DRAFT

September 13, 2022

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W.

Room 445-G

Washington, DC 20201

***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.***

Dear Administrator Brooks-LaSure:

On behalf of the Washington State Hospital Association (WSHA) and our more than 100 member hospitals and systems, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) hospital outpatient prospective payment system (OPPS) proposed rule for fiscal year (FY) 2023. We have significant concerns over the proposed payment update for OPPS hospitals for FY 2023 To ensure that Medicare payments for acute care services more accurately reflect the actual cost of providing hospital care, we urge CMS to consider and implement the specific changes below.

**Market Basket Increase**

For FY 2023, CMS proposes a market basket update of 2.7 percent, less a productivity reduction of 0.4 percentage points. Unfortunately, this update lags far behind actual increases in the cost of providing care experienced by hospitals in the current inflationary environment. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future**.** We appreciate the consideration of this concern that occurred in the final IPPS rule. The same inflationary dynamics that affect inpatient services also apply to outpatient care. We request similar consideration be made when determining the final marketbasket rate. Share information regarding the increases in costs experienced by your facility.

**Productivity Adjustment**

Additionally, we ask that CMS reduce or eliminate the productivity cut for FY 2023.The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and assumes the hospital field can adopt productivity gains at a rate that partially offsets increases to input costs. This is not possible when costs increase more suddenly and rapidly than efficiency and productivity gains can occur, particularly given the disruptions to normal hospital processes as a result of the public health emergency. Share information regarding the struggles of maintaining productivity increases during the PHE. Therefore, we have strong concerns about the proposed productivity cut given the extreme and uncertain circumstances in which our hospital is currently operating. We urge CMS to reduce or eliminate the productivity cut for FY 2023.

**340B Hospital Payments**

WSHA supports the proposal to return to the payment policy in place prior to 2018, that is payment at the prior ASP + 6% rate. Regarding the time period from 2018 to 2022 where payments were made at the reduced ASP – 22% rate, we ask that CMS calculate the difference in payments specific to the drug component of the claims and make prompt lump sum payment to the affected 340B hospitals for the underpaid claims. We recommend this be done without reprocessing to avoid any impact on patient coinsurance. Also, we recommend no retroactive recoupment be made for the budget neutrality adjustment to the regular OPPS services. We do not believe hospitals, whether they be 340B or non-340B should be penalized for CMS’ application of a policy determined to be unlawful. Retroactive recoupment of payments made over a 5-year period would create enormous financial strain on hospitals already struggling with the impacts of the public health emergency. Share regarding your hospital’s financial need and impact of the reduced payments and need for prompt payment of the amounts that were improperly reduced. Also share the negative impact of any retroactive recoupments OPPS payment as a result of the budget neutrality adjustment.

**Site Neutral Clinic Visit Cuts**

WSHA appreciates CMS’ admission that it has determined that the reduction in independent physician clinics that has occurred over time is not due to the payment levels provided hospital-based clinics and that the cuts to hospital clinic payment have in fact threatened access to care for Medicare and other patients. There are many factors that contributed to the reduction in independent clinics, and we believe the anecdotal narrative that formed the rationale for the cuts has been discredited. In our experience, the growth in hospital-based clinics has resulted from the need to preserve services in the community that were not sustainable as independent clinics, or provision of new clinics to address specific needs not otherwise met in the community, especially for Medicare and Medicaid patients. The policy’s characterization of preserved and improved access to care as “unnecessary” has significantly impacted the ability of hospitals to provide the range of services needed in their communities. Share regarding impact of the cuts on your community and need for resumption of full OPPS payment for HOPD clinic services.

We strongly support CMS’s proposal to restore full OPPS payments to clinics operated by rural sole community hospitals. We also strongly support restoration for other rural hospitals. We ask CMS to consider restoration of full OPPS payment to include hospital-based clinics in urban areas, particularly those who can demonstrate that they service a high proportion of Medicare, Medicaid, and other underserved patients. The erosion of independent clinics able and willing to see Medicare and Medicaid patients is not limited to rural areas. Full reversal of the clinic cuts would serve CMS’s goals of access and equity.

**Hospital Outpatient Outlier Payments.**

WSHA is concerned about the proposed increase to the outlier threshold. While we support the concept that a relatively small proportion of claims should be paid under an outlier methodology versus regular OPPS payment, the emphasis should be on ensuring adequate payment for services rather than shifting a greater proportion of the cost to hospitals. Washington state has a lower inpatient admission rate than most other states because our hospitals perform many surgeries that can be performed either inpatient or outpatient on an outpatient basis. This reduces aggregate inpatient costs but does mean a higher complexity for outpatient services. Application of a higher outlier threshold would penalize hospitals that provide care in the most cost-effective setting. We request CMS reexamine the methodology before implementing this change. Share regarding impact of the proposal on you provision of high-complexity procedures.

**Payment Adjustments for N95 Respirators**

WSHA supports efforts to encourage use of domestically produced N95 respirators. However, we have concerns about providing a payment adjustment on a budget neutral basis. While higher payment will make production and acquisition of domestic N95 respirators more feasible for both hospitals and manufacturers, there are differences in the degree that hospitals have access to domestic respirators due to their size/scale and geography. We are concerned a budget neutral approach will penalize more vulnerable hospitals that are not able to procure domestic respirators at the same rate as other hospitals. We encourage CMS to provide an adjustment for domestic acquisition that is not offset by reductions to hospitals that cannot access the domestic supplies. Share regarding impact on your facility if unable to obtain domestic N95s at reasonable cost.

**Coding for Reporting Discarded Amounts of Single Use Drugs.**

CMS proposes to require hospitals, ASCs, and physician office bill a “JZ” code to indicate cases where certain drugs are used in its entirety, and none was discarded. These entities already must bill “JW” in cases where discarding took place, so a separate coding requirement in the absence of discarding would be duplicative and not improve accuracy. We believe greater accuracy can be obtained through improved provider education rather than a new billing requirement. Share regarding the impact and additional coding burden if the CMS proposal is implemented.

**Rural Emergency Hospitals**

We appreciate the CMS’s proposal to enable hospitals to transition to a Rural Emergency Hospital model. Since this would be a major change that would not be limited to Medicare enrollees. We request CMS provide more specifics regarding the program would operate, particularly as hospitals transition from cost-based to OPPS-based reimbursement. As noted earlier in this letter, inflationary increases greatly surpass the rate of payment increases under OPPS. This is a significant issue for small rural hospitals. Since a REH would need to cease operations of many of its current services, their ability to cross-subsidize losses from other services and payors would be very limited. Also, more clarity is need on how a transition to an REH would impact payment for hospital-based rural health clinics. In many communities, hospital RHCs are the main or only source of primary care. We believe that conversations regarding transition to this model must ultimately be led at the local level in partnership with rural communities. We firmly believe that states and local communities must maintain the autonomy to make informed decisions about appropriate care models. Such models must remain voluntary. Share regarding what information needed to fully evaluate the feasibility of the REH proposal for your facility and community.

Thank you for your consideration of our comments. If you have questions regarding our comments, please contact Andrew Busz, Policy Director Finance, at andrewb@wsha.org.

Sincerely,

 

Jacqueline Barton True Andrew Busz

VP, Rural and Federal Programs Policy Director, Finance

Washington State Hospital Association Washington State Hospital Association