WISCONSIN HOSPITAL ASSOCIATION

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September 13, 2022

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: Comments on Proposed Rule CMS–1772–P: **Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating**

Dear Administrator Brooks-LaSure:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed CY 2023 rule related to the Medicare Program Hospital Outpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

CMS's Proposed Payment Update is Inadequate Given Extreme Inflation and Other Cost Increases

In this rule, CMS proposes to update outpatient rates by 2.7% for calendar year (CY) 2023. This change includes a market-basket update of 3.1%, as well as a statutorily-required productivity cut of 0.4 percentage points. ***Given the current extreme levels of inflation our health care system is facing, this payment adjustment is sorely inadequate. WHA strongly urges CMS to increase this update like it did for the 2023 inpatient rule.***

The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on hospitals. While COVID cases have been much more manageable recently, and while the hope is we are returning to a post-covid normal, hospitals are facing mounting fiscal pressures stemming from COVID, including:

- Rising labor costs from a nationwide workforce shortage and historic inflation. Labor costs often make up 60% or more of a hospital's operating cost.
- Stagnant reimbursement from government payors like Medicare and Medicaid, which make up more than half of inpatient care for 94% of Wisconsin hospitals.

- Longer average lengths of stay due to hospitals treating higher-acuity patients and the lack of available long-term care settings for patients. These patients require more staffing resources and yet our antiquated payment structure does not take this into account.
- A return of the Medicare Sequester cuts at 1% on April 1, and 2% on July 1.
- Depletion of COVID relief dollars and funding for COVID tests and treatment for the uninsured.

A recent report from Kaufman Hall surveying budget data from over 900 hospitals nationwide found that hospitals have experienced seven straight months of negative median operating margins. Labor expenses were up 13.9% and overall costs were up 9.6% largely driven by labor and inflation. The report surmised that 2022 would be the worst financial year for hospitals in a very long time.

Despite numerous financial pressures, hospitals have worked hard in recent years to keep costs down. According to data from the Bureau of Labor Statistics, hospital prices have grown an average of 2.1% per year over the last decade, about half the average annual increase in health insurance premiums. However, with the combination of historic inflation, an unprecedented workforce shortage, and sustained underpayments by federal government health care programs, hospitals are facing significant fiscal pressures going forward.

Wisconsin ranks 16th lowest in terms of per-beneficiary spending according to the Kaiser Family Foundation, and yet, is not rewarded for being a low-spending state when it comes to Medicare. Wisconsin hospitals receive, on average, around 73% of what it costs them to provide Medicare services, well below the national average. At the same time, Wisconsin is also the 16th highest state in terms of the percent of its population on Medicare. As people move off private insurance and onto Medicare, it compounds the impact of insufficient Medicare reimbursements, as Wisconsin has seen **annual Medicare underpayments to Wisconsin hospitals grow from $1.77 billion in 2016 to $2.78 billion in 2022, a 57% increase in 4 years**

Unlike other industries, hospitals cannot simply raise prices to bring in additional revenue. Hospitals can only bring in additional revenue by renegotiating higher payments with employers and health insurers, something that is increasingly difficult in the current fiscal environment. ***Given these immense challenges, CMS must recognize the need for its payment policies to correspond to the actual inflationary environment hospitals are operating in.***

Medicare Area Wage Index

The area wage index is designed to adjust payments based on local differences in labor costs. WHA has often noted concerns about manipulation of the Medicare Area Wage Index in the prospective payment system. CMS has echoed these concerns in recent proposed rules, noting that results of making the rural floor budget neutral on a national basis, as required by the Patient Protection and Affordable Care Act Section 3141, is that all hospitals in some states receive an artificial wage index that is higher than the what the single highest urban hospital wage index would otherwise be. WHA has previously joined with associations in other states to garner support from Congress to address this patently unfair payment manipulation, which has specifically benefited hospitals in states on the east and west coasts and has been commonly referred to as the "Bay State Boondoggle."

WHA applauds CMS for continuing policies designed to restore fairness to the wage index, such as bringing up those hospitals in the bottom quartile and excluding urban hospitals that reclassify as rural from the overall calculation of each state's rural floor. WHA opposed efforts by Congress to manipulate the rural floor by restoring the imputed rural floor for all-urban states.

It was unfortunate that Congress included this blatant earmark in the American Rescue Plan Act of 2021, as it unfairly manipulates the wage index to benefit only 3 states. We understand that they purposely did not apply budget neutrality to the restoration of this policy, in order to hold other states harmless. However, we still feel that this policy is unfair; with the Medicare Trust Fund facing more solvency concerns than ever, states should

not be artificially steering a finite amount of Medicare taxpayer dollars by manipulating Medicare payment formulas.

More than ever, this shows the need for CMS to accelerate opportunities to pay Medicare services based on outcomes and the value of care provided. Wisconsin hospitals receive only 73% of costs from Medicare while the national average is closer to 87% of cost. While Medicare should be focusing on incentivizing and rewarding states like Wisconsin, payment policies such as this all too often create perverse disincentives to provide such care. Wisconsin hospitals and health systems continue to pursue high quality, high value health care and we continue to support CMS finding ways to correct past manipulations of the Medicare payment system in favor of incentivizing high-quality, high-value care.

In Addition to Exempting Rural Sole Community Hospitals, CMS Should Reverse Site-Neutral Cuts

In the CY 2023 proposed rule, CMS indicates it has continued to assess how its site-neutral payment policy has been implemented, and how it affects both the Medicare program itself and the beneficiaries it serves. CMS notes that there are a number of special payment provisions designed to maintain access to care in rural Sole Community Hospitals (SCHs). These include the 7.1% increase in payment for all services and procedures to compensate them for their higher costs relative to other OPPS hospitals and their exemption from CMS' policy to reduce payment for 340B program drugs from ASP+6% to ASP-22.5%.

CMS also recognizes that many rural providers are often the only source of care in their communities, which means beneficiaries and providers are not choosing between a higher paying off-campus provider-based departments (PBDs)of a hospital and a lower paying physician's office setting. The closure of inpatient departments of hospitals and the shortage of primary care providers in rural areas further drives utilization to off-campus PBDs in areas where rural SCHs are located.

WHA fully supports the proposal to exempt SCHs from site-neutral cuts in this rule. Additionally, WHA believes CMS's recognition of the dangers of applying site-neutral cuts to SCHs should lead them to reverse these cuts altogether. WHA cited concerns in its initial comments to CMS against site-neutral payments which were very similar to the concerns CMS is now citing in this proposed change. For instance, many of the HOPDs that have received site-neutral cuts were previously purchased by hospitals and converted to HOPDs because they were otherwise in danger of closing. Hospitals did this in order to help keep access to care in their local communities when independent physician practices were at risk of closure due to poor payor mixes, provider shortages, and low rates paid by the physician fee schedule.

While we are encouraged that CMS sees the importance of keeping SCHs financially viable, it must also recognize that there are hospitals that do not meet the criteria of a SCH, but still play the vital role of maintaining access to care in their communities. This absolutely includes Medicare Dependent, Low-Volume Adjustment, and other rural hospitals, which should also certainly be exempted. However, in addition to these hospitals, CMS must recognize that other hospitals which do not meet these special rural criteria nevertheless play the same important role in meeting the needs of the most vulnerable in the communities they serve. Site-neutral payment policies harm their ability to fulfill that mission.

CMS Should Not Add Additional Services to the Prior Authorization Program

In this rule, CMS proposes to add the service category of facet joint interventions to its prior authorization program. ***WHA has strong concerns against CMS adding more services to the prior authorization program at a time when the practice of prior authorization is under growing scrutiny due to its significant negative impact on patient care.***

While CMS cites unnecessary increases in the volume of these services and a desire to thus control costs in the Medicare program, there is growing evidence that the prior authorization program adds costs borne by

hospitals and patients when deployed improperly. For instance, health care practitioners spend considerable time navigating the prior authorization maze for patients and health insurers and government agencies spend considerable time reviewing prior authorization requests. And, growing evidence shows that the prior authorization process is all too often used to deny access to appropriate care, such as an April 2022 report by Health and Human Services' Office of Inspector General which found, among other things, that Medicare Advantage Organizations (MAOs) inappropriately denied 18% of payment requests in a one-week period in 2019, as well as a 2018 report from the same OIG which found that health care practitioners successfully overturned 75% of their prior authorization requests to MAOs.

While we appreciate that CMS has proposed a more complex form of justification for this service line's prior authorization proposal than in years past, we are nevertheless concerned that CMS is too quickly jumping to a conclusion that may be inaccurate. For instance, CMS does not seem to consider that one reason for the increase in these types of services may be that practitioners were adjusting to changing pain management practices as a result of a national movement toward reducing opioid prescriptions. Furthermore, they do not seem to account for the fact that current data shows the trend of an increase in these procedures is already subsiding, even when adjusting for the lull in services that resulted from the COVID-19 pandemic.

For these reasons, we urge CMS to withdraw this prior authorization proposal. Instead, CMS should further study this dynamic, and focus on provider education as a first step in curtailing what it deems to be an abnormal increase in such services.

CMS Should Not Recoup Payments from non-340B Hospitals to Correct its Own Error

In the proposed rule, CMS is finally recognizing that it can no longer continue the unlawful policy of reducing payments to 340B hospitals in light of the unanimous Supreme Court decision in *American Hospital Association v. Becerra.* However, it unfortunately is proposing to reduce payments from other hospitals through an adjustment in the conversion factor. Furthermore CMS requests feedback on a remedy for repaying 340B hospitals for the cuts from 2018 to 2022, and it has previously suggested that it will need to recoup funds that have already gone out to non-340B hospitals from the prior years' application of budget neutrality.

WHA strongly urges CMS to hold all hospitals harmless when correcting this error, both for this year and for prior years. Hospitals were not responsible for CMS's decision to make the prior unlawful payment cuts and they should not be penalized for CMS's decision. Furthermore, for the reasons previously mentioned earlier in this comment letter, hospitals cannot afford further unanticipated cuts from the Medicare program given the rising costs they are bearing for labor and from inflation.

CMS should instead ensure that the conversion factor is adjusted appropriately so that no hospital is underpaid in 2023 and that no recoupments are sought from hospitals in remedying the underpayments for 340B hospitals from 2018-2022. It's worth noting that budget neutrality is to be applied on a prospective basis, and there is no legal basis for recouping payments that have already gone out based on prior years' payment rules.

New Rural Emergency Hospital Designation

In the 2022 OPPS rule, CMS solicited comments on how it should establish the new Rural Emergency Hospital designation authorized by Congress in the Consolidated Appropriations Act, 2021. This designation was created for hospitals that have seen dwindling inpatient volumes and financial challenges. It would allow a hospital with fewer than 50 beds to continue serving its community with an emergency department 24 hours a day and 7 days a week as well as provide certain hospital level outpatient services but no inpatient hospital services.

WHA previously commented that CMS should establish flexibility when creating this new designation for hospitals and not be overly prescriptive. We are glad CMS is going forward with creating this new designation and is including a payment structure that could be a lifeline for certain communities allowing them to keep emergency services in their community as well as observational beds. Given that the designation will be starting during a period of significant financial uncertainty for hospitals, we urge CMS to continue listening to the needs of hospitals and rural communities as they work toward establishing the full regulatory and payment structure of this program, and making the new payment model sustainable.

WHA Supports CMS Continuing Remote Outpatient Mental Health Services Permanently

WHA appreciates that CMS has been advocating for permanently extending payments for telehealth services that are within the jurisdiction of CMS – services first made possible due to the COVID-19 pandemic public health emergency (PHE) waivers. While WHA continues to advocate for Congress removing all statutory barriers to a more permanent Medicare telehealth policy, it appreciates CMS recognizing that patients and practitioners alike do not want to go backward in time once the PHE expires. WHA especially appreciates that CMS recognizes the need to continue covering audio-only services due to both a lack of adequate broadband infrastructure and the personal preference of certain patients.

Regarding the payment of these services, WHA urges caution as CMS moves forward with permanent payment policies. Due to the fledgling nature of these services, it is not currently widely understood how all hospitals and practitioners are billing for these services, and it is doubtful that the three codes created by CMS will fully account for the wide range of services provided. It is worth noting that Wisconsin hospitals already receive on average only 73% of what it costs them to provide hospital services. It is also worth noting that assumptions about remote services reducing overhead are not always accurate, as the technology to provide services remotely itself represents a new cost for practitioners and facilities.

Given that CMS's payment rates are already well-behind the true rise in labor, inflation, and other costs borne by hospitals, and that behavioral health service lines already typically operate at a loss, CMS must be careful to ensure that payments for these services make them sustainable for hospitals to offer long-term.

RFI on the Impact of Hospital Consolidation

WHA strongly cautions CMS against pursuing heavy-handed approaches aimed at tamping down perceived negative impacts of hospital consolidation. Too often, these approaches are by nature one-sided, relying on inaccurate perceptions about what drives consolidation. Additionally, they often ignore the true drivers of consolidation, such as overregulation by government and consolidation of the health insurance market.

While Wisconsin is fortunate to have a more competitive health insurance market than most states, our hospitals continue to face challenges in negotiating fair contracts and providing timely patient care due to the immense pressure and power health insurance companies exert when establishing plan contracts. Wisconsin hospitals are reporting more problems than ever in providing timely patient care due to obstacles created by insurance companies such as unnecessary prior authorization, and hidden changes to plan agreements.

Additionally, independent hospitals often do not have the resources to comply with the complex regulations and payment policies created by CMS and Wisconsin's Medicaid program, leading them to rely on resources provided by larger health care systems. WHA urges CMS to focus its data on the unnecessary complexity added to the U.S. health care system by overly complex health insurance policies, unnecessary prior authorization, over-regulation, and unnecessary complexity in federal hospital rules and payment policies.

WHA Supports Utilizing Telehealth and NPPs to Provide Supervision

WHA is greatly encouraged by CMS's proposals to extend flexibilities for telehealth direct supervision of cardiac and pulmonary services and making permanent the ability of non-physician practitioners to supervise diagnostic services. WHA appreciates CMS's recognition that payment and regulatory policies must adjust to respond to advances in care. Given the immense workforce shortages our health care system currently faces, we must use every tool available to maximize the ability of existing providers to care for their patients. Recognizing the utility of telehealth and advanced practice providers like physician assistants and nurse practitioners is an extremely important part of this.

RFI on IPPS and OPPS Payment Adjustments for Wholly Domestically Made NIOSH-approved Surgical N95 Respirators

WHA appreciates CMS seeking feedback on how to deal with supply-chain disruption such as PPE and investigating enhanced payments for resource costs associated with domestically made PPE. If the COVID-19 pandemic has exposed anything, it is how interconnected and fragile our supply-chain lines can be. Not only did we face severe PPE shortages early on, but we now face shortages for contrast media dyes, leading hospitals to have to implement conservation strategies for patients needing scans or procedures that rely on contrast IV.

We appreciate CMS investigating an enhanced reimbursement rate for obtaining domestically made products as a way of encouraging more domestic production. In addition to something like this, we believe this ongoing challenge may require a deeper, more strategic response that takes into account the complexities of modern manufacturing, business structure, suppliers and the interwoven relationships between all parties. We appreciate CMS recognizing that hospitals have had to deal with the challenges of rising costs created by these supply chain disruptions and urge them to consider other broader impacts as hospitals deal with significant increases in input costs. According to a recent report by the American Hospital Association, supply expenses for hospitals nationwide were 15.9% higher by the end of 2021 compared to the end of 2019 and 20.6% higher per patient.

WHA appreciates the opportunity to provide comment on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO