Sept. 6, 2022 **D R A F T**

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 Proposed Rule to Update the Hospital Outpatient Prospective Payment System for Calendar Year (CY) 2023***

Dear Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) hospital outpatient prospective payment system (OPPS) for calendar year (CY) 2023. As officially proposed, t**he rule is estimated to increase FFS payments to Michigan hospitals by only $43 million, or 2.25%, at a time when hospitals** continue to experience unprecedented inflationary increases for labor, supplies and pharmaceuticals during the ongoing COVID-19 pandemic. Please note that the MHA submitted comments on Aug. 16 regarding the proposed changes related to 340B drug payments and requested that the CMS find new funds to restore these payments to average sales price plus 6% rather than funding through a reduction in the outpatient conversion factor as suggested in the proposed rule. We are also submitting a separate comment letter regarding the rural emergency hospital policies proposed in this rule. This letter provides comments on other broader provisions in the proposed rule and are below.

**PAYMENT UPDATE**

The rule results in a net rate update of 3.1% for 2023 after the market basket update of 3.1% is reduced for the productivity adjustment of 0.4 percentage points and other budget neutrality adjustments are made. The MHA has significant concerns regarding the proposed update for 2023 and the 2022 payment update of 1.7% which are woefully inadequate and fail to capture the unprecedented inflationary environment hospitals are experiencing. Since the market basket is a time-lagged estimate that uses historical data to forecast into the future, it is not an accurate predictor of future changes due to the current inflationary environment and has resulted in inadequate updates. This is essentially what has occurred when forecasting the 2022 and 2023 market basket and productivity adjustments. More recent data from IHS Global Inc. indicates a market basket of roughly 4% for the current year, significantly above the 2.7% implemented for FY 2022. In addition, the latest data reflects decreases in productivity rather than gains. **We appreciate the CMS’ use of second quarter 2022 forecast data in the inpatient PPS final rule which resulted in a higher update and urge the CMS to adopt this market basket update in the OPPS final rule to increase payments to better reflect the current economic reality faced by hospitals given the rapidly changing health care system dynamics and current inflationary environment.**

Specifically, the MHA urges the CMS to:

* **Implement a retrospective adjustment for 2023 to account for the difference between the 1.7% market basket update implemented for 2022 and what the market basket is currently projected to be for 2022, which is roughly 4% and**
* **Eliminate the 0.4 percentage point productivity cut for 2023.**

**Permanent 5% cap on Wage Index Decreases**

In efforts to align with changes finalized in the FY 2023 PPS rules for inpatient and post-acute care and increase predictability in OPPS payments, the CMS proposes a permanent budget neutral approach to mitigate changes in the pre-floor/pre-reclassified hospital wage index. Specifically, the CMS proposes a permanent 5% annual cap on negative wage index changes. **As indicated in our comments on other FY 2023 proposed rules, the MHA is supportive of this policy but urges the** **CMS to implement it in a budget-neutral manner rather than through a reduction to the outpatient conversion factor as proposed. We urge the CMS to fund this policy initiative using separate and additional funds.**

**Site-Neutral clinic visit cuts**

Existing policy uses the physician fee schedule (PFS) to determine rates for clinic visits provided at off-campus hospital outpatient departments (HOPDs) with payments at roughly 40% of the OPPS rate, also known as the site-neutral clinic visit policy. The CMS proposes to exempt rural sole community hospitals from the site-neutral clinic visit payment policy by paying these services at the full OPPS rate for clinic visits provided in a grandfathered off-campus HOPD of the rural SCH. The CMS is soliciting comments on applicability to other rural hospitals, such as those under 100 beds.

The MHA appreciates that this proposal would restore payments to 100% of the OPPS rate for certain rural hospitals. **However, we continue to urge the CMS to reverse the clinic visit cut policy all together and restore full OPPS payment for hospital outpatient clinic visits provided in grandfathered off-campus HOPDs**. Nevertheless, the MHA supports the CMS proposal to exempt rural SCHs and urge the CMS to expand it to other hospitals including rural hospitals with 100 or fewer beds, urban SCHs where access to care is also challenging, essential access community hospitals (EACHs), and hospitals located in health professional shortage areas.

**outlier payments**

The CMS proposes to increase the outlier fixed-dollar threshold to $8,350 in 2023, a 35% increase from the current $6,175 threshold. Outlier payments are proposed to continue to be paid at 50% of the amount by which the hospital’s cost exceeds 1.75 times the ambulatory payment classification (APC) payment amount when both the 1.75 multiplier threshold and the fixed-dollar threshold are met. This increase will result in a significant decrease in outlier payments to hospitals for treating high-cost patients. **The MHA is concerned about the scale of the proposed threshold increase and urges the CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate this significant increase and the negative impact on hospitals.**

 **Proposed Reporting for Certain Single-Dose/Single Use Drugs**

The Infrastructure Investment and Jobs Act requires drug manufacturers to provide a refund to the CMS for certain discarded amounts from a single-dose container or single-use package Medicare Part B drugs. The CMS proposes that physician offices, HOPDs and ambulatory surgical centers (ASCs) report:

* JW modifier to identify discarded amounts of these refundable drugs/biologicals that are separately payable under the OPPS or ASC payment system. This modifier has not been required since 2017.
* A new modifier, JZ, in cases where no billing units of single-dost/sing-use container drugs/biologicals were discarded.

**The MHA opposes the use of the new modifier JZ due to its redundancy and administrative burden on providers. Instead, the MHA, along with the American Hospital Association and others, urge the CMS to educate providers regarding proper reporting of the JW modifier.**

**Prior Authorization**

The CMS currently requires prior authorization (PA) for seven service categories with the agency proposing to add Facet Interventions to the list effective March 1, 2023. This category would consist of facet joint injections, medical branch nerve blocks, and facet joint nerve destruction. These procedures are often used, with or without a steroid, to diagnose or treat chronic neck and back pain. The CMS justification is that there has been an increase in utilization--a 2.5% annual increase for injections/medical branch nerve blocks and a 7% annual increase for nerve destruction procedures. The CMS also references a February 2021 report [Noridian Healthcare Solutions, LLC, Made Improper Medicare Payments of $4 Million To Physicians in Jurisdiction E for Spinal Facet-Joint Injections (A-09-20-03010). (hhs.gov)](https://oig.hhs.gov/oas/reports/region9/92003010RIB.pdf) by the Office of Inspector General (OIG) that highlights improper coding and overpayment for these procedures. The report indicates that the improper payments occurred due to the Medicare Administrative Contractor’s education of physicians and their billing staff being insufficient to ensure compliance with billing requirements for spinal facet-joint injections.

The MHA recognizes that PA, when used appropriately, can reduce unnecessary costs and care that is not medically necessary and was initially designed to apply to expensive care and services that have a history of overutilization and misuse. However, there are problems with PA including:

* 1. Delays in care and treatment abandonment due to lack of an efficient, standard submission method
	2. Application of PA requirements by health plans without adequate justification.

The MHA appreciates the CMS’ justification based on research and evidence of billing issues. We recommend that the CMS consider requiring Medicare Advantage Organizations and other plans over which they have oversight responsibilities to provide researched reasoning to their PA expansions. The MHA agrees with the OIG report that calls for increased education and provider outreach to correct the issue. We oppose expansion of PA and believe that:

* + Application to a non-opioid pain management therapy such as facet interventions may explain some of the utilization increase
	+ Local and national coverage determinations are responsible for many of the improper utilizations detailed in the OIG report
	+ Requiring PA for pain management procedures results in patients waiting in pain which the inefficient process is completed which is not appropriate.

**The MHA urges the CMS to abandon its proposal to expand PA to these services and instead focus on educating physicians and their billing staff.**

**Payment for Blood Not Otherwise Classified (NOC) Code – P9099**

Effective Jan. 1, 2020, the CMS established a new HCPCS code, P9909 (Blood component or product NOC), which allows providers to report unclassified blood products before blood product specific HCPCS codes are available, status indicator (SI) “E2” (Not payable by Medicare when submitted on an outpatient claim). For 2021, the CMS changed the SI for HCPCS code P9099 from “E2” to “R” (blood and blood products) paid under OPPS. Separately payable at a rate equal to the lowest paid separately payable blood product in the OPPS with a payment rate of $7.79 per unit. In August 2021, the Hospital Outpatient Payment Advisory Panel recommended assigning SI “F” to HCPCS 9099 which would have authorized MACs to compensate hospitals for new blood products temporarily billed with HCPCS P909 based on the 2022 OPPS/ASC proposed rule. The CMS did not approve the SI change to “F”. Addendum B of the current proposed rule indicates a 2023 payment rate of $56.58 per unit for any blood product billed with HCPCS code P9099. **The MHA urges the CMS to reconsider the recommended SI change or other alternatives.**

**Payment for Outpatient Mental Health Services**

The MHA thanks the CMS for taking steps to help overcome the challenges faced by rural Americans in obtaining critical mental health services. Covering mental health services provided remotely by hospital staff to patients in their homes will increase access and options for Medicaid beneficiaries requiring mental health care. We also commend the CMS for permitting critical access hospitals (CAHs) to bill for these services even though they are not paid under the Medicare OPPS. Again, these services provide a vital lifeline to needed care for many Medicare beneficiaries. We recommend that the clinical staff providing mental health services do not need to be physically present “in” a hospital outpatient department while providing services to patients in their homes. We urge the CMS to amend Section 410.27(a) of 42 C.F. R. to include an exception for mental health services provided to patients remotely. This will increase the number of available clinicians and improve access to these vital services.

The MHA also supports the CMS’ proposal to continue the use of audio-only technology for mental health services following the end of the COVID-19 PHE since many beneficiaries cannot use audio/video technology due to broadband limitations in their area or may choose to use audio only. Rural areas are more likely to have limited access to broadband and have experienced significant benefits from audio-only visits during the pandemic and it’s crucial that these services can continue beyond the PHE.

**Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients**

The MHA supports the ability of nonphysician practitioners (NPPs) to practice at the top of their license and clinical training. We thank the CMS for proposing that NPPs may provide general, direct, and personal supervision of outpatient diagnostic services, per state scope of practice laws. Workforce flexibilities are crucial for providers, especially those in rural areas, as providers continue to experience unprecedented challenges in recruiting and retaining an adequate workforce as they continue to experience to other pandemic-related challenges. NPPs are critical to maintaining and increasing access to healthcare. We urge the CMS to continue allowing NPPs to provide services with broader supervision privileges.

**Outpatient Quality Reporting (OQR) Program**

Although the CMS does not propose to adopt any new measures or remove any measures from the OQR the agency proposes to modify one previously adopted measure and requests feedback on potential changes to the OQR.

**Proposal to Change Cataracts Measure from Mandatory to Voluntary**

The CMS proposes to allow for voluntary rather than mandatory reporting of the Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (OP-31/ASC-11) beginning with the CY 2027 payment determination (CY 2025 reporting period). The measure was initially adopted for voluntary reporting in the CY 2015 OPPS/ASC final rule, then finalized for mandatory reporting beginning with the CY 2025 reporting period in last year’s final rule despite the measure’s significant shortcomings.

The MHA supports the CMS proposal to no longer require reporting of this measure. While the agency suggests that it makes this proposal due to ongoing concerns about the reporting burden of this measure due to national staffing and medical supply shortages as well as changes in patient case volumes—which are legitimate challenges—the measure continues to suffer from the same deficiencies as when it was first proposed for adoption that significantly limit its utility. The rationale for initially adopting the measure for voluntary reporting only was based on several concerns, including:

* The measure is operationally difficult for hospitals to collect and report.
* The results of the survey used to assess the patient’s pre-operative and post-operative visual function were not consistently shared across clinicians, making it difficult for hospitals to have knowledge of the visual function of the patient before and after surgery.
* Clinicians used inconsistent surveys to assess visual function, as the measure allows the use of any validated survey.

The measure’s specifications remain unchanged, and the CMS has not adequately addressed with this measure. In this proposed rule, the CMS notes that it plans to continue to evaluate this policy moving forward and consider mandatory reporting after the end of the PHE, but unless and until the CMS can demonstrate that the problems with this measure have been ameliorated, the MHA does not support the required reporting of this measure in any future year.

**Request for Comment: Measure for Outpatient Volume**

The CMS seeks comment on whether it should consider adopting a measure assessing procedure volume for the OQR and ASCQR. The agency explains that surgical procedures are increasingly moving into the outpatient setting, and thus believes it is important to track the volume of outpatient procedures. One way to do this would be to re-implement the previously removed measures from the OQR and Ambulatory Surgical Center (ASC) QR that assessed surgical volumes; another would be to create a novel measure related to procedure volume.

The CMS acknowledges in the proposed rule that “quality measurement efforts moved away from procedure volume as it was considered simply a proxy for quality rather than directly measuring outcomes,” and that while larger facility surgical volume may be associated with better outcomes, these outcomes are likely attributable to other characteristics that are proven to improve care (such as effective care teams and robust surveillance). However, the agency also reasons that a volume measure would provide information to Medicare beneficiaries and other interested parties on numbers and proportions of procedures by category performed by individual facilities.

The MHA does not support the re-implementation of existing volume measures or the development of new volume measures for the OQR or ASCQR as methods to assess quality of care. We would be especially concerned by using volume measures for performance comparison purposes – including hospital star ratings – for a variety of reasons.

Volume measures are inconsistent with the important and strategic goals of the CMS’ own Meaningful Measures 2.0 framework, and we are concerned that the agency would consider moving forward with an idea that is so incongruous with the significant work it has undertaken to streamline and focus its quality reporting programs on the most important and useful measures. According to the CMS, “Meaningful Measures 2.0 will promote innovation and modernization of all aspects of quality.” It would be diametrically contrary to this goal to pursue a measure that was removed years ago due to a lack of evidence linking the measure to improved clinical quality, and which was initially adopted before the National Quality Forum began reviewing measures for usefulness in the CMS programs. In that intervening time, no definitive information has emerged about the exact volumes of procedures at which patient outcomes will improve significantly. As a result, any prescribed number of procedures against which a hospital is measured has a significant chance of being arbitrary. Performance comparisons based on those volumes also could mislead, rather than inform, the choice of facilities for patients.

Furthermore, more sophisticated and meaningful measures of quality and safety of care have emerged, and we believe a modernized approach to measurement should look forward to these new approaches, rather than backwards at measures the agency already has concluded do not meaningfully advance quality and safety.

In addition, the CMS also notes that its framework “will further shape the entire ecosystem of quality measures that drive value-based care.” By definition, value-based care replaces the traditional fee-for-service approach in which providers are paid based on the volume of services they deliver by instead focusing on health outcomes on a larger scale. Thus it is again inconsistent to consider measuring volume to inform a system seeking to improve outcomes.

Finally, it is unclear how such a measure of volume would fit into the CMS’ streamlined priorities in its 2.0 framework. We support the agency’s efforts to use only high-value quality measures that impact key quality domains and align measures across programs; no other CMS quality reporting program utilizes a measure regarding procedure volume.

**The MHA urges the CMS to continue to support the priorities in its Meaningful Measures framework by focusing on high-value measures and avoid undoing the progress it has made to date by considering re-implementing measures without evidence linking them to improved outcomes.**

**Closing the Health Equity Gap**

We encourage the CMS to reference the comments that were submitted by the MHA on June 17 regarding the FY 2023 Inpatient Prospective Payment System proposed rule.

**Summary**

The MHA appreciates this opportunity to provide comments to the CMS on the 2023 outpatient proposed rule and believe that our proposed changes will have a positive impact on hospitals and all patients they serve. If you have questions regarding this comment letter, please contact me at vkunz@mha.org.

Sincerely,

Vickie Kunz

Senior Director, Health Finance