Illinois Health and Hospital Association

September 7, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: CY24 Outpatient Prospective Payment System Proposed Rule (CMS-1786-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year 2024 (CY24) Outpatient Prospective Payment System (OPPS) proposed rule.

Illinois hospitals have faced unprecedented challenges over the past several years. Our providers and their colleagues continue to confront issues created by the pandemic. Frontline providers have seen their colleagues understandingly burn out and leave the medical field in droves, particularly among registered nurses and allied staff. This is exacerbating a labor shortage that predates the COVID-19 pandemic. And constant economic uncertainty looms, with inflation remaining high and supply chain interruptions constantly threatening to impede hospitals' abilities to serve their patients and communities.

With these challenges in mind, we ask the Centers for Medicare & Medicaid Services (CMS) to consider our comments below. We understand the limitations of CMS' authority, and appreciate that certain issues are out of the agency's control. However, we are concerned that some of the overarching initiatives coming from CMS over the past few years may force our hospitals to cut service lines or otherwise curtail access to the care our communities deserve.

There is a growing disconnect between how hospitals are paid and how CMS governs the Medicare program. Many of CMS' policies in recent years have pushed to modernize the Medicare program, incentivizing the use of integrated technologies and instilling important patient protections that increase transparency and work to drive down out-of-pocket costs. At the same time, many of CMS' longstanding payment methodologies are based on the very concepts that these policies push against. While modernizing hospital infrastructure is a goal we and our members share with CMS, it requires resources and funding that the federal government is not providing. When the Medicare program reimburses hospitals below cost, it cannot expect providers with

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negative margins to quickly invest in, and implement, costly policies.

Thus, we strongly urge CMS to reexamine portions of this proposed rule and finalize policies and payment updates that better reflect the economic and logistical realities hospitals currently face.

Proposed CY24 Rate Update

We are disappointed with CMS' proposed CY24 OPPS rate update. After accounting for all proposed payment and policy changes and the sequestration reduction, we estimate that Illinois hospitals will realize a 2.8% increase in OPPS payments compared to CY23. This rate update is woefully inadequate given the current fiscal realities faced by our hospitals. Our hospitals have specifically expressed that labor costs alone have increased 4.5-5% over the last two years.

In this proposed rule, CMS relies on IHS Global Inc.'s fourth quarter 2022 forecast to calculate the market basket update. The fourth quarter 2022 forecast is based on historical data through the third quarter of 2022. Using these data, CMS proposed a market basket update of 3%.

We recognize that CMS intends to update this methodology in the final rule using IHS Global Inc.'s second quarter 2023 forecast. Similar to the Inpatient PPS (IPPS) final rule, we expect to see a slight increase in the final rate update due to the use of more updated data. However, it is clear that the methodology used by CMS in updating rates does not track with real-time costs of providing healthcare.

Given this evidence, it is clear that CMS' rate update is inadequate as proposed. This is primarily because the market basket is a time-lagged estimate that uses historical data to predict the future. When historical data are no longer a good predictor of future changes, the market basket becomes obsolete.

IHA urges CMS to do everything within its statutory authority to increase payments to OPPS hospitals. **Specifically, we suggest CMS reassess the data and methodology used for the annual market basket update, and formulate a rate update that better reflects the fiscal reality hospitals currently face.**

340B

IHA supports CMS' proposed payment for 340B-acquired drugs at average sales price plus 6%. We submitted comments on the proposed payment remedy for 340B-acquired drugs (CMS-1793-P) which can be found *here*.

Price Transparency Proposals

IHA strongly supports providing patients with meaningful and relevant information about their health coverage to make informed decisions about their care. We encourage CMS to work with the U.S. Depts. Of Health and Human Services, Labor, and Treasury to continue refining and aligning initiatives across hospital price transparency requirements, the Transparency in Coverage Act, and the No Surprises Act. The largest problem we see with these three sets of rules is that patients

face numerous and potentially conflicting sources of pricing information, particularly because the insurer will ultimately have the best information for a patient on their out-of-pocket costs.

IHA suggests CMS continue to convene patients, providers and payers and seek input on how to make federal price transparency policies as patient-centered as possible. Feedback from our members suggests patient use of consumer-friendly pricing tools varies widely by facility. We received feedback from members that patients often forgo the pricing tools altogether and call the hospital directly for pricing information, further draining limited resources. Thus, it is imperative that CMS continue to improve and integrate these three sets of pricing requirements.

To that end, we are generally encouraged with the direction CMS presented in this proposed rule. We agree that standardization and improved guidance around hospital price transparency requirements will not only mitigate confusion for provider and patients, but will also curtail inaccurate analyses from third parties that purport hospital noncompliance.

If finalized, we strongly urge CMS to enforce a compliance date that is six to twelve months after the release of technical guidance. Implementing hospital price transparency requirements has been burdensome and costly for all hospitals, but especially so for small, rural, and Critical Access Hospitals (CAHs). One Illinois Critical Access Hospital shared that they use a third party vendor to manage the required files because they do not have in-house expertise. Changing file formats will surely increase fees, and require internal staff to spend time gathering the data required by the vendor. Surely this is a common experience across the country. As explained above, our hospitals are experiencing increased labor and supply costs that far outpace the increase to payments proposed or finalized across Medicare payment systems. Thus, it is in the best interest of the provider, the patient, and CMS that thorough technical guidance is made available, and that providers have sufficient time to comply.

Remote Outpatient Mental Health Services

Illinois hospitals quickly adapted to the use of telehealth for furnishing mental health services during the COVID-19 public health emergency (PHE). Indeed, patients have also embraced telehealth. According to the Medicare Payment Advisory Commission's report to Congress in June, telehealth use and expenditures peaked in the second quarter of 2020, then leveled off in 2021, the most recent year with complete data available. During these years, evaluation and management services accounted for approximately 98% of telehealth spending, with a growing share of these services for behavioral health. MedPAC also found that the distribution of outpatient visits for established patients across codes used by clinicians during these years implied that telehealth services and in-person visits take about the same amount of time and that complexity of care provided is comparable. MedPAC's report indicates that telehealth spending has settled after an initial increase in utilization, while the primarily outpatient services being provided have been delivered consistently with in-person care, aligning with past studies on telehealth cost, quality, and accessibility.[1]

[1] MedPAC Report to the Congress – *Medicare and the Health Care Delivery System*. Available from: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf. Accessed Sept. 7, 2023.

IHA appreciates and supports CMS' proposal to continue paying for mental health services furnished to Medicare beneficiaries via telehealth and expand coverage to group psychotherapy. Similarly, we agree that it is in the best interest of patients and providers to continue covering mental health diagnosis, evaluation, and treatment services available via telehealth to beneficiaries in their homes as hospital outpatient department services.

IHA also appreciates and supports delaying the requirement for an in-person visit within six months prior to the first remote mental health service and within 12 months after each remote mental health service until Jan. 1, 2025. We ultimately hope, though, that CMS removes this requirement because it may result in patients discontinuing care rather than going to an annual office visit, resulting in access issues. The discontinuation of services may be more likely if a patient has a transportation issue, would need to miss work, or has a child care issue (e.g., a grandparent with guardianship of a child), so this requirement could exacerbate health equity issues. Additionally, we encourage CMS to ensure in-person treatment appointment requirements are based on medical necessity.

Additionally, we are concerned with CMS' assumption that hospitals do not accrue the same costs when beneficiaries receive care in their home. While it is true that many upfront costs of providing mental health services via telehealth are "fixed" and already paid for, there are other telehealth characteristics that introduce fiscal variability. These include routine costs such as electronic medical record maintenance and equipment upgrades, as well as more dynamic issues, such as labor costs, as demand for mental health services currently outpaces supply.

Given increasing demand for mental health services and a plethora of fiscal and logistical variables, we urge CMS to reconsider using the Physician Fee Schedule, and instead use OPPS payment rates to reimburse hospital outpatient departments for mental health services delivered via telehealth. We also ask CMS to reconsider the requirement for an annual in-person visit. We believe mental health services represent an area of healthcare that has been historically underfunded and understaffed, thus leading to stark inequities in terms of access and utilization across Illinois communities. At a minimum, we expect CMS to monitor this space and make reimbursement and policy adjustments as appropriate to ensure it fulfills the Administration's goals of ensuring equitable access to mental health services.

Intensive Outpatient Program (IOP) Benefit and the Partial Hospitalization Program (PHP)

IHA thanks CMS for its thorough review of the Medicare IOP and PHP benefits and reimbursement. However, we question how CMS differentiates these two programs. It appears the differentiation is based on the number of hours of services provided each week in each program. Our concern is that this differs from how commercial insurers distinguish between IOP and PHP and their use of Medical Necessity Criteria, such as Milliman Criteria. Commercial insurers require a minimum of three hours per day for nine hours per week for IOP versus six hours per day for 20 hours per week for PHP. Individuals in PHP and IOP can attend five to six days a week in both levels of care. We urge CMS to consider aligning IOP and PHP requirements with commercial insurers and consider a differentiated rate between PHP and IOP on a per diem basis.

Community Mental Health Centers (CMHCs) Conditions of Participation (CoP)

IHA applauds CMS' commitment to mental health, and the decision to provide Medicare reimbursement for mental health counselors and marriage and family therapists. However, we question whether the rule as written limits the provisions of these services to CMHCs, or can a private practice or Hospital-Based Outpatient Department (HOPD) Licensed Clinical Professional Counselors/Licensed Marriage and Family Therapists (LCPC/LMFT) bill and be reimbursed by CMS as well. Allowing private practice and HOPD LCPCs and LMFTs to bill for these services would significantly increase access to mental health services for CMS beneficiaries.

Supervision by Non-Physicians of Certain Rehabilitation Services

IHA supports CMS' proposal to expand the practitioners who may supervise certain rehabilitation services, and to include those practitioners with those that are also allowed to supervise virtually. Our hospitals are asking for clarification, and hopefully confirmation, that this flexibility applies to both PPS hospitals and CAHs.

Payment for Intensive Cardiac Rehabilitation (ICR)

IHA supports CMS' proposal to correct an unintended reimbursement disparity caused by the Medicare Improvements for Patients and Providers Act of 2008 and pay for ICR services provided by an off-campus, non-excepted, provider-based department of a hospital at 100% of the OPPS rate rather than 40% of the OPPS rate

Request For Information (RFI) on Potential Payment for Stockpiling Essential Medicines

IHA understands and appreciates CMS' motivation for potential payment for stockpiling essential medicines. However, after speaking with our member hospitals and health systems, we believe these efforts might be better focused on manufacturers and distributers, not hospitals. Hospitals are concerned with stockpiling products that may go unused. Should these medicines expire before being used, it will lead to additional unnecessary costs, including the cost of disposing them.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association