Illinois Health and Hospital Association

September 5, 2024

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: CY25 Outpatient Prospective Payment System Proposed Rule (CMS-1809-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 2025 (CY25) Outpatient Prospective Payment System (OPPS) proposed rule. We appreciate the attention CMS paid to past comments for extended flexibilities and improved reimbursement for certain services, as well as CMS' continued commitment to work with the provider community to ensure access to high quality care for Medicare beneficiaries.

However, we are concerned with CMS' continued underpayment of Medicare services, not only for services paid via the OPPS, but services paid under other Medicare payment systems as well. As we have commented before, CMS utilizes a methodology to update payment rates that does not keep pace with the economic and political realities of healthcare. **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 CY25 Rate Update

We are disappointed with CMS' proposed CY25 OPPS rate update. After accounting for all proposed payment and policy changes and the sequestration reduction, we estimate that Illinois hospitals will realize a mere 1.6% increase in OPPS payments compared to CY24.

The most recent data show that total hospital expenses year-to-date for the past year are up 6% nationally.[1] We understand CMS' longstanding reliance on IHS Global Inc.'s

[1] https://www.kaufmanhall.com/sites/default/files/2024-08/KH-NHFR_June-2024-Metrics.pdf

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forecast data to calculate market basket updates. As we have stated in past comment letters, the use of this data source results in an undervaluation of the true increase in costs to America's hospitals. And while we recognize that CMS intends to update this methodology in the final rule using more recent data, we do not expect the final increase to match the 6% rise in costs experienced by hospitals.

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. It is clear that CMS' continued use of this data source and the associated methodology does not track real-time costs of providing healthcare, resulting in an ever-deepening financial hole when it comes to Medicare reimbursement.

IHA urges CMS to do everything under its 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 faced by hospitals.**

Site-Neutral Payment Policies for Off-Campus Provider-Based Departments (PBDs)

IHA supports CMS' proposal to continue exempting excepted off-campus PBDs of rural sole community hospitals (SCHs) from its site-neutral clinic visit payment policy that reimburses such services at 40% of the OPPS payment rate. We also ask CMS to revisit its interest in exempting other rural PBDs with fewer than 100 beds, a potential policy for which it solicited comments in the CY23 OPPS proposed rule. In the CY23 OPPS final rule, CMS stated it would "continue to take information submitted by the commenters into consideration for future analysis." **We request CMS not only release analysis completed on the potential exemption of small, rural PBDs, but also strongly consider improving access to clinic services by reversing this payment policy for all PBDs operating in underserved areas, rural or urban.** This is particularly important given CMS' continued under-reimbursement of the OPPS, as described above.

Separate Payment for High-Cost Diagnostic Radiopharmaceuticals

IHA appreciates and supports CMS' proposal to pay separately for diagnostic radiopharmaceuticals with per-day costs above a threshold of $630. We also support CMS' proposal to update the $630 threshold in CY26 and subsequent years by the Producer Price Index for Pharmaceutical Preparations, as well as CMS' proposal to pay for separately payable diagnostic radiopharmaceuticals based on their Mean Unit Cost derived from OPPS claims. **Illinois hospitals thank CMS for this thoughtful proposal and encourage the agency to finalize it as proposed.** Doing so will undoubtedly support utilization of advanced diagnostic technology, improving beneficiary access to these technological advancements and increasing providers' abilities to assess organ function and bone growth, predict surgery effects, assess

changes since beginning treatment (e.g. cancer treatment), and diagnose specific conditions such as abscesses, infections, blockages, and diseases.

Proposed Conditions of Participation (CoPs) for Obstetrical (OB) Services in Hospitals and Critical Access Hospitals (CAHs)

IHA shares CMS' concern over the United States' ongoing maternal health crisis. Data show that maternal mortality rates in the U.S. continue to outpace other high-income countries,[2] which is one of several reasons why Illinois stakeholders created the Illinois Perinatal Quality Collaborative (ILPQC).[3] In Illinois, 99% of births occur at hospitals participating in ILPQC initiatives, meaning mothers are giving birth at facilities that are already implementing the policies set forth in these proposed CoPs or OB services. Further, Illinois has a robust regionalized perinatal system, and will soon operationalize a maternal levels of care system across the state. The addition of maternal levels of care will require birthing hospitals to be certified both for their abilities to care for babies as well as mothers. This comprehensive system, including the participation in quality programs (both within and outside of ILPQC), is already a key component of what birthing hospitals in Illinois must do to maintain their perinatal designation.

Illinois' birthing hospitals enthusiastically participate in the ILPQC while facing real financial and operational challenges. Chief among these challenges is a lack of resources, both clinical and administrative. While IHA generally agrees with the policies proposed by CMS, we believe creating new CoPs would be administratively burdensome, likely creating duplication and confusion for our birthing hospitals, particularly our CAHs. These CoPs would create one more challenge to our small, rural, and critical access hospitals that are struggling to remain open. In many cases, these hospitals are the only birthing facilities for miles, making them invaluable to the health and safety of families for multiple communities.

Given the real challenges that parents, babies, and providers have in maintaining access to OB services, and the commitment of our hospitals to providing high-quality and innovative services in coordination with the Illinois Dept. Of Public Health and entities such as ILPQC, we ask CMS to refrain from creating another set of CoPs that are frankly unnecessary for Illinois hospitals. The unintended consequences of these CoPs will harm the good work already happening in our state. We are committed to the health and safety of patients seeking obstetric and neonatal services, and our hospitals will continue to work with the ILPQC to end maternal and infant mortality.

[2] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.pdf
[3] https://ilpqc.org/

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

IHA strongly supports the flexibility that CMS continues to provide by separating partial hospitalization and intensive outpatient services into two categories, addressing patient needs for varied service intensity. However, the Medicare Policy Manual (pp. 26-41) indicates that certification for these services must be carried out by a physician, unnecessarily restricting clinical practice for advanced practice providers that deliver these services. **To improve access to these services, which can prevent unnecessary hospital admissions and reduce recidivism following hospitalization, we strongly encourage CMS to include advance practice nurses and physician assistants to the clinicians that may carry out PHP and IOP certification.**

Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR) Services and Diagnostic Services

IHA supports CMS' continued extension of flexibilities allowing virtual supervision of CR, ICR and PR services and diagnostic services through Dec. 31, 2025. These flexibilities have improved access to care for many Illinoisans, particularly at small and rural hospitals that experience workforce challenges limiting their ability to provide such services with in-person supervision. **As we did when this policy was first proposed, we encourage CMS to take the next step and make these virtual supervision flexibilities permanent, rather than continuously renewing them for an additional calendar year.**

Remote Mental Health Services

IHA commends CMS for continuing to pursue innovative solutions to enhance critical access to healthcare services via telehealth. Providing behavioral health services via telehealth has proven particularly useful, allowing providers to overcome longstanding obstacles to treatment including stigma, workforce shortages in local expertise, and transportation barriers.

In the CY23 final rule, CMS finalized a requirement that a beneficiary receive an in-person service within six months prior to the first remote mental health service and within 12 months after each remote mental health service. Subsequent legislation has delayed implementation, with the latest Consolidated Appropriations Act of 2023 extending the delay in implementation of the in-person visit requirement until Jan. 1, 2025. **IHA strongly urges CMS to consider removing the requirement for an in-person visit within six months prior to the initiation of telehealth services and within 12 months thereafter.**

Requiring in-person visits will result in unnecessary obstacles to care for the many individuals who demonstrate they do not need or prefer in-person services. In fact, the United States Substance Abuse and Mental Health Services Administration issued guidance for implementing telehealth services that states, "requiring in-person visits can create a barrier to seeking or accessing care, so the decision to have in-person visits should be made in collaboration with the

client." Instead of blanket requirements for in-person services, Medicare beneficiaries would be better served if they were able to devise a treatment plan with their providers, allowing the provider and patient to determine whether in-person appointments are necessary for optimal health outcomes.

Outpatient Quality Reporting (OQR) Program: Hospital Commitment to Health Equity

We appreciate CMS' continued commitment to understanding, measuring, and advancing health equity. Illinois hospitals are committed to improving access and pursuing equitable outcomes for all Illinoisans.

Illinois hospitals have already implemented the proposed Hospital Commitment to Health Equity measure in the Inpatient Quality Reporting Program. The measure consists of five domains that inquire about facility-wide policies and commitments. They do not differentiate between inpatient and outpatient departments. As such, adding this measure to the OQR is duplicative, unnecessary, and administratively burdensome.

We also ask CMS to reconsider the structure of this measure. At present, a hospital earns points within each domain if they attest to all aspects of the domain. There is no partial credit for intermediate steps a hospital might take to meet a domain. This all or nothing approach does not paint an accurate picture of what hospitals are doing to address health equity, as they will not be acknowledged for the steps within a domain they *have* taken. Rather, if they cannot attest to all aspects of a domain, they are treated as doing nothing in that space.

To best represent the progress hospitals have made, we ask CMS to (1) refrain from adding this duplicative measure to the OQR when it is already being reported in the IQR and (2) reassess the methodology behind the measure to allow for accurate acknowledgement of what steps hospitals are taking to advance health equity in their facilities and communities.

Public Reporting of Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients

We recognize that hospital outpatient departments already report median ED throughput times for patients seeking psychiatric or mental health services to CMS. However, the measure is not publicly reported; rather, the data must be downloaded from the Care Compare website. Historically, this has been because of concerns that this throughput rate may be influenced by the low availability of community resources to assist individuals seeking psychiatric or mental health services.

We are concerned with the potential impact this information could have if it is made public by CMS without focusing equally on service coverage and reimbursement that would address associated access barriers. There continues to be a lack of access to residential, inpatient and

community-based psychiatric and mental health resources for patients seeking this care. In many communities, the hospital ED may, unfortunately, be the best option for patients requiring immediate mental health services, especially if the patient is in crisis. It would be unfortunate if a patient refrained from seeking the care they need due to the publication of median throughput times that lack context, especially as suicide rates are rising steadily.[4] **We ask CMS to either refrain from publicly displaying ED throughput rates for patients seeking psychiatric or mental health services, or to clearly acknowledge the contributing factors to such throughput times when providing the data to the public.** Alternatively, we recommend CMS continue to pursue ways to cover more comprehensive behavioral healthcare services, including crisis and wrap-around services in community-based settings like Certified Community Behavioral Health Clinics.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule. Please direct questions or comments to Cassie Yarbrough, Assistant Vice President, Health Policy and Finance, at 630-276-5516 or cyarbrough@team-iha.org.

Sincerely,

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

[4] Curtin SC, Garnett MF, Ahmad FB. *Provisional Estimates of Suicide by Demographic Characteristics: United States, 2022*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; November 2023. Accessed Sept. 3, 2024. https://www.cdc.gov/nchs/data/vsrr/vsrr034.pdf