Washington State
Hospital Association

DRAFT

September 17, 2021

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-1753-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals

Dear Ms. Brooks-Lasure:

On behalf of the Washington State Hospital Association's more than 100 hospital and health system members, we appreciate the opportunity to comment regarding the proposed outpatient prospective payment hospital and ambulatory surgical center rule. We are commenting on a few of the proposed rule's provisions that we believe are of greatest impact for our members.

Proposal to Preserve and Reinstate the Inpatient-Only List

WSHA strongly supports CMS' proposal to halt the three-year phased elimination of the IPO list that was finalized in CY 2021 and reinstate the 298 services removed from the IPO list in CY 2021 back to the IPO list beginning in CY 2022. As we stated in our comments on the 2021 OPPS rule, believe the IPO list helps reduce administrative burden and provides financial certainty for patients. It is beneficial for patients and hospitals to have certainty regarding coverage and payment for specific services where there is a high likelihood that inpatient resources will be necessary.

We also support CMS's proposal to exempt for two years from medical site of service review those procedures that were removed from the IPO list on or after Jan. 1, 2021. Hospitals should

not have to endure the administrative burden and financial risk of justifying to payors the appropriateness of inpatient care where IPO status for the service has been reinstated.

[Share the beneficial impact of the proposed change in reducing burden and risk for your facility, particularly during the PHE.]

Proposal to Re-Adopt ASC Covered Procedures List Criteria

WSHA strongly supports CMS's proposal to re-adopt the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020 and remove 258 of the 267 procedures that were added to the ASC CPL in CY 2021. We applaud CMS's recognition that a thoughtful process is necessary to ensure services that are performed in ASCs can be safely performed. As we mentioned in our comments on the 2021 proposed rule, the criteria provide important patient safety guardrails intended to exclude from coverage those procedures that would pose a high-risk of complications that ASCs are not equipped to handle, yet allow appropriate surgical procedures to be added to the ASC-CPL.

[Share regarding the impact of the change in protecting patient safety by ensuring services are provided in an appropriate setting.]

Medicare Payment for Drugs Provided by 340B Hospitals

WSHA opposes CMS' proposal to continue its policy to pay for 340B drugs at Average Sales Price (ASP) minus 22.5 percent, about a thirty percent reduction from the payment rate prior to the cuts. On July 2, the Supreme Court of the United States agreed to take up a request by the American Hospital Association and other hospital organizations that the Court review an appeals court decision affirming the cuts. We believe the magnitude of the cuts exceed CMS' authority and CMS should cease reductions through rulemaking until after the reconsideration has been completed.

For more than 25 years, the 340B program has been critical for hospitals to stretch scarce federal resources to reach more eligible patients and provide more comprehensive services. Hospitals rely on these savings to provide important services and resources that they may otherwise be unable to provide, many of which are targeted to low-income and otherwise vulnerable communities. These savings have proved especially important as 340B hospitals are also on the front lines of the COVID-19 PHE. WSHA continues its opposition to any payment cuts made to 340B hospitals and asks HHS to immediately reverse this harmful policy and ensure these hospitals can continue to provide vital services for the patients and communities they serve.

[If a 340B Facility, share the impact of the cuts on your ability to provide care for your patients and communities.]

WSHA Opposes the Continued Application of Site Neutrality to Grandfathered Hospital Clinics

WSHA strongly urges CMS to reconsider and rescind its reduction to clinic services provided at grandfathered off-campus hospital department sites. For CY 2022, CMS would continue to pay for the hospital outpatient clinic visit services in off-campus excepted provider-based departments at 40% of the OPPS payment amount. WSHA continues to believe that the payment cut for hospital outpatient clinic visits threatens access to care, especially in rural and other vulnerable communities, and that CMS has undermined clear congressional intent and exceeded its legal authority.

We disagree with CMS' rationale that the growth of the volume of services provided by hospital clinics is "unnecessary" and could have been and would have been provided in a different setting in the absence of hospital-based payment. Expansion of the proportion of care provided through hospital-based clinics is a reflection and result of hospitals' efforts to address access issues that are result of an unsustainable physician payment model. Hospital-based clinics are not the cause of these issues but are an important means for patients to access care in light of them.

In addition to the legal grounds for restoration of payment, we believe the hospital-based payment is justified based on health care policy and access. Clinics operated by hospitals and health systems provide a significant proportion of the primary care and specialty care physician services available to Medicare patients, particularly in rural areas. The cuts threaten hospitals' ability to provide needed services, in some cases where there are few or no freestanding clinic alternatives in the community.

[If you operate hospital-based clinics, share specific examples of how they provide specific services that would not otherwise be available to Medicare and other patients in your community.]

For several reasons, including unsustainable low reimbursement in Medicare fee schedule payments, payer mix, and increasing regulatory and technology requirements, many private practices have closed or severely limited access for Medicare patients. Specialized services such as cancer care, wound care and other specialized services are clinically and financially unsustainable in a non-hospital context. As a result, hospital-based clinics are the primary or only source of clinic services for Medicare and Medicaid in many communities. In some cases, establishment of off-campus hospital clinics was necessary to preserve services that would otherwise be forced to close; in other cases, to meet growing demands for services that had previously been unmet. During the current COVID emergency, hospital clinics have generally remained open to care for patients where many of their freestanding counterparts were not available.

All of this discussion supports the conclusion that CMS should reverse its unlawful and harmful policy reducing payment for outpatient clinic visits in excepted hospital-based clinics.
We appreciate your consideration of our comments. If you have questions, please contact Andrew Busz at andrewb@wsha.org.

Sincerely,

Jacqueline Barton True
VP, Rural and Federal Programs
Washington State Hospital Association

Andrew Busz
Policy Director, Finance
Washington State Hospital Association