Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 13, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore MD 21244

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs for Calendar Year 2023 (CMS-1772-P)

Dear Ms. 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 2023 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; makes modifications to CMS's 340B policy for separately payable drugs; implements the Rural Emergency Hospitals provision; 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.

- **Payment Update**

CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, resulting in a CY 2023 update of 2.7%. The market basket estimates are based on historical data through the fourth quarter of CY 2021. They do not therefore adequately reflect the historic inflation and increased labor and supply costs faced by the health care industry that began in late 2021 and have continued at an increased pace in 2022. **We are deeply concerned that the proposed market basket update is woefully insufficient and urge CMS to take action to increase the market basket in the final rule to better account for these extraordinary circumstances in order to ensure that beneficiaries continue to have access to needed, quality outpatient care.** We also are concerned about the proposed reduction for productivity, which we believe does not make sense given the effect of COVID-19 on productivity in the health care sector.

CMS should reduce the productivity cut in the final rule. At the very least, CMS should elaborate with specificity on the basis for the proposed 0.4 productivity offset.

- **340B Payment Policies**

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 percent. On June 15, 2022, the United States Supreme Court held that the Secretary may not vary payment rates for drugs and biologicals among groups of hospitals in the absence of having conducted a survey of hospitals' acquisition costs. In the proposed rule, CMS indicates the Supreme Court's decision is only applicable to 2018 and 2019 but that it fully anticipates adopting ASP+6 percent in the final rule for drugs acquired under the 340B program effective beginning with 2023.

Given the timing of the Supreme Court's decision shortly before the proposed rule, CMS lacked the necessary time to reflect a payment policy other than the one it was intending to propose—ASP-22.5 percent—in the proposed rule although CMS did provide alternative files to analyze what payment rates would be at ASP+6 percent. **CHA supports CMS proposed intent to pay for drugs acquired under the 340B program at ASP+6 percent effective for 2023.** We are appreciative to CMS for applying this policy to years beyond those that were decided by the Supreme Court.

The Supreme Court did not specify a remedy for prior years. CMS is still evaluating how to apply the Supreme Court's recent decision to prior cost years and is interested in public comments on the best way to craft any proposed, potential remedies affecting calendar years 2018-2022. **CHA believes that CMS must compensate hospitals for underpayment of 340B drugs and urges CMS to determine the most expeditious and feasible way of furnishing 340B hospitals with the additional payments they are owed for the five years 2018-2022.**

Another issue associated with reversal of the 340B policy for past years would involve whether the patient would owe coinsurance on the additional Part B drug payments. On June 25, 2010, the Office of the Inspector General (OIG) permitted providers to waive additional coinsurance in response to the retroactive increases in payment resulting for the operation of new Federal statutes or regulations (in this case, a retroactive increase in physician fee schedule (PFS) payments due to an Act of Congress). The OIG indicated that "they [providers] will not be subject to Office of Inspector General (OIG) administrative sanctions if they waive Retroactive Beneficiary Liability [subject to specific conditions.][1]

We believe the OIG precedent should apply to retroactive increases in Part B drug payments made to 340B hospitals in past years that result from the changed CMS policy. That is, hospitals should

[1] *OIG Policy Regarding Providers, Practitioners, and Suppliers That Waive Beneficiary Cost-Sharing Amounts Attributable to Retroactive Increases in Payment Rates Resulting from the Operation of New Federal Statutes or Regulations,* OIG Policy Statement re Retroactive Beneficiary Cost-Sharing Liability Waivers (hhs.gov)

not be subject to administrative sanctions if they waive coinsurance for past years on the additional Part B drug payments CMS will be making for 2018 through 2022.

CMS implemented its 340B policy budget neutral in 2018 by offsetting the reduction in payments for drugs acquired under the 340B program with a +3.2 percent increase ($1.6 billion) in non-drug OPPS payments (82 FR 59370). One question CMS may be considering is whether the additional payments for non-drug OPPS services must be recouped for the 5-year period 2018-2022 as result of making additional payments drugs acquired under the 340B program for these years.

CHA urges CMS to consider actions in took with respect to a budget neutrality adjustment involving laboratory services beginning with 2014. In 2015, CMS realized that it did not correctly apply budget neutrality for packaging laboratory services into OPPS rates beginning in 2014. Under the authority of section 1833(t)(3)(C)(iii) of the Act, CMS made an adjustment to OPPS rates for 2016 so the overpayment would not carry forward into future years. However, CMS did not recoup any additional payments made in 2014 and 2015. CMS stated "the proposed -2.0 percent adjustment to the conversion factor would not recoup ''overpayments'' made for CYs 2014 and 2015 (80 FR 70354). We believe this example is the appropriate precedent for CMS to consider in the context of past year payments. **CHA urges CMS to hold the entire hospital field harmless for this policy for CYs 2018-2022 by not recouping any additional payments made as a result of its 340B budget neutrality adjustment in past years.**

- **Determination of the OPPS Conversion Factor**

The reversal of CMS' policy on 340B drugs also has implications for the calculation of the OPPS conversion factor. In the 2018 OPPS final rule (82 FR 59482-59483), CMS described its methodology for determining the savings associated with its 340B policy of paying for separately payable drugs at ASP-22.5 percent. Based on modeling assumptions and data from that time, CMS estimated that OPPS drug payments would be reduced by $1.6 billion and a budget neutrality adjustment of +3.19 percent would be applied to all non-drug OPPS items and services to meet the statutory budget neutrality requirement. CMS has not changed or updated this budget neutrality adjustment despite public comments asking CMS to do so.[2]

CMS' failure to update the 340B adjustment is inconsistent with its application of other policy adjustments (outliers, pass-through, wage index) where CMS updates budget neutrality adjustment based on updated data even when the policy is unchanged. For outliers and pass-through, CMS annually removes the prior year adjustment before applying the new payment year adjustment. CMS' failure to follow this same practice for 2020, 2021 and 2022 has resulted in underpayments to hospitals for these years as the proposed rule indicates that the budget neutrality adjustment for 2023 would now be higher than 3.19 percent.

[2] 85 FR 86054 and 86 FR 63648

CMS now proposes in the final rule to reverse its 340B policy and apply a budget neutrality adjustment of -4.04 percent (0.9596) even though it only ever increased OPPS rates for the reduction in 340B drug payments by 3.19 percent. This proposed policy will result in a permanent reduction in OPPS payments equal to the 0.85 percentage point difference between the +3.19 percent adjustment made in 2018 and the -4.04 percent adjustment CMS proposes to apply for 2023 or $410 million based on data in the 2023 proposed rule.

This adjustment is inequitable and inconsistent with the statutory requirement for budget neutrality under section 1833(t)(9)(B) of the Act. CMS is limited to removing the +3.19 percent adjustment it added to OPPS rates in 2018 for the 340B policy. **CHA requests that CMS only apply a budget neutrality adjustment of -3.19 percent for reversing its 340B policy in 2023.**

Another issue that CMS must consider is the effect of the 340B policy on pass-through payments. On page 44528 of the proposed rule, CMS says the difference between pass-through payments is 1.24 percent in 2022 and 0.9 percent in 2023 or a net adjustment of +0.34 percentage point to the update for budget neutrality. However, on page 44661 of the proposed rule, CMS says after taking into account the 340B policy that will be adopted in the final rule, pass-through payments will be nearly $593 million lower or 0.21 percent of OPPS payments. As pass-through payments will be 0.21 percent of OPPS payment, the net adjustment for pass-through will be the difference between 1.24 percent in 2022 and 0.21 percent in the final rule. The net adjustment should now increase to +1.03 percentage points. **CHA requests that CMS apply a net +1.03 percentage point adjustment for pass-through payments in the 2023 final rule.**

- **Reporting Discarded Amounts for Single Use Vial Drugs**

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.

CMS' proposal will require that hospital outpatient departments report the JW modifier or any successor modifier to identify discarded amounts of refundable single-dose container or single-use package drugs or biologicals that are separately payable under the OPPS or ASC payment system. In addition, CMS proposes to require hospitals to use a separate modifier, JZ, in cases where no billing units of single use container were discarded.

The requirement to append the JW modifier has been in place since 2016. CMS believes that compliance with JW modifier policy has been poor as hospitals are paid the full amount for a single drug vial whether the entire vial is used or a portion administered and a portion discarded. As a result, CMS proposes a new requirement beginning with 2023 for hospitals to append the JZ modifier attesting that the entire amount of product in the single use vial was administered and none was discarded. CMS believes the JZ modifier requirement will improve provider compliance with this provision.

CHA asks CMS to consider that use of this additional modifier places an additional administrative burden on hospitals even though the discarded drug refund provisions apply to drug manufacturers. Further, the payment policy incentives to hospitals are unchanged—the hospital will continue be paid for the entire single use vial irrespective of whether a portion is administered and a portion discarded irrespective of whether the hospital uses the JZ modifier or no modifier and the JW modifier. **Rather than requiring hospitals to append an additional modifier to the claim, CHA requests that CMS improve its provider education to hospitals** by explaining the importance of using the JW modifier on the claim to be in compliance with the law and that the absence of a modifier is functional attestation that no drug product from a single use vial was discarded.

- **Mental Health Services Furnished to Patients in their Homes**

During the pandemic CMS has used its waiver authority to allow beneficiaries to receive services, including mental health services, in their homes from a clinical staff member of a hospital or CAH using communications technology. Once the PHE ends, without changes to the regulations, beneficiaries would need to travel to be physically present in hospital settings to continue receiving outpatient hospital mental health treatment services from hospital clinical staff. CMS is concerned about the negative impact this could have on access to needed mental health services, especially in the face of the mental health crisis our country is facing. Therefore, CMS proposes to amend the regulations to designate certain services provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder performed remotely by clinical staff of a hospital using communications technology to beneficiaries in their homes as hospital outpatient services payable under the OPPS.

CHA strongly supports the proposed regulatory change to allow at-home mental health services under the OPPS to continue after the PHE. We share CMS' concerns about the urgent need to ensure that beneficiaries have access to mental health care. Supportive and readily available mental health services and substance use disorder treatments are essential facets of holistic, person-centered and effective health care. CHA and its members support efforts to increase access to these services and to ensure that they become fully integrated into our health care system.

CMS has proposed to create new OPPS payment codes for these services based upon PFS facility payment rates because it believes the cost of providing the care will be the same as would be provided in the PFS setting. However, expanded access to virtual and remote services does not negate the need for hospitals to maintain capacity for in-person care, which is how most patients receive their care. While hospital staff may be using communications technology to furnish a service remotely rather than in-person, the hospital outpatient departments continue to have the same administrative cost (e.g,, scheduling, billing, and the electronic health record) and staffing costs (nursing staff to "virtually room" the patients). **CHA urges CMS to reconsider the proposal to base the OPPS rates on the PFS.**

Consistent with analogous provisions that apply under the PFS, in rural health clinics (RHCs) and federally qualified health centers (FQHCs), CMS proposes that there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service. The proposal would allow for what it calls "limited exceptions" to this requirement if the patient and practitioner agree that the benefits of an in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record, the in-person visit requirement will not apply for that 12-month period. **We agree with the inclusion of an option to waive the requirement and urge CMS to apply it in a manner that does not unduly restrict patient access to mental health services. We also support the proposal to delay the in-person visit requirements for 151 days after the end of the public health emergency.**

CMS further proposes to allow practitioners to provide mental health telehealth services via audio only communications where the beneficiary is not capable of, or did not consent to, use of two-way, audio/video technology and the hospital may use audio-only communications technology given an individual patient's technological limitations, abilities, or preferences. **CHA supports this proposal**.

- **Use of Claims Data for CY 2023 Rate-setting Due to the PHE**

CMS deviated from its normal practice of using the latest available claims and cost report data for setting the 2022 OPPS rates because of concerns about the impact of the COVID-19 PHE on the data and, in turn, the rate setting process. As a result of these concerns, CMS continued to use claims data and cost reports from prior to the PHE to set OPPS rates. CHA supported that policy. For 2023, CMS is proposing to use 2021 claims but continue to use cost reports from prior to the pandemic to set 2023 OPPS rates. While 2021 claims may continue to be affected by the PHE, CMS believes they will be a better approximation of utilization in 2023 than 2019 and are showing less impact on the rate setting process than if CMS used 2020 utilization. **CHA believes CMS is making a reasonable assumption and supports use of 2021 utilization in setting 2023 OPPS rates.**

The same opportunity to skip over 2020 cost reports in setting 2023 rates is not yet available as there is a time lag of three years between the year of the cost reports used in rate setting (2020) and the payment year for which rates being set (2023). CMS proposes to use pre-2020 cost reports to set rates for the 2023 OPPS, the same cost reports that were used to set rates for the 2021 and 2022 OPPS rates. If CMS were to follow its normal practice, it would use cost reports beginning in 2020 to set 2023 OPPS rates. The proposed rule indicates that use of these data would have "significant impact at the service level when incorporating these cost reports into rate-setting and the effects on billing/clinical patterns, similar to what [CMS] observed in the CY 2020 claims when reviewing them for the CY 2022 OPPS/ASC rulemaking cycle." [Source is 87 FR 44681]. However, CMS also considers the alternative of using cost reports that begin in 2020 to set 2023 rates and provides an alternative impact file on its website in the event public comments are interested in CMS

returning to its traditional practice of using cost reports that begin in the calendar year 3 years prior to the rate year (2020 for 2023) for OPPS rates setting**.**

CHA supports CMS' proposal to use pre-2020 cost reports in the rate setting process and opposes the alterative that CMS indicates it would consider adopting based on public comments. CHA appreciates CMS consideration of potential alternatives and seeking public comment on them but believes there has been a general consensus in public comments to avoid COVID affected data from 2020 in the rate setting process.

- **Supervision by Non-physician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients**

CMS proposes to clarify that certain non-physician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwifes) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable state law. **CHA supports allowing providers and practitioners to practice at the top of their license.**

- **Payment Adjustments: Domestic NIOSH-Approved Surgical N95 Respirator Masks**

CMS proposes to make a payment adjustment under the OPPS and inpatient prospective payment system (IPPS) for the additional resource costs that hospitals face in procuring domestic National Institute of Occupational Safety and Health (NIOSH)-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023. Payment would be on a reasonable cost basis as a biweekly interim lump-sum payment that would be reconciled at cost report settlement. The payment would be based on the cost difference between a domestic NIOSH approved N95 mask and non-domestic manufactured mask.

While CHA is grateful to CMS for subsidizing the purchases of the highest quality masks that can protect hospitals patients and their employees against the future spread of infections, we remain concerned about the complex payment methodology and cost reporting requirements that will be imposed on hospitals. Further, CMS proposes a budget neutrality adjustment for the additional payment subsidy for OPPS payments that is counterintuitive to the policy goal of subsidizing the purchase of these supplies.

CHA supports CMS' proposal to subsidize the purchase of domestically manufactured N95 masks but requests CMS explore a simpler option to meet the same goal that does not require an offsetting budget neutrality adjustment.

- **Exempting Rural SCHs from Clinic Visit Office-Campus Payment Limitation**

Since 2019, CMS has been paying a PFS equivalent rate for a clinic visit provided in a grandfathered or excepted off-campus provider-based department (PBD). The PFS equivalent rate has been 40 percent of the full OPPS rate since 2020. Beginning in 2023, CMS proposes rural sole community hospitals will be excepted from being paid the PFS-equivalent rate in an excepted off-campus PBD. **CHA supports exempting rural SCH's from the site-neutral policy and urges CMS to exempt other rural hospitals from the clinic visit cuts,** such as rural hospitals with fewer than 100 beds, and all Medicare-dependent Hospitals (MDHs), Low-volume Adjustment (LVA) program hospitals and rural referral centers**. CHA continues to oppose the application of the PFS equivalent rate to any excepted off-campus PBDs and urges CMS to abandon this policy across the board.**

- **Rural Emergency Hospitals (REHs)**

Section 125 of the Consolidated Appropriations Act (CAA), 2021 establishes REHs as a new Medicare provider type that will furnish emergency department services and observation care. The REH must have a staffed emergency department 24 hours a day, seven days a week. In addition, an REH may elect to furnish other medical and health services on an outpatient basis as the Secretary may specify through rulemaking. REHs may not provide acute inpatient services, with the exception of skilled nursing facility (SNF) services that are furnished in a distinct part unit. CMS is proposing to define "REH services," as all covered outpatient department services that would be paid under the OPPS. **CHA supports this proposal.**

Consistent with the law, CMS proposes that payments for REH services will equal the applicable OPPS payment for the same service plus an additional 5 percent. **CHA supports this proposal.** CMS notes that its definition of REH services, by law, cannot include services that may be provided in outpatient departments that are not paid under the OPPS such as laboratory services and outpatient rehabilitation therapy services. The REH may be required by the conditions of participation to provide these services but they are ineligible for the five percent additional payment as they are not paid under the OPPS. **CHA appreciates that CMS' authority is limited. Nevertheless, we appreciate CMS's consideration of applying the five percent bonus to all services provided by the REH including those that are not paid under the OPPS.**

In addition to the five percent bonus on OPPS payment, REHs are also eligible for a monthly payment of $268,924 that will be indexed to inflation after 2023. Under the law, this additional payment is determined as the difference between how much a CAH was actually paid in 2019 and how much it would have been paid for inpatient, outpatient, skilled nursing facility services under the applicable prospective payment systems. The proposed rule includes a complex description of how CMS determined these calculations. **CHA supports the additional monthly payment for REHs**.

We note that the additional monthly payment and the five percent bonus will likely only result in the lowest revenue CAHs and small rural hospitals converting to REH status as these are the only facilities where revenue as an REH is likely to exceed payment as a CAH or small rural hospital. Nevertheless, if the REH program provides an incentive for a CAH or small rural hospital to maintain an outpatient presence in a community where an inpatient hospital or CAH cannot be maintained, CHA believes the program will be serving a worthwhile policy goal.

- **Prior Authorization**

Effective for dates of services on or after March 1, 2023 CMS proposes to add the service category, Facet Join Interventions, to the prior authorization list, a policy CMS first established beginning in 2020 over the objections of CHA and many other public commenters. Facet joint injections are often used as an alternative to opioids to treating chronic pain. Subjecting this procedure to prior authorization could lead physicians to prescribe opioids for their patients. **CHA believes that CMS should be encouraging rather than discouraging non-opioid treatment alternatives given the epidemic of opioid addiction in the United States and respectfully requests that it not subject facet joint injections to prior authorization.**

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

Cataracts Improvement Measure

CMS proposes to return this measure to voluntary instead of mandatory reporting status beginning with the CY 2025 reporting period/CY 2027 payment determination and deferring further activity related to status of this measure until the end of the COVID-19 PHE. **CHA appreciates the proposal by CMS to return this measure to voluntary reporting status and reassess its decision after the COVID-19 PHE ends.** This measure has had a complicated history. Despite multiple refinements it continues to have low uptake by hospitals for voluntary reporting. We appreciate the value that a meaningful cataract outcome measure could add to the OQR Program but OP-31 does not appear to be successfully fulfilling that role. Before CMS reconsiders mandatory reporting, we encourage CMS to seek input from hospitals that have consistently not reported this measure voluntarily to better understand the potential barriers to this measure's adoption. Re-proposing the same measure seems likely to be similarly unsuccessful for CMS or hospitals.

Aligning OQR Program Patient Encounter Quarters to the Calendar Year

CMS proposes to align the patient encounter quarters for the OQR program's chart-abstracted measures with the calendar year. All four quarters would be based on the calendar year that is two years prior to the applicable payment determination year.

CHA supports this proposal. Alignment between hospital quality programs wherever feasible reduces provider burden. We ask that CMS clarify the clinical data submission deadlines for CY

2024 as there appears to be a mismatch between deadlines previously finalized in the CY 2022 OPPS/ASC final rule and what is shown in Table 66 of this proposed rule.

Hospital OQR Program Validation Requirements

CMS proposes to adopt an additional targeting criterion for use in hospital selection for OQR program data validation beginning with the CY 2023 reporting period/CY 2025 payment determination for hospitals having less that 4 quarters of data available or validation after having been granted an extraordinary circumstances exception (ECE) for those data. **We appreciate that CMS wants to ensure fair treatment of hospitals that have experienced situations leading to ECE waivers, and CHA supports this change.**

- **RFI: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures**

CMS requests input on the potential inclusion of a procedure volume measure in the Hospital OQR Program, to be accomplished either by (1) re-adopting the *Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP–26)* measure or (2) adopting another volume indicator. The agency also invites comments on what volume data hospitals currently collect and if it is feasible to submit those data to the OQR Program as an approach to minimizing collection and reporting burden of a new volume measure.

CHA recognizes the potential value to beneficiaries of HOPD procedure volume data when making decisions about where to undergo outpatient procedures. We agree with CMS that procedure volume in part may serve as a proxy for adjuncts to high-quality care such as dedicated teams for certain types of procedures (e.g., ophthalmologic, orthopedic) but volume data in isolation are not sufficiently robust to guide beneficiary decision making or accurately portray a hospital's overall quality performance. If CMS decides to pursue adding procedure volume metrics to the OQR Program, we favor a few, carefully-selected measures that are procedure or specialty specific and that are backed by evidence showing patient outcomes are improved by higher hospital volumes.

- **RFI: Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs**

CMS rightly states that significant inequities in healthcare outcomes persist in the United States and reiterates a potential role for quality measure results stratification to identify and quantitate disparities in Medicare's quality programs. CMS directs readers to the RFI "Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs" in the FY 2023 IPPS proposed rule and asks readers to provide input on the topics addressed in that RFI from the perspective of applicability to the OQR, ASCQR, and Rural Emergency Hospital (REH) QR Programs. CMS notes that the RFI focuses on principles for measuring disparities and describes 5 key considerations as a framework for stakeholder responses. CMS defines health equity as *"the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation,*

gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes". CMS also adopts a definition of measure stratification as *the calculation of measure results for specific groups or subpopulations of patients*.

CHA appreciates the continued commitment by CMS to address health inequity and care disparities across its quality enterprise. The Catholic health ministry is committed to achieving health equity, eliminating racial and ethnic disparities in health outcomes and improving access to quality health care for all, a commitment that is deeply rooted in our mission. In 2021 CHA and our members launched our Confronting Racism by Achieving Health Equity pledge/We Are Called initiative to recommit to ending health disparities across our country and to dismantling the systemic racism that remains ever-present in our society. The initiative is our shared effort to achieve equity in our own health systems and facilities and to advocate for change in the wider health care sector and our society. Almost 90% of our members have signed on to the four pillars of the pledge: working to achieve equity in COVID-19 testing, treatment and vaccination; putting our own houses in order; building just and right relationships with our communities; and advocating for change at the federal, state and local levels to end health disparities and systemic racism.

We direct you to our detailed comments on the FY 2023 IPPS proposed rule which provide the basis for our comments below, organized under the agency's key considerations and modified to focus on ambulatory care settings. As we noted in our earlier comment letter, we urge CMS to proceed in manner that prioritizes collaboration over competition.

Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs

CHA believes that facility-specific stratified results can support meaningful analyses by ambulatory providers of their within-facility and cross-facility outcomes. It is important to avoid measurement and selection biases during stratification. As a check on data validity and reliability, we urge CMS to routinely check results for internal inconsistencies as well as consistent directional trends for interrelated stratification variables.

Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting

CMS should ensure that measures focused on health equity and disparities are:

- Data-driven: Developed based upon well-documented disparities in outcomes of ambulatory care having clear associations to well-defined social risk factors;
- Actionable: Designed to yield performance results for ambulatory care settings for which change is possible;
- Focused on utility: Ambulatory care process measures may be more feasible initially and could point the way to meaningful outcome measures
- Informative: Constructed for timely performance scoring and prompt provider feedback; and

- Feasible: Based on considerations of provider burden in ambulatory care settings and operational capabilities at CMS to manage ambulatory care data.

Principles for Social Risk Factor and Demographic Data Selection and Use

CHA recommends that CMS begin disparity analyses and stratified reporting with demographic and social risk variables for which CMS already has large data sets potentially relevant to ambulatory care settings (e.g., Part B claims data, beneficiary enrollment files). Variables used for disparities analyses should have clear and standardized definitions, recognize differences between the HOPD, ASC, and REH settings and take into account practical barriers to the number of ambulatory care variables given finite provider and CMS resources. CMS should also seek out alternative sources of social risk factor data being used in other HHS initiatives, other federal programs, and activities underway outside of HHS (e.g., MedPAC).

Identification of Meaningful Performance Differences

CHA believes that preferred methods for identifying differences in ambulatory care settings should reflect the quality measure and program, the sociodemographic variable being studied, provider type, and intended audience for the results. Decision making should most often rest at the ambulatory care program level though domain, subgroup, and measure level decisions could be appropriate in select circumstances. CMS should assess whether results from chosen methods will be effective tools in leading ambulatory care providers to conduct self-directed analyses that could lead to effective interventions to reduce disparities in ambulatory care settings. CMS should carefully tailor preferred method choices to the specific HOPD, ASC, and REH settings, avoiding a "one size fits all" strategy.

Guiding Principles for Reporting Disparity Results

CHA believes that confidential reporting to providers is appropriate for ambulatory care measures and initiatives involving stratification for demographic and social risk factors when preceded by a review and correction process and being subject to data validation. Transition to public reporting of ambulatory care measures should be planned and implemented in an unhurried manner, and only after the data collected have demonstrated a high degree of reproducibility and a period of confidential reporting sufficient to identify unintended consequences has elapsed.

- **Request for Comments on Potential Rural Emergency Hospital Quality Reporting (REHQR) Program Measures**

The statute requires the Secretary to establish quality reporting requirements for REHs, require data submission at least quarterly, and publicly post performance data. In the 2022 OPPS PFS proposed rule, CMS solicited public comments to inform its policy making for REHs including quality measurement (86 FR 42288). A recent proposed rule addressed REH Conditions of Participation,

but quality measure specifications and quality reporting requirements for REHs were deferred to future rulemaking (87 FR 40350).[3] In the current RFC, CMS provides a comprehensive discussion of potential program frameworks and measures.

CHA appreciates the breadth of thought that is reflected in the material presented by CMS. We recommend that the initial measure set be limited and include measures that have been successfully reported by most CAHs in the past. Gradual expansion of the program's measure set will be a more successful strategy that hasty adoption of a large measure set to which multiple revisions will quickly be needed. We note that the REHQR Program should be especially attentive to avoiding the imposition of time and cost burdens on these facilities with limited resources and who are in their start-up phase. We regard the agency's request for comment as the opening step of an ongoing dialogue.

In closing, thank you for the opportunity to share these comments on the proposed 2023 OPPS 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

[3] The comment period for this proposed rule closed August 29, 2022.