AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 9, 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-1809-P Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems

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) 2025 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include over 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 2025 OPPS proposed rule:

- Conditions of Participation for Facilities Providing Obstetrical Services
- Quality Reporting Measures
- Safety of Care Within Medicare Star Ratings
- Hybrid Hospital-Wide All-Cause Readmission and Standardized Mortality Measures
- Removal of HCPCS 0266T from the New Technology APC 1580
- Medicaid and CHIP Continuous Eligibility
- Prior Authorization Timeline

Conditions of Participation for Facilities Providing Obstetrical Services

CMS proposes to implement new Conditions of Participation (CoP) on hospitals and Critical Access Hospitals (CAH) providing Obstetrical (OB) services outside of their emergency departments, and on any hospital or CAH with an emergency department. AHPA seeks to provide the highest possible care to the mothers and babies for whom we care. In 2023, nearly 70,000 babies were born in an AHPA facility.

While the proposed COPs are considered best practices and likely already implemented in larger, metro-area facilities, we are concerned that they may prove burdensome to smaller hospitals or rural facilities that lack the resources and infrastructure needed to comply. CMS' own cost estimates put the additional costs for compliance at approximately $180,000 per hospital per year. With hospitals and CAHs already facing financial difficulties and severe workforce shortages, many may not be able to afford the cost of compliance. In the last decade, over 200 hospitals have closed their Labor and Delivery (L&D) units; this year alone, at least 24 hospitals have announced plans to close or pause L&D units' operations.[1]

The proposed CoPs have the potential to exacerbate access to care issues if facilities either opt to close their OB units or are penalized for noncompliance by losing their Medicare certification. **AHPA urges CMS to work with stakeholders to identify alternative means to achieve CMS' goal of ensuring high quality care for mothers and babies.** We suggest providing financial incentives for facilities located in OB deserts or rural areas that adopt these measures. Instead of being a CoP that could lead to additional OB unit closures, this financial incentive would make it more feasible for rural hospitals to make those investments.

Should CMS decide to finalize the proposed CoPs, we ask that the agency address the following key issues:

Implementation Timeline

In the OPPS Proposed Rule, CMS does not give an estimated timeline for implementation. This leaves us to assume that, if finalized, the new CoPs would be implemented January 1, 2025, as is the standard with OPPS proposals unless otherwise stated. Given that the OPPS Final Rule is due for release by November 1, 2024, this would leave facilities with a very tight timeframe in which to implement such comprehensive requirements. This is especially a concern for smaller, rural hospitals and CAHs that may

[1] 24 Maternity Service Closures in 2024 – Becker's Hospital Review

need to hire additional staff to comply with the Quality Assessment and Performance Improvement (QAPI) requirements or to purchase considerable expensive equipment. Should CMS finalize this proposal, **we recommend adopting an enforcement grace period of no less than 12 months to avoid exacerbating access to care issues for OB services.**

Annual Performance Improvement Projects

As part of its proposals for the QAPI Program, CMS proposes to require hospitals and CAHs to conduct at least one performance improvement project focused on improving health outcomes and disparities among the hospital's population every year. We believe that performance improvement should be a critical part of addressing maternal and neonatal mortality. We also believe, however, that addressing such a broad goal is best achieved when working collaboratively with our communities. Most states and counties in the U.S. have implemented such collaboratives to address maternal and neonatal mortality in their regions. **We believe that CMS should instead encourage hospitals to engage with these collaboratives to more effectively address the root causes leading to maternal and neonatal mortality in their communities.**

Quality Reporting Measures

Hospital Commitment to Health Equity (HCHE) Measure

CMS is proposing to adopt the attestation-based HCHE measure into the Hospital Outpatient Quality Reporting (OQR) Program. AHPA has long been committed to the work of health equity and is pleased to see CMS taking action to encourage this work across the U.S. health care system. **We are supportive of this measure, particularly as it is identical to the HCHE measure already adopted in the Hospital Inpatient Quality Reporting (IQR) Program.**

We urge CMS to continue engaging with stakeholders as they work to finetune and expand health equity initiatives. We also urge CMS to look towards data that is already being collected, such as claims data, to measure the efficacy of various health equity goals. At AHPA, our hospitals have adopted health equity plans to target clinical areas in which we have found health disparities within our patient population. While we continue to work on these plans, it would be helpful for CMS to publish its own findings and lessons learned from the data shared by hospitals and other nationwide initiatives.

Screening for Social Drivers of Health (SDOH) and Screen Positive Rates for SDOH Measures

CMS proposes to adopt the same SDOH screening measures in the outpatient setting that were already adopted for inpatient care. While we support maintaining consistency across payment systems, we are concerned that it will be more difficult and therefore require more time to implement these measures in the outpatient setting. Whereas in the inpatient setting, where patients are present often for multiple days, allowing sufficient time for case workers to screen patients for SDOH; this is not the case in the outpatient setting, especially ambulatory settings, due to the short length of visits and the volume of patients seen. Often, visits in the outpatient setting have a duration of 15-30 minutes, leaving little time for additional screening on top of providing adequate patient care. In order to successfully screen patients for SDOH, providers would need to hire additional Care Managers or Social Workers that could conduct that screening in advance of a patient visit.

Because of the continued growth of outpatient care due to advances in technology and consumer preferences, adopting this screening throughout all outpatient sites of care would require significant resources as well as training and education at a much larger scale than in the inpatient side. Not only are there more facilities in the outpatient setting but the population size that would need to be screened is also considerably larger than in the inpatient setting. In addition to hiring new personnel and conducting needed training, providers would need to also build community networks for all their outpatient sites to ensure that patients who screen positive are referred to community-based organizations in the area. While the ultimate goal should be to screen and refer patients to needed resources in *all* health care settings, potentially preventing a hospital admission, achieving that goal may take more time. **If CMS finalizes this policy, we ask that the agency delay mandatory implementation until at least 2027, which would give providers at least two years to prepare and build the needed infrastructure and community networks.**

As more patients are screened, we also urge the Agency to work with other agencies within HHS and Congress to provide grants to community-based organizations. As we strive to provide whole person care, it is important that our community-based organizations have the capacity to support the amount of referrals being made. Hospitals are regularly seeking partnerships to support the needs of our communities, but given the increased volume of referrals, it would be helpful for the federal government to also provide additional funding support.

We are also concerned that CMS is proposing to extend these measures to the outpatient setting while the Agency is still working on finetuning the measures in the inpatient setting. Just recently, CMS clarified that inpatients should be screened at every visit but that only the results from the last screening of the performance period should be reported. If these measures are adopted in the outpatient setting, similar clarity on the required frequency of the screenings would be needed as patients are seen more often.

Stakeholders are also waiting for CMS to issue guidance on what constitutes a "positive" screening. **We strongly recommend that CMS continue to finetune and stress test these measures in the outpatient and ambulatory settings through voluntary reporting *before* making them mandatory.**

CMS also proposes to allow health providers to choose their own survey instruments but indicated that it may work towards standardizing surveys in the future. AHPA appreciates that health providers would be given the flexibility to design survey processes that work best within their existing infrastructure and processes. We realize that this may lead to inconsistent data being reported to CMS, which makes it difficult for stakeholders to accurately compare and utilize the data. **Therefore, we urge CMS to work closely with stakeholders when designing any potential future standardized survey questions while allowing health systems the flexibility to design survey protocols that fit the needs of the patients in their community.**

Patient Understanding of Key Information Related to Recovery After a Facility-Based Procedure of Surgery or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer PROM)

CMS is proposing to adopt this Patient Reported Outcomes Measure (PROM) into the OQR, which would assess the level of clear, personalized information related to recovery from a surgery or procedure in a Hospital Outpatient Department (HOPD). Voluntary reporting would begin in 2025 and mandatory reporting would begin in 2026. AHPA is supportive of PROMs, as they can help facilitate conversations between patients and providers and promote information sharing. However, at this time, we are concerned that the one-year voluntary reporting period may be insufficient as many health systems would need to build out their EHR systems and implement training for providers around this measure.

Following the adoption of two other PROMs in the CY 2024 OPPS Final Rule, many health systems have reported difficulties with reporting these measures in the inpatient and outpatient settings. **Therefore, we recommend that CMS extend the voluntary period by 12 months to allow health systems to build out and stress test the infrastructure needed.** We also recommend that CMS provide a list of surgery and procedure codes that would be included in the denominator, and to clarify whether there will be a threshold for percentage of patients to return surveys.

MRI Lumbar Spine for Low Back Pain & Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery

CMS is proposing to remove these two measures from the OQR program. CMS indicates that performance on these measures has had negligible effects on patient outcomes. **AHPA agrees with this**

assessment and encourages CMS to continue evaluating similar measures that may be adding administrative burden on health systems while having no positive impacts on patients' care and outcomes.

Safety of Care Within Medicare Star Ratings

CMS issued a Request For Information (RFI) on how it might modify the Overall Hospital Quality Star Ratings ("Star Ratings") methodology so as to make it harder for hospitals scoring in the lowest quartile of the Safety of Care domain to receive a five-star rating. In the RFI, CMS lays out three potential future proposals: 1) Reweight the Safety of Care Measure Group; 2) Policy-Based 1-Star Reduction for Poor Performance in Safety of Care; and 3) a combination of these two previous proposals.

We are concerned that these proposals as outlined in the RFI would deemphasize the other measure quality groups, which are critical to evaluating patient care: mortality, readmission, patient experience, and timely and effective care. **We urge CMS to look at other means to address patient safety concerns outside of the Star Ratings program, such as through the Hospital-Acquired Condition Reductions and the Hospital Value-Based Purchasing programs.**

Should CMS decide to continue pursuing such changes to the Star Ratings program, **we urge CMS to make exceptions for small, rural, and critical access hospitals, which may be adversely impacted due to their limited qualifying measures given the fewer service lines and populations they serve.** Unfairly penalizing these smaller hospitals could create greater access to care issues if patients are discouraged from seeking critical care at the only hospital in their area leading to service line or hospital closures.

Hybrid Hospital-Wide All-Cause Readmission and Standardized Mortality Measures

Mandatory reporting for the Hybrid Hospital-Wide All-Cause Readmission and Standardized Mortality Measures is set to begin in FY 2026. In the rule, CMS proposes to extend the voluntary period for an additional 12 months with mandatory reporting beginning in FY 2027. Failure to meet the reporting thresholds would result in a one-quarter reduction to hospitals' annual payments for the fiscal year, unfairly penalizing hospitals for experiencing technical issues.

While we support the proposal to delay the mandatory reporting period, we are concerned with making the FY 2027 submission mandatory as that reporting period will have already finished

before the FY 2026 results are available. Additionally, FY 2027 is also the first time that Medicare Advantage (MA) patients will be included in the population. The proposed FY 2027 mandatory reporting period does not provide hospitals and EHR vendors with any time to adjust based on FY 2026 results nor any understanding of the impact from the MA population. **Therefore, AHPA urges CMS to extend the voluntary reporting period by at least 24 months.**

Removal of HCPCS 0266T from the New Technology APC 1580

CMS proposes to remove the Healthcare Common Procedure Coding System (HCPCS) Code 0266T – *Implantation or Replacement of Carotid Sinus Baroreflex Activation Device,* from the New Technology APC designation to the Level 5 Clinical APC 5465. Such a change would result in significant underpayments and create an access issue for Medicare beneficiaries. This Barostim procedure is clinically different from the technologies categorized in APC 5465, which are generally older spinal cord stimulators to treat chronic pain. Currently, the Barostim is designated by the Food and Drug Administration (FDA) as a Breakthrough Technology to treat symptoms of heart failure.

We recommend that CMS create a Level 6 APC that would more accurately reflect the costs associated with the Barostim procedure. In the meantime, we urge CMS to leave this procedure in the New Technology APC 1580 for at least another year or until a sixth APC level is created.

Medicaid and CHIP Continuous Eligibility

CMS proposes to update the Medicaid and Children's Health Insurance Plan (CHIP) regulations in accordance with the Consolidated Appropriations Act (CAA) 2023. The proposed changes would require 12-months of continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP; remove the previous options of applying continuous eligibility to only a subgroup of enrollees or limiting continuous eligibility to a period less than 12 months; and for CHIP, remove the failure to pay premiums as an optional exception to continuous eligibility. **AHPA enthusiastically supports these proposals, which would extend access to care for minors in need of health care during their developmental years.**

Prior Authorization Timeline

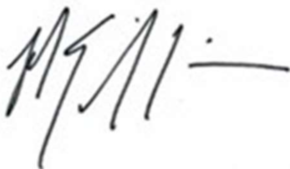
CMS proposes to change the standard review timeframe for prior authorizations from 10 business day to seven calendar days to align with the CMS Interoperability and Prior Authorization (IPA) final rule. The IPA Final Rule requires standard review of prior authorization requests to occur within seven calendar days; expedited requests must be reviewed within 72 hours. Currently, OPPS requires expedited prior authorization requests to be reviewed within two business days. CMS indicates that it is still deciding whether the expedited prior authorization timeline should be changed as well to align with the IPA Final Rule since alignment in this case would mean extending the timeline.

AHPA strongly supports CMS' proposal to align the standard prior authorization review timeline with the IPA Final Rule as this would shorten the amount of time for review. For expedited reviews, we recommend not changing CMS' existing timeline as it is faster than what was finalized in the IPA final rule and the Agency should strive to always conduct reviews for Medicare beneficiaries in the fastest feasible time.

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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