Catholic Health Association of the United States

*A Passionate Voice for Compassionate Care*

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: **Medicare Program: 2025 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1809-P)**

Dear Administrator Brooks-LaSure:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the calendar year 2025 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment rates. This proposed rule updates OPPS payment policies that apply to outpatient services provided to Medicare beneficiaries; the hospital outpatient quality reporting program and implements a provision of law that provides three years of separate payment under specific conditions for non-opioid drugs and devices that provide pain relief. There are also proposed new conditions of participation for hospitals and Critical Access Hospitals (CAH) that provide obstetrical services.

We appreciate your staff's ongoing efforts to administer and improve the payment systems for outpatient hospital and ambulatory surgical services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **OPPS Update**

CMS is proposing to update hospital OPPS rates by 2.6 percent for calendar year (CY) 2025. This rate update equals the hospital market basket of 3.0 percent less 0.4 percentage points for total factor productivity and is the same update that was proposed for the FY 2025 IPPS.

By law, CMS is required to update OPPS rates by the same update that applied under the IPPS. As CMS has already finalized an update of 2.9 percent for the FY 2025 IPPS, it is clear that CMS will be adopting a CY 2025 final rule OPPS update of 2.9 percent (3.4 percent market basket less 0.5 percentage points for total factor productivity). Nevertheless, CHA reiterates our FY 2025

IPPS proposed rule comments and requests that CMS reconsider adopting a market basket that does not fully recognize the increase in hospital costs over the last several years.

As we indicated in prior year comments, upward pressure on hospital costs occurring throughout the pandemic has not been well represented in past year hospital market baskets, particularly for FY 2022. The FY 2022 hospital update was 2.7 percent but the hospital market basket based on historical data was 5.7 percent—a difference of 3.0 percentage points. These figures were 0.6 and 0.7 percentage points respectively for FYs 2021 and 2023, making the update over three years for FYs 2021 through FY 2023 a combined 4.3 percentage points less than the rate of inflation.

These updates lower than inflation result in a permanent understatement of IPPS and OPPS rates. In our FY 2025 IPPS proposed rule public comments, we requested that CMS consider a forecast error correction when the increase in the actual market basket based on historical data differs from the estimated increase applied to IPPS and OPPS rates by more than a threshold percentage.

CMS has established such a policy for the skilled nursing facility (SNF) prospective payment system (PPS) and the capital PPS. Above a difference of 0.5 percentage points for the SNF PPS and 0.25 percentage points for the capital PPS, CMS applies a prospective adjustment for prior year forecast error correction. If CMS were to adopt such a policy, we recognize that it would be applied as either an upward or downward adjustment to the market basket but would have the advantage of not making permanent large differences between the market basket update based on a projection and its actual increase based on historical data.

Given recent history and the large difference between the forecasted market basket and the actual market basket, CHA believes the CY 2025 update would be the ideal time to adopt such a policy. **CHA requests that CMS adopt a forecast error correction policy for the OPPS update beginning with CY 2025 that accounts for three years of understatements of the market basket between FY 2021 and FY 2023, totaling 4.3 percentage points.**

- **Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT)**

During the COVID-19 PHE, CMS allowed outpatient therapy services, DSMT and MNT to be furnished by hospital employed staff to patients in their homes using real-time interactive telecommunications technology. Following the declared end of the COVID-19 PHE on May 12, 2023, CMS issued sub-regulatory guidance to extend the ability of hospitals to provide these services to patients in their homes through the end of 2023.[1] The Consolidated Appropriations Act of 2023 (CAA, 2023) extended most telehealth waivers though the end of 2024 and the CY 2024 OPPS final rule incorporated the waivers for outpatient therapy services, DSMT and MNT.

[1] See questions 21 and 22 at this link: https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf.

The telehealth waivers are slated to expire on December 31, 2024. CMS notes that if Congress again extends the telehealth waivers CMS expects to align payment policies for outpatient therapy, DSMT, and MNT services furnished remotely by hospital staff to beneficiaries in their homes with policies for Medicare telehealth services. **CHA supports this and urges CMS to work with Congress for permanent extension of the telehealth waivers.**

- **Periodic In-Person Visits for Mental Health Visits Furnished by Hospital Staff to Beneficiaries in their Homes**

In the 2023 OPPS final rule, CMS adopted a policy to allow OPPS payment for remote mental health services when a hospital outpatient is receiving these services in their home. Consistent with analogous statutory requirements that apply to the Medicare telehealth benefit under the physician fee schedule (PFS), CMS requires an in-person visit within 6 months prior to or after the remote mental health service. The visit after the first encounter must occur within 12 months.

The CAA, 2023 delayed the application of the telehealth in-person visit requirements through December 31, 2024, for professionals billing for mental health services via Medicare telehealth and for rural health clinics and federally qualified health centers furnishing remote mental health visits. CMS adopted the same delay for remote outpatient mental health services provided by hospitals and CAHs through December 31, 2024, in the CY 2024 OPPS rule.[2]

As the CAA, 2023 delay to the in-person visit requirements furnished under the telehealth benefit will expire on December 31, 2024, the same policies that apply when hospital employed staff provide mental health services to beneficiaries in their homes will also expire. To the extent that these in-person visit requirements are delayed by statute for the telehealth benefit, CMS anticipates aligning its policies that apply to hospitals with the statutory extension through rulemaking. **CHA supports this and urges CMS to work with Congress for permanent extension of the behavioral health telehealth waivers.**

- **Virtual Direct Supervision for Specific Services**

During the COVID-19 PHE, CMS adopted policies to allow direct supervision of cardiac rehabilitation services (CR), intensive cardiac rehabilitation services (ICR), pulmonary rehabilitation services (PR) and diagnostic services to be furnished remotely via two-way, audio/visual communication technology (but not audio only). These flexibilities were extended by law through December 31, 2024 by the CAA, 2023 after the COVID-19 PHE ended.

In the 2025 PFS proposed rule, CMS is proposing to extend the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through December 31, 2025. Similarly, CMS is proposing to allow for the direct supervision of CR, ICR, PR services and

[2] 88 FR 81874

diagnostic services via audio-video real-time communications technology (excluding audio-only) under the OPPS through December 31, 2025. **CHA supports extending virtual direct supervision to CR, ICR, PR and diagnostic services under the OPPS consistent with CMS' proposed 2025 policy for the PFS. We further urge CMS to permanently adopt a policy for both payment systems that will allow virtual direct supervision for CR, ICR, PR and diagnostic services**

- **Add-On Payment for High-Cost Drugs: Indian Health Service (IHS) and Tribal Facilities**

IHS and tribal facilities are paid under an All-Inclusive Rate (AIR) rather than under the OPPS for outpatient hospital services.[3] For 2024, the AIR is $667 for the lower 48 states and $961 for Alaska. The AIR will include Medicare payment for drugs and biologicals that are separately paid under the OPPS.

CMS is concerned that this policy creates equity and access concerns if IHS and tribal hospitals provide drugs that cost more than the AIR. In response to public comments on this issue in the 2024 OPPS rule, commenters expressed universal support for establishing a policy that would allow IHS and tribal healthcare facilities to receive separate payment for drugs that cost more than the AIR.

Beginning January 1, 2025, CMS proposes to separately pay IHS and tribal hospitals for drugs furnished in hospital outpatient departments through an add-on payment to the AIR when those drugs have per day costs that exceed twice the AIR in the lower 48 states ($1,334 in 2024). CMS proposes to pay for drugs with per day costs above the $1,334 threshold at ASP without the 6 percent add-on because IHS and tribal hospitals can obtain drugs under the federal supply schedule at prices that are less than those available to other hospitals.

**CHA supports CMS' proposed policy to pay separately for expensive cancer drugs furnished by IHS and Tribal hospitals.** However, we request that CMS consider using the standard drug packaging threshold of $140 rather than $1,334 to better recognize the costs of IHS and tribal facilities that furnish expensive drug treatment services to Native Americans with cancer.

- **Payment Adjustments for Domestic Personal Protective Equipment (PPE)**

CMS requests public comment on whether to make a payment adjustment under the IPPS and OPPS for the additional resource costs that hospitals face may face in procuring domestically produced PPE other than N95 respirator masks. This comment solicitation does not include N95 respirator masks because CMS adopted a policy in the 2023 OPPS rule to subsidize hospital

[3] Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248), Public Law 83–568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) provide authority for the AIR.

costs for these types of masks. CMS is now considering expanding this policy to other types of PPE if there were to be another public health emergency analogous to COVID-19.

While CHA is grateful to CMS for subsidizing the purchases of the highest quality masks that can protect hospitals patients and their employees against the future spread of infections, we remain concerned about the complex payment methodology and cost reporting requirements that are imposed on hospitals to receive the subsidy. Further, CMS adopted a budget neutrality adjustment (albeit very small) for the additional OPPS payments. Applying a budget neutrality adjustment is counterintuitive to the policy goal of subsidizing the purchase of these supplies as it does not increase the total amount that hospitals are being paid to enable the subsidy to serve its purpose.

**If CMS is going to expand its policy and subsidize the purchase of additional PPE, CHA requests that CMS explore a simpler option to meet the same goal that does not require an offsetting budget neutrality adjustment.**

- **Payment for HIV Pre-Exposure Prophylaxis (PrEP) in Hospital Outpatient Departments**

On July 12, 2023, CMS published a "Proposed National Coverage Determination [NCD] for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Infection Prevention" for covering PrEP under Medicare Part B. This would include coverage for the HIV PrEP drugs, drug administration, HIV and hepatitis B screening, and individual counseling performed by either physicians or certain other health care practitioners. If finalized as proposed, all components would be covered as additional preventive services without Part B cost sharing (i.e., deductibles or co-pays). The final NCD has not yet been issued.

If covered in the final NCD, CMS proposes to pay hospitals for HIV PrEP drugs and related services beginning in 2025. CMS believes the resource costs for these HCPCS codes would be similar across different settings of care, including the HOPD and physician office, and therefore proposes that payment amounts for these services in the 2025 PFS proposed rule would be appropriate for use under the OPPS as well. PreP drugs would be paid under the average sales price methodology.

**CHA supports CMS' proposal to pay for PreP services as preventive services without patient coinsurance.** However, consistent with the comments made by the American Hospital Association, we request that CMS use the standard OPPS payment methodology rather the PFS, to pay for non-drug OPPS services that would be covered under this policy (if the proposed coverage determination is finalized).

- **Non-Opioid Drugs, Biologicals and Devices**

Section 4135(a) and (b) of the CAA, 2023 directs CMS to unpackage and provide separate payment for three years beginning January 1, 2025, for non-opioid treatments for pain relief. A non-opioid treatment for pain relief is defined as having "demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer- reviewed journal." CMS discusses its proposed policy in the ASC section of the proposed rule, but the policy would apply under both the OPPS and ASC payment systems.

**CHA supports payment policies that encourage the use of non-opioid drugs and devices to treat pain. We have been concerned about past policies that discourage appropriate use of opioids to treat chronic, intractable pain and now welcome new policies that can treat pain without the potential risk of opioid addiction.**

- **Prior Authorization**

As part of the 2020 OPPS/ASC final rule with comment period (84 FR 61446 through 61456), CMS established a nationwide prior authorization process and requirements for certain hospital outpatient department services. Hospitals must submit to the MAC a prior authorization request for any service on the list of outpatient department services that require prior authorization.

CMS proposes to change the current review timeframe for provisionally affirmed or non-affirmed *standard* review requests (as opposed to *expedited* review requests*)* for these services from 10 business days to 7 calendar days. This proposal is consistent with an analogous requirement in the CMS Interoperability and Prior Authorization final rule that applies to Medicare Advantage organizations and applicable integrated plans, CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities.[4]

Expedited review requests must be acted upon within 2 business days under Medicare's current regulation. Under the Interoperability and Prior Authorization final rule, the time frame to act upon expedited review requests is 72 hours. CMS is not proposing to change the Medicare standard for expedited prior authorization review requests from 2 days to 72 hours because it would not reduce beneficiaries' wait time in all circumstances.

**CHA supports CMS' proposals.**

- **Health and Safety Standards for Obstetrical Services**

CMS is proposing new health and safety standards for obstetrical services to address the maternal health crisis. CHA strongly supports improving prenatal, labor and delivery, and post-

[4] 89 FR 8758

partum care for mothers and newborn infants. The United States still suffers from a high rate of maternal deaths, with data showing that in 2021, 32.9 maternal deaths occurred per 100,000 live births, which is more than ten times the estimated rates of some other high-income countries. Further, there is an alarming racial disparity in that the maternal death rate among Black Americans is much higher than other racial groups; in 2021 it was 69.9 per 100,000, which is 2.6 times higher than the rate for White women. This is a crisis that must be addressed. **However, CHA has significant concerns about CMS' proposal to accomplish that goal by creating new conditions of participation (CoPs) for hospitals and critical access hospitals.**

New CoPs for obstetrical care may actually be counterproductive to CMS' goal. Failure to comply with the new CoPs would result in the loss of Medicare certification while the burden of compliance could also result in at least some hospitals deciding to no longer furnish obstetrical care. Following each new CoP, CMS provides compliance costs for the new regulations. CMS' estimates that hospital compliance costs associated with these new CoPs could be as much as $180,000 per hospital per year. If hospitals decide to no longer furnish obstetrical and neonatal care in response to these new regulations, access to access to obstetrical care would be more limited and rates of maternal morbidity/mortality may increase. We are concerned that communities across the country will face more closed maternity wards as hospitals are unable to comply with the expense and burden of these COPs.

CHA urges CMS to work with stakeholders on a range of effective strategies for improving maternal health outcomes, building on standards and resources created by federal, state and professional entities for furnishing high quality labor and delivery, prenatal and post-partum care for mothers and infants. Taking this collaborative approach would also minimize the likelihood that any resulting federal regulatory proposals would overlap or conflict with existing state requirements, avoiding unnecessary burdens for hospitals

Finally, we urge CMS to work with stakeholders and other entities to find additional funding to support maternal care in struggling hospitals and CAHs. We have seen numerous hospitals and CAHs suspend or eliminate their maternal and obstetric services due to the rising costs of meeting regulatory requirements (in addition to other factors like workforce shortages). Maternity care is, on the whole, a cost-intensive and reimbursement-light service. Our members provide the care because it aligns with our mission to serve our communities, not to bolster the bottom line. But as regulators add more requirements for compliance, the cost of providing care may become too high to offset elsewhere in the facility. The struggle is especially dire in rural communities and health professional shortage areas.

- **Medicaid Provisions**

In the CAA, 2023, CMS required states to provide 12 months of mandatory continuous eligibility in Medicaid and CHIP for children under age 19, with limited exceptions. CMS proposes to eliminate several exceptions, including one that allows states to disenroll children from CHIP during a continuous eligibility period for failure to pay premiums. Health insurance coverage for children is critically important for healthy development, and research continues to find that

investments in children's health insurance coverage are associated with future benefits for the workforce, tax revenue and other long-term fiscal effects. **CHA supports CMS' efforts to close the coverage gap for children who are eligible and enrolled in Medicaid and CHIP by codifying the continuous eligibility provisions of the CAA, 2023.**

Current regulations prohibit Medicaid from paying for clinic services provided outside the four walls of a clinic, except when provided to unhoused individuals. CMS proposes to add three additional exceptions: a mandatory exception for Indian Health Service/Tribal clinics and optional exceptions for behavioral health clinics and clinics located in rural areas. These changes would improve access to services for eligible individuals in certain settings. Moreover, these exclusions could prove to be important tools to address the behavioral health crisis for certain providers and states. For example, expanding access to care outside the four walls of a Medicaid clinic could help reduce patient acuity and increase provider capacity. **CHA supports CMS' efforts to expand access by adding exceptions to the four walls requirements for Medicaid clinic services.**

- **Individuals Currently or Formerly in the Custody of Penal Authorities**

CMS' longstanding policy is that individuals in custody of penal authorities are generally considered public charges with no obligation to pay for medical care, therefore falling under the "no legal obligation to pay" Medicare payment exclusion. The agency's current definition of "custody" is broad and includes individuals on parole, probation, bail, and supervised release, effectively denying Medicare coverage for such individuals. CMS is proposing to narrow the definition of "custody" to no longer include an individual on parole, probation, or home detention. The special enrollment period (SEP) for formerly incarcerated individuals would be available to individuals released from incarceration or on parole, probation, or home detention.

CHA and our members strongly believe that health care is a basic human right that is essential for protecting the dignity of every individual and that is essential for all individuals to participate in society and contribute to the common good and well-being of the community. All individuals should have access to affordable health care, and we believe that our nation's health care system should support the health and well-being of all individuals by promoting such access. We support in general policies that broaden access to health care and further these goals. **CHA, therefore, supports the agency's proposals to narrow the definition of "custody" and to revise the eligibility requirements for the SEP for formerly incarcerated individuals**. We support these proposals as they effectively broaden access to care by facilitating Medicare payments for care furnished to individuals who may otherwise be excluded from access and by streamlining the process for determining eligibility for the SEP. Both policies remove barriers to access to care as well as provide support to individuals who are already facing a multitude of challenges in order to reintegrate into society.

- **Cross-Program Proposals for Quality Reporting Programs**

*Hospital Commitment to Health Equity (HCHE) and Facility Commitment to Health (FCHE) Structural Measures*

CMS is proposing the HCHE measure for inclusion in the Hospital Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting (REHQR) programs and the FCHE measure for inclusion in the Ambulatory Surgical Center Quality Reporting (ASCQR) program beginning with the 2025 reporting period. Both measures are attestation-based and assess the hospital's or facility's commitment to health equity across five domains (equity in strategic priority, data collection, data analysis, quality improvement, and leadership engagement). The measures and domains are intended to incentivize hospitals and facilities to collect and use data to identify equity gaps, implement plans to address those gaps, and provide resources for initiatives on health equity. The HCHE measure is currently part of the Hospital IQR and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) programs, and the FCHE measure is currently included in the IPFQR program and ESRD QIP.

CHA and our members remain fully committed to eliminating health disparities and to achieving equity in the provision and quality of health services. This commitment is rooted in Catholic social teaching, which calls us to promote and defend human dignity, care for the poor, and contribute to the common good. The community-focused mission of our member hospitals supports their efforts to address social risk factors. Our member hospitals have considerable experience with the delivery of culturally competent care as well as care that meets the special needs of patients whose social risk factors complicate their care, such as physical and sensory disabilities, housing and food insecurity, and limited English proficiency. CHA supports our member efforts to address the social determinants of health, including by providing guidance and resources. We support the deployment of EHR capabilities in our hospitals that enable improved collection; our members routinely collect race, ethnicity, and language preference data and are expanding their efforts to link those data to quality measurement. We continue to support efforts to address the social determinants of health and believe that promoting safer communities and policies that eliminate health disparities and other inequities is a strong path toward healthier communities.

**Therefore, CHA supports inclusion of this type of measure in the Hospital OQR, REHQR, and ASCQR programs and looks forward to working with the agency on health equity improvement now and in the future.** However, the measure has not yet been reviewed by the consensus-based entity (CBE) and we urge CMS to submit it for review and endorsement as soon as possible. We recommend that CMS consider giving partial reporting for systems that are committed to health equity but are in the process of implementing new policies and procedures. We also urge CMS to ensure there are sufficient resources and guidance available to hospitals and facilities to assist them in interpreting and attesting to each of the statements in a consistent manner and to enable hospitals and facilities that may not have access to needed resources to adequately participate in the measure. As one example, some of our members' inpatient and outpatient departments roll up to the same leadership and board of directors, making the separate

inpatient and outpatient HCHEs duplicative. It is likely that it will even be the same person entering the HCHE attestation for the IQR and the OQR. We urge CMS to consider ways to simplify reporting by combining the OQR and IQR reporting under one submission in the HQR portal for entities with the same leadership or board structure.

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

CMS proposes the adoption of the companion process measures, Screening for SDOH and Screen Positive Rate for SDOH measures, into the Hospital OQR, REHQR, and ASCQR programs. Reporting would at first be voluntary and then become mandatory for the 2026 reporting period. The Screening for SDOH measure assesses the total number of patients screened for five health related social needs (HRSNs) – food insecurity, housing instability, transportation needs, utility, difficulties, and interpersonal safety. Hospitals and facilities would be able to use a self-selected screening tool to collect data on the measure. The Screen Positive Rate for SDOH measure tracks the percentage of screened patients reporting positive for at least one of the five HRSNs.

CHA and our members are steadfast in our commitment to furnishing holistic and compassionate care to all patients and supporting initiatives that enhance a more just and compassionate health care system. We recognize and appreciate the value and importance of screening for HRSNs as a way of furthering these goals. CHA strongly believes that quality measures should provide actionable information that can drive improvements in health outcomes.

**With respect to the Screening for SDOH measure, we appreciate that CMS is proposing an initial voluntary reporting period and appreciate the flexibility proposed by CMS to enable hospitals and facilities to select the screening tool of their choice.** If the agency decides to finalize adoption of this measure, we encourage CMS to extend the voluntary reporting beyond the first year. This measure has been adopted in the Hospital IQR program. If this measure is finalized for the Hospital OQR program we urge the agency to align and combine reporting requirements on the measure, as feasible, across the programs to reduce unnecessary administrative burden on providers which detracts from the ability to focus on our members' priority of providing quality care to all patients. In addition, this proposed measure has not yet been endorsed by the CBE, and we urge the agency to expeditiously submit the measure for review.

**With respect to the Screen Positive Rate SDOH measure, CHA recommends CMS postpone its inclusion for mandatory reporting in the quality reporting programs.** We have several concerns.

CMS believes the use of this measure could help connect patients screened positive for an HRSN with relevant community-based services that would address those needs and support improvements in health outcomes. However, the link between performance on this measure to better health outcomes is unclear, as noted during review of the measures by the Partnership for Quality Measurement.[5] The screen positive rates will be extremely difficult to interpret since

[5] https://p4qm.org/sites/default/files/2024-01/PRMR-Hospital-Public-Comments-Final-Summary.pdf

their denominators will not be specific to the HRSN in the numerator for which a rate is being calculated. It is unclear how this information by itself will promote connection with services in the community or how the results of the measure could be utilized by patients or hospitals to determine the quality or equity of care provided. We are concerned that hospitals and facilities will be expending resources on collecting data that is not actionable. Further, while many of our members are using screening tools and have partnerships with community service providers, establishing relationships with appropriate social service providers can be difficult in some areas.

We are concerned that, as noted in the comments regarding the measure within the review conducted by the Partnership for Quality Measurement, the measure does not account for geographic variations in communities and therefore could be overlooking the specific needs relevant to the community involved. It is also concerning that the Partnership for Quality Measurement did not reach consensus for recommending the measure. In addition, because this measure does not provide information about care furnished by the hospital or facility, we have concerns about publicly reporting the results. It could be misused as a way to compare hospitals on factors outside of their control. If CMS finalizes adoption of this measure, we strongly urge that the voluntary reporting period be extended and that CMS work with hospitals and facilities to monitor its implementation to ensure it has a positive effect on efforts to engage community partners and improve health outcomes.

CHA emphatically believes that the concepts and intentions of these measures are of great importance to holistic, patient-centered care delivery by hospitals, facilities, and health systems. We agree that screening for social needs has the potential to be a valuable tool in improving health care including by addressing health inequities. But to be truly effective it should be conducted as part of a larger community-wide system to provide the services needed and encourage participation by social service providers and patients. To achieve this, screening must be done in a culturally sensitive and appropriate manner and in a way that minimizes burdens on caregivers. Identifying needs without a means to address them is demoralizing for both the caregiver and the patient and could erode the patient's trust. We encourage the agency to work with stakeholders to develop technical support and education about the most effective way to both screen for social needs and work with community and other organizations to address those needs. We support continued work on the proposed measures to produce data that will be interpretable, meaningful, actionable, and reliably assessed and scored, and will not impose excessive burdens compared to the benefits of the information collected.

- **Hybrid Hospital-Wide All-Cause Readmission (HWR) and Standardized Mortality (HWM) Measures**

The Hybrid HWR and HWM measures are included in the Hospital IQR measure set. Both use core clinical data elements (CCDEs), linking variables, and claims data. To satisfy reporting requirements, hospitals are required to submit linking variables on 95 percent of hospital discharges and CCDEs on 90 percent of discharges in a reporting period. There has initially been voluntary reporting on both measures, but beginning for the FY 2026 payment determination,

reporting on the measures will be mandatory and hospitals will need to satisfy these reporting thresholds to avoid payment consequences. During the voluntary reporting periods, CMS noted that about three-fourths of participating hospitals would not have met the reporting thresholds and would have been subject to a one quarter reduction to their annual payment update for the fiscal year. CMS is proposing, therefore, to delay mandatory submission of CCDEs and linking variables by a year so that such submission would remain voluntary for the FY 2026 payment determination and become mandatory beginning with the FY 2027 payment determination.

**CHA very much appreciates and supports the agency's proposal to delay mandatory reporting of CCDEs and linking variables for the Hybrid HQR and MWN measures.** The additional time will be extremely valuable for developing experience with and addressing issues regarding reporting CCDEs and linking variables. We encourage the agency to continue to monitor hospitals' experiences on satisfying the reporting thresholds during the extended voluntary reporting period and to provide the necessary time and resources to support hospitals in effectively and successfully reporting on the measure before adopting mandatory reporting on the measure with payment consequences.

In closing, thank you for the opportunity to share these comments on the proposed 2023 OPPS proposed rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,

Lisa A. Smith
Vice President
Advocacy and Public Policy