AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 11, 2023

VIA ELECTRONIC MAIL
regulations.gov

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: CMS-1786-P Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor

Dear Administrator Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include nearly 100 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole. Specifically, we offer comment to CMS on the following issue areas within the CY 2024 OPPS proposed rule:

- Hospital Price Transparency
- Mental & Behavioral Health
- Quality Reporting Measures
- Request for Information: Inpatient Only List
- Request for Information: Essential Medicines Buffer-Stock Payment

Hospital Price Transparency

CMS proposes to standardize the formatting and data requirements for Machine Readable Files (MRF) in an effort to boost hospital price transparency. CMS also proposes changes to how these MRFs are linked on hospital websites to increase accessibility for patients and automated compliance verification measures.

AHPA supports the proposals to standardize and ease access to machine readable files. However, we urge CMS to consider extending the grace period from March 1 to July 1 of 2024 for enforcement of these changes so as to allow hospitals time to reconfigure their data-reporting systems and update MRF templates.

We also recommend that CMS work with the Departments of Labor and Treasury to align the various current price transparency requirements and minimize confusing or conflicting information for patients. We believe that patients who are "shopping" for a provider and/or procedures need to have access to the breadth of information necessary to create an estimate of cost-sharing responsibility. As mentioned in previous comments to CMS, insurers hold most of a patient's cost information, including whether a patient has met his or her deductible. **Before implementing additional price transparency regulations, we ask that CMS implement the price transparency and surprise billing requirements included in the No Suprises Act for health insurers.**

Mental and Behavioral Health

CMS proposes to establish payment under Part B for intensive outpatient (IOP) treatment services furnished by Opioid Treatment Programs (OTPs). This would be a new benefit that was created by the Consolidated Appropriations Act (CAA) of 2022.

AHPA supports leveraging the new IOP benefit to increase access to treatment for opioid use disorders, particularly given Premier's analysis that the ongoing opioid epidemic costs hospitals more than $95 billion per year.[1] In order to expand access to more intensive partial hospitalization program (PHP) services, **AHPA urges CMS to make permanent the flexibilities instituted due to the COVID-19 public health emergency.** Specifically, we recommend that CMS continue waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623, as well as the provider-based department requirements at 42 CFR §413.65, to allow provider-based PHP programs

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[1] How Opioid Misuse is Costing Health Systems, Premier, Inc. (2023)

to establish and operate, as part of the hospital, any location meeting the conditions of participation that continue to apply.

Quality Reporting Measures

COVID-19 Vaccination Among Healthcare Personnel

For the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) measures, CMS proposes to refine the *COVID-19 Vaccination Among Healthcare Personnel* measure to align with the latest CDC guidance regarding whether an individual is considered up to date with COVID-19 vaccinations.

AHPA supports the alignment of the *COVID-19 Vaccination Among Healthcare Personnel* measure with CDC guidance. However, we are concerned about the increased burden associated with measure updates and question the value of publicly reporting this data given the one-year data lag and the end of the COVID-19 PHE. **We urge CMS to revise the measure to only require annual reporting, which would align with reporting requirements for the influenza measure.**

Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

CMS proposes to revise the *Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* measure for the OQR and ASCQR programs to standardize data collection by limiting hospitals to one of three allowable survey instruments.

AHPA supports the standardization of this measure. Currently, this measure is a voluntarily reported measure, and we continue to urge CMS to maintain this measure as such. Additionally, we believe that this measure is likely best captured under the Quality Payment Program (QPP), as the patient is likely to receive ongoing care following the procedure from an ophthalmologist and not the hospital outpatient department or ambulatory surgical center. We recommend CMS explore adopting it as part of its development of specialist-focused MIPS Value Pathways (MVPs) around ophthalmology care.

Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

CMS proposes to modify the *Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients* measure within the OQR and ASCQR programs to align with updated clinical guidelines. **AHPA agrees with this measure modification as we believe it will promote timely and connected patient care.** As this modification would increase the patient population that is eligible for the measure, we recommend that CMS maintain the same sample size to prevent increased administrative burden.

Facility Volume Data on Selected Outpatient Surgical Procedures

CMS proposes to reintroduce the *Facility Volume Data on Selected Outpatient Surgical Procedures* measures within the OQR and ASCQR programs with modifications to collect and display more granular data for each category on the top five most frequently performed procedures. This measure was removed during CY 2018 rulemaking based on the lack of evidence to support its link to a facility's overall performance or quality improvement with respect to surgical procedures.

AHPA does not believe that this measure is a meaningful indicator of the quality of care a patient receives as procedural volume may vary for a variety of reasons that have nothing to do with a facility's experience or quality of care it delivers. We encourage CMS to work with stakeholders to identify outcomes-based measures that would be appropriate and useful in evaluating the shift in procedures from inpatient to outpatient setting and related quality of care.

HOPD Risk-Standardized Patient-Reported Outcome-Based (PRO) Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty

CMS proposes to adopt the *Risk-Standardized Patient-Reported Outcome-Based (PRO) Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting* (THA/TKA PRO-PM) measure as part of the OQR and ASCQR programs.

AHPA supports the addition of PRO measures related to clinical scenarios for which reliable outcome tools are available for patient completion. However, we are concerned about level of burden associated with data collection for this measure. **We recommend that CMS delay mandatory adoption at this time and that CMS postpone adopting this measure into the OQR and ASCQR programs until the Agency has sufficient information to similarly evaluate implementation of this measure in the IQR Program.** We also believe that CMS should also explore collecting data for this measure through the QPP as part of the MVP for orthopedic specialists as any ongoing follow-up with the patient is likely to occur through the orthopedic practice and not the HOPD or ASC.

Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM

CMS proposes to adopt the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults* Electronic Quality Measure (eCQM) into the OQR program; this measure is similar to a measure proposed into the Hospital IQR program as part of the FY 2024 rulemaking.

AHPA is supportive of the eCQM as an option that hospitals could select from to meet the Hospital IQR eCQM reporting requirements. However, we are concerned that CMS is proposing to mandate the eCQM in the OQR program beginning with 2027 reporting period. This type of information is generally not captured in HOPD Electronic Medical Record (EMR) systems. Adoption of the measure will require facilities to build new templates and implement modifications to their EMR systems in order to operationalize the measure, which takes both time and resources. **We urge CMS to maintain the measure as voluntary for facilities that wish to report the measure and encourage CMS to streamline reporting and allow hospitals to report one set of data for both IQR and OQR programs.**

Request for Information: Inpatient Only List

In the OPPS CY 2024 proposed rule, CMS is soliciting comments regarding whether four services described by CPT codes below are appropriate to be removed from the Inpatient Only (IPO) list:

- 43775: *Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy);*
- 43644: *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-y gastroenterostomy (roux limb 150 cm or less);*
- 43645: *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption;*
- 44204: *Laparoscopy, surgical; colectomy, partial, with anastomosis.*

After gathering information from clinicians, **AHPA does not believe these procedures should be candidates for removal from the IPO list.** Whilst these procedures may, in theory, be performed in an outpatient setting, there are significant safety, health equity, logistical, and outcomes-based concerns.

Patients who are candidates for these procedures are generally higher risk than the average patient population. For these reasons they have less reserve from which they can recover in the event of a serious complication. Performing these procedures in an outpatient setting exposes the patient to serious complications thereby increasing morbidity and mortality. These patients are also frequently classified as *American Society of Anesthesia Class 3* or higher and require more support and monitoring in the recovery period. In the very few instances where these procedures are performed in outpatient settings, the patients frequently experience complications and require further care from their provider, and many older patients end up requiring skilled nursing care whether at home or in a facility; these complications and the need for skilled nursing care are significantly reduced when performed safely in the inpatient setting.

While these surgical procedures may technically be able to be done in an outpatient setting as pertains to length of stay, patients' care both while in the hospital as well as preoperatively and postoperatively require an inpatient level of resources. Reimbursement at outpatient rates would not cover the costs incurred by the facilities and could potentially lead to a reluctance from ASCs to care for the Medicare population, thereby worsening health care inequalities for the Medicare population and opening them up to age discrimination. Furthermore, similar procedures are used for gastric neoplasm/cancer operations; none of these are being considered for removal from the IPO list when they are practically the same operation. Removing codes for the treatment of obesity but not cancer is incongruous with CMS' commitment to health equity.

Request for Information: Essential Medicine Buffer-Stock Payment

CMS solicits comments on the potential of providing a separate inpatient Medicare payment for hospitals establishing and maintaining access to a buffer stock of essential medicines for a period of three months. Under the proposal, hospitals would be required to maintain a stock of 86 essential medicines included in the report "Essential Medicines Supply Chain and Manufacturing Resilience Assessment." Payment under the Inpatient Prospective Payment System (IPPS) would *not* be budget neutral and could be made for cost-reporting periods beginning as early as January 1, 2024. The payments would be in addition to payments for the essential medicines themselves, whether those payments are bundled with other items and services or separately paid. An adjustment under the OPPS could be considered for future years of rulemaking.

Overall, AHPA supports the concept of providing an additional payment for hospitals to create and maintain access to buffer-stocks of essential medicines. **However, we do have a few concerns with the outlined approach. Incentivizing over 6,000 hospitals to create and maintain buffer-stocks of the same 86 essential medicines would put incredible strain on an already-struggling pharmaceutical supply chain.** Creating an incentive for more demand will not solve the current supply chain issues. We are also concerned that the 86 essential medicines prioritized by CMS may become outdated very quickly, making the list irrelevant.

Additionally, we fear that larger hospitals with more financial resources may disproportionately reap the positive benefits of the proposal. We believe the proposal as laid out does little to bridge the gap to help small and/or rural providers who have the greatest resource limitations.

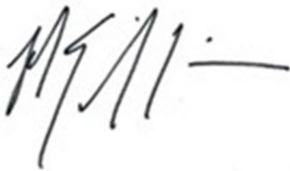
We recommend that CMS revise the policy to provide payment for hospitals to maintain access — whether onsite or further upstream in the supply chain — to drugs for certain disease states or conditions rather than on specific drugs. There are multiple drugs that could be used when treating a

specific disease or condition, making it easier for health providers to maintain a buffer stock of medicines. This revised approach would avoid creating a rush to purchase specific drugs already experiencing shortages and allow enough flexibility for providers to also acquire less expensive alternatives when the price of a drug increases significantly. Furthermore, basing the additional payment on maintaining drugs for the treatment of a disease state or condition rather than specific drugs would reduce reliance on a singular manufacturer for a specific drug. Relying on a single manufacturer could pose supply chain risks should that manufacturer have to recall drugs for safety concerns.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me or Susana Molina Ramos, Director of Public Policy at Susana.MolinaRamos@AdventHealth.com.

Sincerely,



Michael E. Griffin
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