MISSOURI HOSPITAL ASSOCIATION

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September 15, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals (CMS-1753-P)

Dear Administrator LaSure:

On behalf of its 142 hospital members, the Missouri Hospital Association offers the following comments in response to the Centers for Medicare & Medicaid Services' proposed regulatory changes to the Medicare Outpatient Prospective Payment System for calendar year 2022.

RURAL EMERGENCY HOSPITAL

Congress enacted a new type of hospital classification known as a rural emergency hospital within the Continuing Appropriations Act of 2021. CMS is seeking comments about the implementation, payment methodology and enrollment process of the REH model. MHA thanks CMS for providing key stakeholders the opportunity to provide feedback.

Fixed Payment Rate

CMS posits that the REH fixed monthly payment for 2023 will be based on "the excess (if any) of the total amount that was paid to all CAHs in 2019 over the estimated total amount that would have been paid to CAHs in 2019 if payment were made for inpatient hospital, outpatient hospital, and skilled nursing facility services under the applicable prospective payment systems for such services during such year." This amount then would be divided by the total number of CAHs in 2019. In its Request for Information, CMS did not provide the calculated fixed payment. Whether the REH model is a viable option largely will depend on the fixed payment amount. In order for hospitals to fully assess the viability of the REH model, MHA urges CMS to provide the amount of the fixed payment in publishing its final version of this proposed order of rulemaking.

It is possible that total spending of the program will increase based on the proposed fixed payment calculation. CMS further states that "REHs also will be required to maintain detailed information as to how they have used these payments." With no apparent statutory authority to increase the total pool of payments to participating REHs and a requirement to disclose how the fixed payments are used, MHA is concerned that CMS will change or rebase future fixed payment rates. MHA recommends that CMS provide greater transparency about the fixed payment amount and provide clear regulatory language that would prevent changes in the fixed payment formula or future rebasing. MHA urges CMS to provide transparency as to what reporting processes will be mandated and how the information will be used.

Federal statute dictates that the 2023 fixed payment is based on 2019 data. It also prescribes that future payment updates be based on a "hospital market basket percent increase." Beginning in 2020, the COVID-19 pandemic upended most hospitals' cost structures. They incurred high costs for personal protective equipment, upgrading ventilation systems and building and renovating treatment space to accommodate new clinical needs and expectations. They also bore and continue to bear skyrocketing expenses for wages, recruitment, and retention. It is unclear whether or how future adjustments based on a hospital market basket index will adequately capture the recent turbulence in hospital costs and utilization and its longer-term reverberations. If CMS does not accurately account for the effect of the pandemic in determining future market basket increases, the amount of unreimbursed REH cost will be significant and the effect of the omission likely will be magnified over time. MHA recommends that CMS adopt regulations that explicitly accommodate the effect of the pandemic.

Conversion from REH back to a CAH

The CAA includes language allowing a hospital that converted to a REH to return to its former designation. Specifically, the CAA states that REH "enrollment shall remain effective with respect to a facility until such time as — (i) the facility elects to convert back to its prior designation as a critical access hospital or a subsection (d) hospital (as defined in section 1886(d)(1)(B)), subject to requirements applicable under this title for such designation and in accordance with procedures established by the Secretary." Although REHs would have the option to convert back to a full-service hospital, it is unclear whether a hospital converting from an REH back to a CAH could do so based on necessary provider status. CAH eligibility is dependent, among other things, upon its proximity to another hospital or having been designated as an NP prior to December 31, 2005. Many hospitals in Missouri are eligible due to the NP exception. Due to the opaque language within the statute, MHA recommends that CMS clarify and clearly articulate that an REH wishing to convert back to a CAH may do so by utilizing the NP status that was obtained prior to becoming an REH for new enrollment purposes. Without clear language, hospitals will be very reluctant to convert to an REH.

Swing Bed Services

Hospitals report that one of the most problematic aspects of the REH model is the requirement to discontinue swing bed services. The discontinuation of these services will limit access and promote patient and family disruption in rural areas. Access to nearby swing bed services is prized by many rural Medicare beneficiaries and their families. Further, the coronavirus pandemic has perhaps been more impactful on older adults. The need for access to appropriate care facilities — particularly in rural areas — is essential. Within the CAA, REHs have the option to "include a unit of the facility that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services." While MHA applauds the option of continuing skilled nursing services as a distinct unit, MHA is disappointed the statute and regulation do not allow for the continuation of the cost-based payment methodology used within the swing bed program. If a CAH were to continue offering skilled nursing services, it would need to convert a unit into a skilled nursing PPS facility. The complexities and cost of converting to a SNF PPS facility will discourage hospitals' interest and participation in the REH program. MHA recommends that CMS provide regulatory language and opportunities that would allow an REH to provide swing bed/skilled nursing services reimbursable outside of the SNF PPS system. Finally, we would urge CMS to closely monitor the conversion and the loss of any SNF PPS services. We believe the agency should report annually on capacity and supply of these services, along with wait and drive times beneficiaries are experiencing in accessing an appropriate placement as a result of CAHs' inability to stand up and support a distinct part licensed SNF facility.

Use of OPPS to Reimburse REH

The OPPS system is established based on assigning the resources consumed by full service prospective hospitals into weights used to pay for outpatient services. Since the REH program will not be a full-service hospital, utilizing the OPPS APC weighting system to determine reimbursement may not provide sufficient alignment of the resources needed to care for REH patients. MHA recommends that CMS create a new weighting scale for REHs and adjust the OPPS APC weighting scale based on REH resource consumption. Although this would not be possible until enough historical REH claim data have been received, MHA urges CMS to begin drafting proposed language that would be used to establish REH weights.

Medicare Advantage Prior Authorizations for Transfers

As part of the requirements to become a REH, the annual average per patient length of stay must be 24 hours or less. REHs also must have a transfer agreement with a level I or level II trauma center. Although the Medicare fee-for-service system does not have a formal prior authorization process for patient transfers, prior authorizations will be required for some of the Medicare Advantage patient transfers. Hospitals have long complained about the slow turnaround times, as well as lack of prior authorization approvals by MA plans. MHA recommends that CMS work with and compel the MA plans to provide expedited authorizations for REHs needing to transfer a patient into an inpatient bed.

RADIATION ONCOLOGY MODEL

CMS is proposing to implement a radiation oncology demonstration model effective January 1, 2022. Participation in the RO Model will be mandated for providers and suppliers of radiation therapy services who are in a predetermined core-based statistical area and ZIP code. In doing so, CMS is using its regulatory powers to create competitive advantages and disadvantages based on the location of the facility. Hospitals and other providers should compete based on their efficiency and effectiveness, not by their location in an area selected by regulatory fiat.

Within the proposed rule, CMS wrote, "The RO Model is designed to test whether making site-neutral, prospective episode-based payments to HOPDs, physician group practices and freestanding radiation therapy centers for RT episodes of care preserves or enhances the quality of care furnished to Medicare beneficiaries while reducing or maintaining Medicare program spending." MHA previously voiced concern to CMS about such demonstration models in the Medicare program. They are designed as national "experiments" with multilayered "control" and "experimental" groups to enable a scientifically valid evaluation. Laudable as the concept may be, it treats the nation's hospitals and clinicians as "lab rats" in the experimentation.

MHA long has supported innovative ways to improve quality, patient satisfaction and cost efficiency. CMS should be commended on the various innovation models that are available to physicians and hospitals. However, CMS should stop deploying mandated experimental demonstration models and allow providers to choose whether participation is conducive to the population it serves and the operations of the hospital. MHA recommends that CMS change the model from mandatory to voluntary participation.

ELIMINATION OF THE INPATIENT ONLY LIST

CMS implemented a policy that would phase out and eliminate the inpatient only list beginning in CY 2021. MHA previously commented about the unintended consequences and encouraged CMS to revisit the decision to finalize the proposal. MHA applauds CMS for revisiting the issue and proposing to add 298 services back to the IPO list beginning CY 2022. The IPO list maintains a common standard of medical judgement in the Medicare program, rather than defaulting to the judgement of individual practitioners, which may be influenced by regional or state-specific differences in liability or regulatory standards. This is a national program. We believe CMS should avoid policies that unleash wide variations in Medicare coverage between states, regions or even practitioners within a group practice. MHA believes that CMS should remain involved in managing the review, removal and additions to the IPO services, as deemed clinically appropriate. CMS neither should set a policy goal of increasing or eliminating the IPO list. CMS should review and change the IPO listing based on national standards.

MEDICARE WAGE INDEX REVISIONS

CMS proposes to apply the wage index standards of the Acute Inpatient PPS to adjust payment rates for the outpatient PPS. Within the IPPS wage index final rules, CMS established a minimum area wage index for hospitals in all urban states for FFY 2022 and onward, not implemented in a budget neutral manner, and applied after the application of the rural floor. While MHA opposes the policy, MHA applauds Congress for implementing the imputed rural floor in a nonbudget-neutral methodology. MHA also continues to oppose the application of a nationwide rural floor budget neutrality adjustment used within the IPPS wage index. While CMS is following federal statute, such policies will do nothing more than exacerbate the "downward spiral" for low wage index hospitals.

In the IPPS payment and policy update, and within the OPPS proposed rule, CMS has neglected to include a table that includes details by state of the effects of the nationwide rural floor budget neutrality adjustment and the imputed rural floor. MHA is disappointed that CMS has not repeated its earlier publications of this type of data and encourages CMS to include it in future rulemaking. MHA urges CMS to be transparent and provide state-specific details about the financial redistribution of funds due to the national budget neutrality wage index adjustments.

Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

Andrew Wheeler
Vice President of Federal Finance

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