COVID-19 PHE on May 12, 2023. However, using sub-regulatory guidance, CMS later extended the ability of hospitals to provide these services to patients in their homes through December 31, 2023. Waivers also allowed these services to be provided by physical, occupational and speech language pathologists.

CMS is proposing to extend the ability of hospitals to provide these services in patients' homes through the end of 2024 consistent with the statutory provisions that extended the ability of these services to be provided through the Medicare telehealth benefit when provided by physical, occupational and speech language pathologists as well dietitians and nutritionists and suppliers of DSMT. **CHA supports extending the provision of these services through the end of 2024 when furnished by hospital-employed staff to patients in their homes.**

- **Payment for 340B Drugs**

Use of the 340B Modifiers for the Discarded Drug Policy

Effective January 1, 2023, section 1847A of the Act requires Part B drug manufacturers to refund discarded drug amounts exceeding 10 percent of total charges for the drug or biological in a given calendar quarter. Drugs acquired under the 340B drug discount program are exempt from this policy by statute.

From January 1, 2018 through September 27, 2022, CMS' policy was to pay for drugs acquired under the 340B program at ASP -22.5 percent. To effectuate this policy, CMS required hospitals to use modifiers "JG" and "TB" on OPPS claims where a separately payable drug was acquired under the 340B program. While the payment adjustment no longer applies, CMS has required all

340B covered entities to report modifiers “JG” and “TB” for 340B acquired drugs to assist CMS in subtracting the units associated with 340B acquired drugs and biologicals from those subject to the inflation rebate.

CMS has reconsidered this guidance and the necessity of needing both the “JG” and “TB” modifiers. The proposed rule states that use of a single modifier will allow for greater simplicity and less burden on providers as they would only have to report only one modifier for all scenarios where a 340B drug is acquired. Effective January 1, 2025, CMS proposes that all 340B covered entities report only the “TB” modifier when a drug is acquired under the 340B program. The “JG” modifier will remain effective through December 31, 2024, and providers will have the option to report either the “JG” or “TB” modifier during 2024. **CHA supports CMS’ proposal and appreciates its consideration in reducing hospital reporting burden.**

340B Remedy Proposed Rule

Beginning in 2018, CMS adopted a policy to pay for drugs and biologicals acquired under the 340B program at average sales price (ASP) -22.5% rather than ASP +6%, the rate for separately payable drugs under the OPSS. The United States Supreme Court rejected that policy in *American Hospital Association v. Becerra*, 142 S. Ct. 1896 (2022) as contrary to the Medicare statute. CMS has proposed a remedy to reimburse 340B hospitals for underpayments for outpatient drugs purchased under the 340B program for CY 2018-2022. **CHA reiterates its appreciation of and support for the proposal to make one lump-sum payment to 340B hospitals. We also reiterate our opposition to the proposal to apply budget neutrality to offset the legally required repayment plan.** We question CMS’ assertion that it has a statutory obligation to proceed with the remedy in a budget-neutral manner and believe that CMS has both the legal flexibility and legal obligation to refrain from recouping funds paid to hospitals due to its own mistaken policy. We urge CMS not to finalize its budget neutrality proposal.

- **Supervision of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Services**

Under current law, cardiac rehabilitation services (CR), intensive cardiac rehabilitation services (ICR) and pulmonary rehabilitation services (PR) must be provided under the direct supervision of a physician. The Bipartisan Budget Act of 2018 provides that, effective January 1, 2024, CR, ICR and PR may be supervised by physician assistants, nurse practitioners and clinical nurse specialists. **CHA supports CMS’ proposed conforming amendments to the OPSS.**

During the COVID-19 PHE, CMS added CR, ICR and PR to the telehealth list when furnished to non-hospital patients and paid under the PFS. CMS permitted physicians to provide direct supervision of these services remotely via two-way, audio/visual communication technology (but not audio only). These PFS flexibilities were extended by law through December 31, 2024. For consistency with the PFS rules, CMS also extended the flexibility for remote direct supervision by a physician in prior OPSS rulemaking. CMS now proposes that physician assistants, nurse practitioners and clinical nurse specialists also provide remote direct supervision through

December 31, 2024. **CHA supports extending the ability to provide remote supervision of CR, ICR and PR by physician assistants, nurse practitioners and clinical nurse specialists through December 31, 2024.**

- **Payment Anomaly for Intensive Cardiac Rehabilitation Services**

Under Section 603 of the Bipartisan Budget Act of 2015, CMS pays for services provided by non-excepted off-campus provider-based departments at the physician fee schedule equivalent rate of 40 percent of Medicare's OPPS rates. A provision in the Medicare Improvements for Patients and Providers Act of 2008 requires that, starting in 2010, intensive cardiac rehabilitation (ICR) services provided in physician offices are to be paid at 100% of the OPPS rate. Thus, ICR services in physician offices are currently paid at the higher OPPS rate and in non-excepted off-campus provider-based departments at the lower physician fee schedule equivalent rate,

The intent of Section 603 was to pay the same rate for services provided in the two settings. Recognizing the existing anomaly in ICR reimbursement CMS proposes not to apply the site neutral payment rate for ICR provided in a non-excepted off-campus provider-based department and to reimburse at the full OPPS rate for ICR services in both settings.

CHA supports this proposal and appreciates CMS identifying and correcting this anomalous payment result. We urge CMS to repay hospitals for the amounts underpaid in previous years.

- **Marriage and Family Therapist (MFT) and Mental Health (MHC) Counselor Services**

The Consolidated Appropriations Act (CAA) of 2023 provides for a new benefit category under Medicare Part B to cover and pay for marriage and family therapist (MFT) services and mental health counselor (MHC) services. While CMS provides proposals on its implementation of this new benefit in the CY 2024 PFS proposed rule and for Rural Health Clinics and Federal Qualified Health Centers in the CY 2024 OPPS proposed rule, it does not indicate how MFT and MHC services will be paid in hospital outpatient departments beginning January 1, 2024.

CHA respectfully requests that CMS address how these services will be paid when furnished in hospital outpatient departments. Specifically, we request CMS address whether these services will be:

1. Paid under the OPPS and the PFS (like other practitioner services such as physicians' services, nurse practitioner or physician assistant services) or just the PFS;
2. Whether the services of hospital employed MFT and MHCs may be billed directly by the hospital on an institutional claim form like any other OPPS service; or
3. If they will be paid only under the PFS (like outpatient therapy services that are billed and paid to hospitals when furnished by their hospital-employed therapists)

We also request that CMS address whether hospital employed MFTs and MHCs are required to enroll in Medicare and have their benefits reassigned to their employer hospital in order for their services to be billed to Medicare and paid to the hospital. Alternatively, hospitals could bill directly for these services under the OPSS or under the PFS as currently occurs with the outpatient therapy services. **CHA looks forward to how CMS will address implementation of this new benefit when provided to hospital outpatients.**

- **Medicare Payment for Dental Services**

By statute, Medicare is prohibited from paying for “services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.” However, the statute excepts dental services from the coverage exclusion when services are being provided in connection with covered medical services.

In the CY 2023 physician fee schedule final rule, CMS adopted a policy to specify that it may cover dental services that are “inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service,” and provided specific covered medical services and related dental services that it would be covered.³ In the CY 2024 physician fee schedule proposed rule, CMS provides additional clinical scenarios where it will pay for dental services that are integral to the success covered medical services.⁴

In the CY 2024 OPSS rule, CMS proposes to assign 229 dental codes to clinical APCs to enable them to be paid under the OPSS when payment and coverage requirements are met. **CHA is appreciative of CMS broadening its policies that allow Medicare payment for more dental services furnished in connection with covered medical services and further facilitating hospital payment for these services when they are covered.**

- **Medicare Payment for Non-Opioid Pain Relief Treatments under the OPSS**

Sections 4135(a) and (b) of the Consolidated Appropriations Act (CAA) of 2023 prohibit packaged payment for non-opioid pain relief treatments effective January 1, 2025, through December 31, 2027. CMS will include proposals to implement this CAA provision in the 2025 OPSS rule. However, CMS does provide a more detailed description of this statutory provision in the ASC section of the proposed rule and solicits comments requesting public input on its implementation of these provisions next year.

In 2020, CMS implemented section 6082 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2019. This provision of statute required CMS to review payments under the OPSS for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices,

³ 87 FR 69663

⁴ 88 FR 52371

nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives. In its rulemaking, CMS only removed several of these drugs from packaging under the ASC payment system when the drugs function as medical supplies.⁵

CHA supports the provisions in the CAA which require CMS to unpackage non-opioid pain management treatments in HOPDs in CYs 2025 through 2028 and appreciate CMS inviting stakeholder input in the ASC proposed rule. **CHA looks forward to working with CMS on implementation of this provision in the CY 2025 OPSS/ASC rule. In the meantime, we urge CMS to consider unpackage non-opioid pain management drugs in the CY 2024 final OPSS rule to align with the current ASC policy.**

- **Price Transparency**

In the Hospital Price Transparency (HPT) final rule published November 27, 2019,⁶ CMS adopted requirements for hospitals to make public their standard charges in two ways: (1) as a comprehensive machine-readable file and (2) in a consumer-friendly format. In the CY 2024 OPSS proposed rule, CMS makes a number of complex changes to the requirements for HPT data, the most significant of which is the development a template that is intended to standardize the data that hospitals make available so it is more easily comparable.

CHA and our members believe delivering people-centered care requires consumers to have access to meaningful information about the price and quality of their care. We support policies that help patients estimate their out-of-pocket costs when making healthcare, and our members are committed to providing this information.

Hospitals spend considerable time and effort working to accurately inform patients about how much a hospital stay will cost them. These efforts give patients a reasonable expectation of their planned out-of-pocket expenses based on their insurance plan and minimize the potential for surprise bills. Patients may also obtain information on their out-of-pocket costs from their health plans. We remain concerned, however, about placing undue burdens on hospitals, especially when the information they are required to provide is of little or no use to patients. Patients are most concerned with the amounts that they will be paying out-of-pocket for health care services when they are in the hospital, not the negotiated rate between hospitals and private insurers.

CMS proposes requiring hospitals to use a standardized format for the hospital price transparency machine-readable file requirements. The new format would include additional required fields, such as information on the contracting method used to derive a negotiated rate and an expected allowed amount for non-dollar rates. CMS proposes allowing hospitals two months to transition to the new standardized format While CHA appreciates CMS intent is to

⁵ 84 FR 61176 and 61404

⁶ <https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf>.

lessen the burden on hospitals by having a standard, we remain concerned about the effort required to post hundreds of private payer rates for thousands of different services. The proposals to require hospitals to provide detailed information on the methodology for negotiated rates and to provide new data fields will not give patients useful information and will impose additional burdens on hospitals. CMS also drastically underestimates the time and cost involved in making these changes. CHA urges CMS not to finalize these proposals and if it does, to give hospitals up to 18 months to implement them.

CHA does not oppose submission of non-proprietary information, **but we strongly oppose the proposed addition of language that would require hospitals and health systems to submit private contract information to CMS.** Specifically, the proposed rule suggests that CMS may require hospitals to submit “contracting documentation to validate the standard charges the hospital displays.” Courts have long held that certain contracting information—especially negotiated rate data—is commercially sensitive information that is shielded from disclosure by numerous legal protections.⁷ There is no indication in existing statute that Congress authorized CMS to override these well-established legal protections by regulatory declaration.

CMS proposes to allow notifications to health system leadership of any compliance activity within their system, as well as notification to the specific hospital’s leadership, to better accommodate health systems with a central office responsible for compliance. **CHA supports this proposal.**

CMS proposes that it be allowed to make public additional information related to compliance, including naming hospitals that are being reviewed for compliance (whether as routine oversight or in response to a complaint), compliance actions taken against specific hospitals and the status and outcome of compliance actions. We are concerned that releasing information before a determination of non-compliance is made could be misleading or be misconstrued. A hospital that is undergoing a routine compliance review or cooperating with CMS as it engages in fact-finding could be unfairly portrayed as non-compliant. If CMS finalizes this proposal, we strongly urge the agency to make clear in the information released that a hospital under review has not been deemed non-compliant.

Finally, we appreciate that CMS understands the challenges presented by the several overlapping federal price transparency requirements and acknowledges the need for policy alignment. It is imperative that, as it develops its regulatory policy, CMS bears in mind the many and often conflicting state and federal requirements that create confusion for consumers and excessive cost and administrative burdens for hospitals and health systems. As it moves forward, we urge CMS to focus on what will actually help patients: streamlining current policies to remove complexity

⁷ E.g., *West Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 12141532 (W.D. Pa. Sept. 16, 2013) (trade secrets protection); *Medical Ctr. at Elizabeth Place, LLC v. Premier Health Partners*, 294 F.R.D. 87 (S.D. Ohio 2013) (discovery protections); 73 Fed. Reg. 30,664-01, 30,675–75 (May 28, 2008) (FOIA Exemption 4).

from the patient experience, narrowing the options for where a patient can get an estimate or pricing information, and ensuring those estimates are as accurate as possible.

- **Inpatient-Only List**

Services on the inpatient-only (IPO) list may be provided only in an inpatient setting and therefore are not paid under the OPSS. These services require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time, or the underlying physical condition of the patient requiring surgery. The IPO list is a necessary safeguard for Medicare beneficiaries against invasive procedures being performed inappropriately in an outpatient setting.

CMS has proposed to add nine new procedures to the IPO list, involving thoracolumbar, lumbar and thoracic vertebral body tethering; skull-mounted cranial neurostimulators; and epiaortic and epicardial ultrasound/placement of transducers. **CHA supports the proposed IPO list additions.**

- **Establishing and Maintaining Access to Essential Medicines**

CMS is seeking comments on creating separate payment under the IPPS for establishing and maintaining access to a three-month buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines during a public health emergency. This separate payment would not be budget neutral. Based on the public comments, CMS would consider adopting a policy that would be effective as soon as cost reporting periods beginning on or after January 1, 2024.

The payment would be based on the additional reasonable costs to the hospital to establish and maintain the essential medicine buffer stock either at the hospital or by contracting with a distributor or wholesaler. A hospital would report these costs in the aggregate on its cost report to CMS. These costs would not include the costs of the essential medicine itself. This information could be used to calculate a Medicare payment to establish and maintain access to a buffer stock of these essential medicines. Payments would be in accordance with reasonable cost principles through a biweekly payment with reconciliation during settlement of the cost report.

CHA supports the concept of CMS subsidizing hospitals to maintain a “buffer stock” of essential medicines and agrees that such an idea would be best supported by paying based on reasonable cost principles. CMS should ensure that the program is voluntary, flexible and accounts for the variation among hospitals. For example, if CMS moves forward with a list of essential medicines, we encourage CMS not to limit additional payments to facilities that stockpile every item on the list. Hospitals likely have different needs and may not need, or have the available space, to stockpile all products on an “essentials” list. Some hospitals or systems will have the capacity to evaluate and stockpile numerous drugs and biologicals, but other

smaller facilities or health systems may not. **We strongly recommend that CMS maintain the utmost flexibility with any implementation of a stockpiling reimbursement plan.**

- **Hospital Outpatient Quality Reporting (OQR) Program**

Proposed Modification to the COVID-19 Vaccination Coverage among HCP Measure

CMS proposes to modify the current Healthcare Personnel (HCP) COVID-19 vaccination measure beginning with the 2024 reporting period, consistent with proposals across all Medicare quality reporting programs. Specifically, CMS would replace the definition of “complete vaccination course” with a definition of “up-to-date” with Centers for Disease Control and Prevention (CDC) recommended COVID-19 vaccines. The agency proposes this modification to incorporate evolving CDC guidance related to booster doses and their associated timeframes.

CHA supports and commends the agency’s ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both HCPs and the patients we serve. However, we are now evolving from a public health emergency (PHE) to an endemic phase of the disease and we are concerned that the data reporting requirements associated with the measure will divert already strained resources from patient care to administrative processes. The CDC definition of “up-to-date” can change every quarter, and it is challenging and burdensome for hospitals to collect and continuously assess the vaccination status of each employee that works in the facility for a given reporting quarter. Further, the requirement that hospitals collect and report on this data for at least one week for each of the three months in a reporting period strains the already stressed workforce. In developing the measure, we understand that CMS relied heavily on the specifications and experience with the Influenza Vaccination Among HCP measure. The flu vaccine measure assesses vaccinations during flu season, which is defined as October through March, and is reported annually. We appreciate there are still questions about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available. However, an annual data collection and reporting process is significantly less burdensome than reporting data for one week for each of the three months in a reporting quarter. As COVID-19 is now endemic (similar to influenza) and given the degree of burden that will be imposed by maintaining the current reporting requirements (which were structured based on a PHE context), **we urge CMS to amend the measure to require only annual reporting.**

Proposed Modification of Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Measure

This measure assesses the percentage of patients aged 50 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. CMS proposes to amend the measure to begin screening at 45 years, in line with the United States Preventive Services Task Force’s 2021 revised recommendations on colorectal cancer screenings. **CHA**

supports this change and appreciates that CMS is working to keep measures in use in its quality reporting programs consistent with current science.

Proposed Re-Adoption with Modification of the Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures

CMS proposes to readopt, with modification, the Hospital Outpatient Department Volume Data measure. This is a structural measure that would collect data on the aggregate volume of the top five most frequently performed surgical procedures in HOPDs which are included in one of eight specified categories. CHA supports the use of measures that provide clear data to help inform patients in their decision-making process. We also appreciate that volume metrics may assist in that process by serving as an indicator of which facilities have experience with certain procedures. However, we caution that a measure should not only be an indicator of experience of a facility in performing a procedure but, to truly be informative to providers and the patients who we serve, should also be an indicator of the quality of care provided and should yield data that are actionable.

Proposed Risk-Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting

CMS proposes to adopt the Risk Standardized THA/TKA PRO-PM measure into the Hospital OQR Program. This patient-reported outcome measure includes standardized functional status data collection preoperatively and for one year postoperatively. CMS proposes to begin with two sets of voluntary collection and submission periods followed by mandatory reporting. Measure results would affect payment determinations starting in 2030.

CHA is generally supportive of PRO-PMs for clinical conditions when reliable outcome tools are available for patient completion, as is true for this measure. We believe that the long-term (12-month) patient-reported follow-up included in the measure has considerable potential value for hospital and surgeon quality improvement initiatives and for beneficiary decision-making. We note that hospitals participating in the Comprehensive Care for Joint Replacement (CJR) bundled payment model have had the option of reporting this measure since the model began in 2016. The measure has been adopted into the IQR program (and the hospital-level measure is CBE-endorsed for such program). CHA is, however, aware that reporting this measure has proven extremely challenging and quite burdensome for hospitals. We appreciate that CMS is proposing two voluntary reporting periods for this measure under the OQR program. **CHA recommends that CMS defer any mandatory reporting requirements until data about its usage in the IQR program are publicly available and have been analyzed.**

Request for Comment: Topics for Potential Future Consideration

CMS solicits comments on patient and workforce safety measures for future consideration for adoption in the Hospital OQR program measure set, particularly the Severe Sepsis and Septic

Shock: Management Bundle measure. CHA applauds the advancement of patient and workforce safety, including through quality initiatives aimed at reducing high-cost and avoidable events. We believe that, as guiding principles, any safety measure adopted into the Hospital OQR program measure set should be data-driven, actionable, have utility, give feedback, and be feasible. We also continue to believe that any such measure should be endorsed by the CBE.

CMS specifically asks about the Severe Sepsis and Septic Shock: Management Bundle measure. While CHA supports CMS in its goals of advancing safety, we have concerns with a measure that requires adherence to a standardized protocol for treatment without explicit flexibilities for the health care provider to exercise their judgment and furnish care as medically needed and tailored to the individual patient. We bring attention to the comments raised in the pre-rulemaking, as well as presented in the FY 2024 IPPS/LTCH PPS final rule in discussing adoption of the measure for the Hospital Value Based Payment program, which voiced concerns over the burden associated with data abstraction, the potentially overly prescriptive nature of the protocol required by the measure, and the potential for risks such as the overuse of antibiotics.

We urge that before CMS considers any future adoption of the measure into the OQR program, that it first gathers sufficient evidence from use of the measure under the Hospital IQR program that supports there is a clear link between adherence to the measure protocol and improved health outcomes and that shows there is clear and explicit flexibility for the health care provider to deviate from the protocol based on the provider's medical judgment and the individual patient's needs.

CMS also solicits comments on behavioral health topics under consideration for measure development, specifically inquiring about measuring suicide screening in the HOPD setting. CHA commends CMS in recognizing the importance of behavioral health care, and access to such care, as well as advancing the quality of such care. Behavioral and mental health are a significant public health concern and the significant consequences of untreated behavioral and mental health conditions cannot be overlooked. A limited and strained workforce is a major impediment to providing adequate and equitable access to behavioral and mental health care in many communities, and therefore we believe appropriate measures that advance access to such care and measure if needs are being screened for and met are important. We also recognize that coordination of care with respect to behavioral and mental health is another important topic to address. It is not unusual for individuals with chronic health conditions to also require management of behavioral and mental health conditions and coordination of care is essential. CHA also agrees with CMS that the topic of suicide prevention and a measure of suicide screening in the HOPD is very worthy of future consideration. Assessment at the HOPD setting, including the emergency department, is a pathway that may lead to appropriate access to care. We support CMS' consideration of adding measures that would address these topics but urge it to ensure that any such measure would not increase burdens on a workforce that is already overburdened.

- **Rural Emergency Hospital Quality Reporting (REHQR) Program**

CMS proposes to adopt for the REHQR program a number of policies that are in alignment with other quality reporting programs, particularly the Hospital OQR program. **CHA generally appreciates and supports the agency's approach to align the REHQR program policies with the known and tested OQR program policies with which the REHs would be familiar.** We especially support CMS' focus on adopting measures that have been CBE-endorsed for the HOPD setting and that are clinically relevant and inform consumer decision-making while furthering quality improvement. **We believe it is essential, however, that the policies and measures adopted are appropriate and relevant to the REH context.** We continue to recommend that the measure set includes measures that have been successfully reported by most CAHs in the past. We also caution that the REHQR program should be especially attentive to avoiding the imposition of time and cost burdens on these facilities, which have limited resources and are still in their start-up phase. We also note that CMS proposes a sub-regulatory process to adopt any non-substantive updates to measure specifications. Understanding that this policy aligns with policies under the OQR and ASCQR programs, CHA is concerned with the use of a sub-regulatory process in certain circumstances, including in the context of a new program where transparency and the opportunity to comment on proposals is so essential.

In closing, thank you for the opportunity to share these comments on the proposed 2023 OPSS proposed rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,



Lisa A. Smith
Vice President
Advocacy and Public Policy