



healthcare financial management association

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Attention: CMS-1786-P
200 Independence Avenue, SW
Washington, DC 20201

Subject: CMS-1786-P

Re: 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; Rural Emergency Hospital Conditions of Participation Technical Correction Proposed Rule (Vol. 88, No. 145), July 31, 2023.

Dear Administrator Brooks-LaSure:

The Healthcare Financial Management Association (HFMA) would like to thank CMS for the opportunity to comment on *Centers for Medicare & Medicaid Services' (CMS) hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2024*. HFMA is a professional organization of more than 100,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

For CY 2024, CMS is proposing a market basket update of 3.0%, with a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. HFMA holds concerns regarding this update. This proposed update fails to adequately address the current environment of unprecedented inflation and the persistent financial challenges faced by hospitals and health systems. Additionally, it does not account for the ongoing high labor composition and supply costs, which have led to continued financial pressures and workforce shortages in the healthcare field.

Therefore, we urge CMS to explore avenues to accommodate these rising costs, ensuring that all patients and communities the industry serves maintain access to quality outpatient care. We also respectfully request the agency to reconsider the productivity cut for CY 2024, as it does not align with the experiences of hospitals and health systems during the public health emergency (PHE), where actual productivity losses were incurred due to COVID-19 impacts.

HFMA fully supports the agency's proposals to:

- Add 26 dental surgery procedures in the Ambulatory Surgical Center Covered Procedures List (ASC CPL). This endorsement is founded on CMS' thorough evaluation of the clinical attributes of these procedures.
- Allow physician assistants, nurse practitioners, and clinical nurse specialists to offer remote direct supervision of CR, ICR, and PR services through two-way audio/visual communication technology in CY 2024. This update will be of significant assistance to community hospitals grappling with ongoing staffing shortages.
- Allow Indian Health Services (IHS) hospitals converting to Rural Emergency Hospitals (REHs) to retain the AIR payment method for hospital outpatient services and for non-hospital outpatient services provided during an outpatient hospital encounter. Additionally, the agency suggest that converted IHS hospitals receive the REH monthly facility payment, like non-tribal or non-IHS REHs. These proposals aim to provide predictability, streamline administration, and allow for an easier transition back to their previous designation if necessary.
- Use a tiered approach to begin implementing the statutory requirement of measures in the REHQR, we agree with our industry colleagues that an approach like the Merit-based Incentive Program (MIPS) where providers report measures that are most relevant to the populations, they serve would be most suitable, given that the services that REHs provided can be regional.

The agency is recommending the implementation of a chart-abstracted measure designed to assess the median duration from when a patient arrives at the emergency department to when they leave. HFMA and our member hospitals eagerly anticipate the opportunity to provide comments and industry insights regarding the proposed wording in this regulation.

CMS is also putting forth several additions and adjustments to the hospital price transparency requirements. These include standardization, modifications to CMS' monitoring and enforcement procedures, and a call for input on enhancing the alignment of various price transparency policies in the future. HFMA is appreciative that CMS is taking steps to simplify and clarify these very complex sets of regulations and HFMA stands at the ready to collaborate with stakeholders and the agency to enhance the hospital price transparency rule, particularly in terms of better harmonizing these requirements with the unenforced Transparency in Coverage (TiC) and No Surprises Act mandates. HFMA appreciates the opportunity to provide constructive feedback and collaborate on this proposal within the rulemaking process.

Cancer Hospital Adjustment

For the calendar year 2024, CMS is suggesting a starting point for the target Payment-to-Cost Ratio (PCR) at 0.89, which was initially established for calendar years 2020 through 2023. Their proposal involves a gradual reduction of 1.0 percentage point each calendar year, starting from CY 2024. This reduction will continue until it reaches the PCR of non-cancer hospitals, as determined using the most recent data, minus 1.0 percentage point, in accordance with the requirements of the 21st Century Cures Act. Consequently, the projected target PCR for CY 2024 would stand at 0.88.

HFMA expresses its support for the proposed methodology outlined. Furthermore, HFMA requests that in the final rule, CMS explicitly verifies that, according to this methodology, the repayments designated for 340B hospitals are accurately factored into the calculation of the final Payment-to-Cost Ratio (PCR) for the calendar year 2024.

Proposed ASC Payment System Update

For the calendar year 2024, CMS has put forth a proposal to increase payment rates for Ambulatory Surgical Centers (ASCs) by 2.8%, contingent upon their compliance with the quality reporting requirements outlined in the ASCQR Program. However, it's crucial to emphasize that Medicare payment rates should accurately reflect the underlying costs incurred by providers and the specific patient population they serve.

Hospitals and ASCs are distinct in their cost structures and the patient demographics they cater to. Consequently, the continued use of the hospital market basket as a basis for updating payments for ASCs is deemed inappropriate by the HFMA, our membership, and industry stakeholders. HFMA opposes CMS's plan to extend this policy and recommends that it be allowed to lapse after the conclusion of calendar year 2023, in line with its original intent.

Moreover, HFMA proposes that CMS collaborates promptly with ASC stakeholders to devise and implement a streamlined method for gathering ASC cost data. This data could then serve as the foundation for establishing an appropriate payment update mechanism for ASCs in the future, should the need arise.

Payment Policy for Outpatient Clinic Visits in Excepted Off-Campus Provider-Based Departments

For the fiscal year 2023, CMS (Centers for Medicare & Medicaid Services) finalized its decision to grant an exemption to rural sole community hospitals from the site-neutral payment policy. However, it's important to note that all other hospital outpatient clinic visit services provided in excepted off-campus Provider-Based Departments (PBDs) received payment at a rate of 40% of the Outpatient Prospective Payment System (OPPS) payment amount.

The choice to maintain the reimbursement rate for services delivered in excepted off-campus Provider-Based Departments (PBDs) at just 40% of the Outpatient Prospective Payment System (OPPS) payment amount perpetuates the vulnerability of off-campus outpatient services and exacerbates the enduring financial hardships faced by community hospitals striving to provide patient-centered access to care beyond their main facilities.

HFMA supports AHA's request to reverse this policy providing evidence in previous comments that:

- contrary to CMS’s assessment, outpatient volume and expenditure growth are not unnecessary;
- continued cuts to hospital reimbursements for clinic visits are excessive and harmful, especially at a time of tremendous financial challenges; and
- site-neutral policies are based on flawed assumptions.

Proposed Changes to the IPPS Medicare Code Editor

CMS has announced that they intend to manage future changes or updates to the MCE through instructions provided to the Medicare Administrative Contractors (MACs). While HFMA acknowledges that the Medicare Administrative Contractors (MACs) are responsible for the technical implementation of these edits, we have concerns about the potential consequences of this future approach. This significant change to the oversight and collaborative input when making changes to the IPPS Medicare Code Editor MCE is significant and could lead to confusion, lack of uniformity, and a failure to comprehensively address all relevant factors when implementing changes to the IPPS Medicare Code Editor (MCE).

HFMA respectfully asks CMS to reconsider this proposal and include it in the forthcoming FY 2025 IPPS proposed rulemaking. This will allow for adequate review and feedback from the relevant IPPS stakeholders.

Health Care Price Transparency

Alignment

HFMA eagerly anticipates collaborating with CMS to enhance the harmonization of federal price transparency regulations with the provisions laid out in the No Surprises Act. HFMA, along with its members, is fervently committed to facilitating patient access to meaningful and accurate healthcare quality data and cost information.

As the healthcare industry and regulatory bodies diligently work on establishing technical standards for implementing Good Faith Estimates (GFEs) and Advanced Explanation of Benefits (AEOBs) for all patients, it has become increasingly apparent that a comprehensive review is necessary. This review should aim to align resources and mitigate the confusion and conflicting information that currently plagues healthcare transparency efforts, causing frustration and misinformation, consumers, patients and stakeholders.

Furthermore, the abundance of data available, including hospital and insurer rates accessible through machine-readable files, has underscored the need for a coordinated approach. HFMA echoes the concerns raised by its peers regarding the fragmentation resulting from Congress, state legislators, and federal regulatory agencies working in isolation. This fragmentation only serves to compound confusion for consumers, patients, clinicians, hospitals, press, and patient advocacy groups regarding healthcare

price transparency.

To address this issue, HFMA recommends that federal regulatory agencies collaborate closely with industry stakeholders, Congress, and state legislatures to ensure that any legislative changes are harmonized with the finalized administrative requirements. This approach will help prevent conflicting requirements and offer clarity to all healthcare stakeholders as they strive to comply with both regulatory and statutory changes.

Standardization

CMS is proposing the implementation of a standardized schema for hospital price transparency machine-readable files, partly in response to feedback from hospitals and other stakeholders. The new format would entail the inclusion of additional mandatory fields, such as information about the contracting method employed to establish negotiated rates and an anticipated allowed amount for non-monetary rates.

While HFMA acknowledges CMS's responsiveness to the concerns raised by hospitals and other stakeholders regarding the existing format, there are apprehensions about the additional burden that these new requirements will impose on hospital staff. Moreover, the relatively short two-month timeline for transitioning to this standardized format following its finalization is of great cause for concern.

Hospitals have typically developed their machine-readable files, often in collaboration with consultants, based on their interpretation of CMS guidance and to accommodate the diversity of contract types between insurer plans and providers. One common challenge shared by hospitals with CMS relates to determining a single rate for a service in cases where payer contracts are not based on straightforward fee schedules but instead incorporate multiple complex factors.

In response to this challenge, CMS is now proposing that hospitals provide extensive information in their machine-readable files, elucidating both the methodology employed to derive negotiated rates and the expected payment amount based on that methodology. The additional fields that outline the methodology (e.g., percentage, algorithm) are anticipated to be exceedingly labor-intensive to generate and would require substantial administrative hours to accurately document.

CMS's proposal to introduce items like additional modifier and drug data fields poses a substantial challenge for hospitals, as incorporating these changes into the machine-readable files (MRFs) would be an extensive undertaking. Furthermore, these additions would significantly increase the file size of MRFs, which are already quite large for most hospitals. This is a critical point to consider.

Specifically, CMS is suggesting that hospitals include relevant modifiers in a new field, which becomes complex as many items and services can be billed with multiple modifiers that affect payment calculations. This would necessitate the inclusion of numerous permutations in the machine-readable file if CMS proceeds with this requirement. Additionally, CMS proposes that hospitals specify drug units

and types of measurement as separate data elements, even though this information is already captured in the item description. These new data fields would substantially elevate the cost of compliance and the maintenance of the new standardized schemas.

Considering these challenges, HFMA requests that CMS grant hospitals a period of up to 18 months to adopt the new standards following the release of the final technical guidance. Hospitals have already committed significant resources to comply with machine-readable file requirements. Given the complexity of the new standardized schema, comprehensive guidance is imperative to ensure consistent implementation across hospitals, thus preventing the need for frequent updates to the guidance, potential civil monetary penalties, negative public perception, and increased confusion and distrust among consumers and patients.

The development of detailed guidance will necessitate collaboration between CMS and hospital technical experts, and it is unlikely to be completed by the time the final requirements are released. Therefore, the implementation period for the standard files should not commence until this guidance is finalized. Attempting to meet the requirements before guidance is available would be inefficient and inequitable to all stakeholders, resulting in added costs and staff time that could be better allocated to patient care and enhancing the patient experience.

Monitoring and Enforcement

HFMA stands with the American Hospital Association in their opposition to the proposed addition of §180.70(a)(2)(v), which would mandate hospitals and health systems to submit specific documentation to CMS. This proposed rule suggests that CMS may demand hospitals to submit "contracting documentation to validate the standard charges the hospital displays."

Importantly, there is no indication in section 2718(e) of the Public Health Services Act, which is the statutory basis upon which the agency relies for this documentation requirement, that Congress authorized CMS to circumvent these well-established legal protections through regulatory means.

HFMA does not however oppose the agency's ability to request submission of other types of information, such as verification of a hospital's licensure status or license number.

HFMA supports CMS's proposal to directly notify health system leadership of any compliance activity taking place within their health system. Furthermore, HFMA endorses the practice of notifying the leadership of the specific hospital involved. This approach serves to streamline communication, particularly in cases where health systems have a central office responsible for compliance for the entire organization.

CMS's proposal to mandate a designated leadership official at the health system level to confirm the receipt of warning notices is a commendable step towards expediting hospital response to identified issues and improving communication with CMS. HFMA appreciates CMS's efforts to streamline this process and mitigate any potential delays arising from communication issues.

In addition to this proposal, HFMA recommends that CMS also copy the primary contact listed on the 855A Enrollment Form. This individual is already positioned to serve as an intermediary between CMS and the hospital and could play a crucial role in ensuring that the letter reaches the appropriate individuals within the hospital promptly.

The Publication of Compliance Actions and Outcomes

CMS's proposal to publicly disclose information related to hospitals under compliance review raises serious concerns for HFMA. While HFMA acknowledges CMS's authority as the sole arbiter of compliance and recognizes the need for transparency in compliance actions, there is a profound worry that certain stakeholders may misconstrue this information and misrepresent its true context and purpose.

HFMA and its members have consistently had to correct misleading statements from stakeholders who misinterpret CMS guidance and erroneously assert that hospitals are noncompliant with federal price transparency regulations. Such misrepresentations can lead to public frustration and erode trust, potentially causing individuals to delay seeking necessary medical care until their conditions become more severe.

Furthermore, it is important to note that there have been historical instances where CMS initially had questions about a hospital's compliance but later determined that the hospital was indeed compliant. This often results from collaborative efforts between hospitals and CMS during the review process, which includes mutual education on the information that should be included in machine-readable files.

If CMS proceeds with this proposal and chooses to release such information, HFMA strongly urges the agency to clarify that hospitals under review are not automatically deemed non-compliant. Alternatively, HFMA recommends that CMS establish a regular schedule for reviewing hospitals' machine-readable files and making that information public. This approach would underscore the fact that all hospitals undergo routine reviews, thereby eliminating any stigma associated with the review process.

HFMA proposes to CMS that all stakeholders obligated to adhere to federal healthcare price transparency laws and provisions should be subjected to equal treatment by the federal regulatory authority. This entails that they should all undergo the same rigorous and publicly accessible audits to ensure that their compliance efforts are consistent and uphold the principles of consumer and patient-centered transparency.

Adoption of the Median Time from ED Arrival to ED Departure for Discharged ED Patients Measure

CMS is recommending the implementation of a chart-abstracted measure designed to assess the median duration (in minutes) from when a patient arrives at the emergency department to when they

leave. The agency supports its request in stating that REH services will likely focus on ED care, and “improving throughput times is important for alleviating overcrowding and reducing wait times.”

HFMA concurs with AHA’s insight that this measure lacks substantial evidence linking it to enhanced patient outcomes. In fact, it lost its endorsement from the Center for Behavioral Education (CBE) in 2018 due to its failure to meet the criteria of being crucial for measurement and reporting. Furthermore, there’s evidence demonstrating that alterations in wait times have any influence on mortality rates or other patient-related outcomes. Additionally, the overall reduction in wait times over several years was marginal, approximately only four minutes.

Moreover, it’s improbable that variations in wait times serve as indicators of disparities in the quality of care, as opposed to factors related to patients, healthcare providers, or market dynamics.

This measure also imposes a significant reporting burden. To comply with it, Rural Exempt Hospitals (REHs) would need to extract relevant data elements from various sources such as claims forms, electronic health records (EHRs), or paper records. Subsequently, they are required to submit this data to CMS on a quarterly basis through the Hospital Quality Reporting (HQR) System.

Considering that REHs are much smaller in scale compared to general acute care hospitals, it’s reasonable to assume they have limited staff resources available for the demanding task of chart abstraction. Furthermore, the measure’s data is segregated into four distinct calculations: an overall rate, a rate excluding psychiatric/mental health and transfer patients, a rate specifically for psychiatric/mental health patients, and a rate for transfer patients. Given the probable lower patient volume in REHs, HFMA agrees with AHA’s assessment that it’s doubtful that they would generate statistically reliable rates for all four of these categories.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS. We take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on these complex issues. If you have additional questions, please reach out to me or Shawn Stack, Director of Perspectives and Analysis at sstack@hfma.org or at 708.571.3955 ext. 607

Sincerely,



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Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 100,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.