September 17, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1753-P: CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS), CY 2022 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P) ("Proposed Rule").

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

We appreciate the opportunity to provide input on the following topics and questions:

- IX.B. Proposed Changes to the Inpatient Only List (IPO)
- X.D.1. Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in their Homes
- XV. Proposed Requirements for the Hospital Outpatient Quality Reporting (OQR) Program
- XVII. Request for Information on Rural Emergency Hospitals
- XVIII. Radiation Oncology Model
- XIX. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

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I. Proposed Changes to the Inpatient Only (IPO) List (IX.B)

CMS proposes to halt the plan to eliminate the Inpatient Only List (IPO), which would add back the 298 services that were removed from the list for CY2021, and to update guidelines for the evaluation and removal of services from the IPO list in the future. The Task Force has previously commented on the IPO list in relation to the potential impact of changes in site of service on financial benchmarking for episode-based payments (*e.g.,* total knee arthroplasty, total hip arthroplasty). Specifically, changes in the available site of service options for Medicare beneficiaries introduces an additional variable for financial benchmarks based on historical spending and risk adjustment methodologies as generally lower risk and less complex cases shift to outpatient and ambulatory center settings. **To this end, we support CMS' current proposal to establish a more measured approach to removing services from the IPO List by relying on data, evidence, and stakeholder input.** The Task Force also encourages CMS to consider how any planned changes in the IPO list may impact current and future benchmarking for alternative payment models, especially episode-based payment arrangements focused on specialty care.

II. Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in their Homes (X.D.1)

The Task Force welcomes the opportunity to provide comments on the extent to which hospitals have been billing for mental health services provided to beneficiaries in their homes through communications technology during the public health emergency (PHE), and whether hospitals anticipate continuing demand for this care delivery mode following the conclusion of the PHE. Like many health care providers, **Task Force members have seen an increase in the use of telehealth services generally since the onset of the pandemic and support efforts to promote access to telehealth for mental and behavioral health services now and beyond the PHE.**

On the question of whether CMS should make changes to the reimbursement policy for mental health services delivered via telehealth, **the Task Force urges CMS to retain the flexibility that allows Medicare beneficiaries in all geographic areas – not just those living in rural areas – to receive telehealth benefits** and permit Medicare to reimburse for in-home telehealth visits. To ensure equitable access to these services for Medicare beneficiaries, we further recommend CMS reimburse for services delivered via both audio/video synchronous technology and audio-only technology. We also support CMS' proposal to implement a method by which the volume of telehealth – and thereby a greater understanding the evolution in telehealth utilization patterns – is documented.

Finally, we want to echo comments that we made to CMS in response to the CY 2022 Medicare Physician Fee Schedule proposed rule. In that letter, we support a number of proposals to improve access to mental health telehealth services in beneficiaries' homes, and we would like to see these policies extended to telehealth services billed by hospital outpatient departments to create alignment, consistency, and most importantly, equitable access to care.

## III. Proposed Requirements for the Hospital Outpatient Quality Reporting (OQR) Program (XV)

### *a. Closing the gaps in health equity via improved data collection strategies*

CMS seeks comment on a number of data-related strategies for how to close gaps in health equity, including: (1) collection of a minimum set of demographic data elements by facilities at admission; (2) using electronic data definitions to permit nationwide, interoperable health information exchange, for the purposes of incorporating into measure specifications and other data collection efforts relating to quality; and (3) stratifying quality measures by race, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status. The Task Force agrees that robust data collection is critical to amassing the volume of data needed to be able to stratify by demographic variables. it is this stratification process that is essential to identifying disparities in health outcomes and care delivery, and subsequently what policies and interventions would be most effective and valuable.

**Thus, we recommend CMS rapidly and meaningfully pursue efforts to improve access and exchange of directly collected race and ethnicity data through reliable and adopted data standards and sources**, including the US Core Data for Interoperability (USCDI) data classes and elements exchanged via standardized APIs. We note that eCQM reporting already requires the inclusion of race and ethnicity data of the affected populations when this information is available at the time of measure calculation. This and other requirements should be catalogued and leveraged before devoting resources to indirect estimation algorithms that are not proven to provide accurate information.

In addition, the Task Force supports wide use of accepted e-data definitions and digital quality measurement (DQM) specifications, which can be deployed across multiple EHR products via interoperable infrastructure, to create efficiencies in how data are collected. Finally, **the Task Force fully favors broadening the minimum set of demographic data elements to align with the current set of data collected via the National Health Interview Survey (NHIS), the Medical Expenditure Panel Survey (MEPS) and the 2020 Census**. These efforts have gone beyond the minimum data collection of R/E data to include categories such as Mexican, Cuban, Puerto Rican, Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese categories, among others. Disaggregating by subgroup is critical because the common demographic groups used in the United States aggregate many distinct communities with widely different experiences with health and health care, structural inequities, and the social influencers of health. For example, data that combines all Hispanic or Asian American and Pacific Islanders often mask deep inequities between subgroups.

In addition to seeking federal data collection vehicles, we urge CMS to continue working with ONC to establish health information exchanges that supports CMS' access to electronic health record (EHR) data. Private sector EHRs are successfully collecting demographic data – in many cases going beyond R/E to include data on other social determinants of health – with high volume and high levels of accuracy.

Finally, we suggest CMS work with stakeholders to identify ways to improve demographic data collection across the healthcare industry. This includes 1) identifying strategies to improve the granularity of race and ethnicity data beyond current OMB standardsl and 2) aligning race and ethnicity assessments and categories across states and with the standards maintained by OMB. Currently, it is a challenge to align with OMB categories when state files do not align.

*b. Mandatory reporting of Outpatient and Ambulatory Surgery CAHPS measures*

The Task Force appreciates the opportunity to comment on CMS' proposal to begin data collection of five survey-based measures derived from the Outpatient and Ambulatory CAHPS (OAS CAHPS) Survey beginning with voluntary data collection and reporting for the CY 2023 reporting period/CY 2025 payment determination followed by mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination and for subsequent years. We appreciate the expansion of the use of the CAHPS survey in the outpatient setting, and believe it will help outpatient departments more strategically identify strengths and weaknesses, and areas for improvement, related to patient experience. **Thus, the Task Force supports the recommendation to mandate OAS CAHPS reporting for all hospitals (with the exemption for those not meeting the low volume threshold) beginning in CY 2024.**

The Task Force supports CMS' proposal to incorporate two more additional administration methods (mixed mode web with mail follow-up of non-respondents and mixed mode web with telephone follow-up of non-respondents) in addition to the three previous administration modes of mail-only, telephone only, and mixed mode of mail with telephone follow-up for non-respondents. The additional administration methods will provide health systems with more data collection flexibility. **The Task Force recommends CMS begin data collection of five survey-based measures beginning with voluntary data collection and reporting for the CY 2023/CY 2025 payment determination and reassess data and request industry feedback prior to implementing mandatory reporting.** The Task Force supports CMS' approval that CAHPS data collection must be "initiated no later than 21 calendar days after the month in which a patient has a surgery or procedure at a hospital and completed within 6 weeks (42 days) after initial contact of eligible patient begins, beginning with voluntary reporting in the CY 2023 reporting period/CY 2025 payment determination and subsequent years.

*c. New measure of adoption of COVID-19 vaccination coverage among health care personnel*

**The Task Force supports the measure of adoption of COVID-19 vaccination coverage among health care personnel**. COVID-19 vaccines have prevented nearly 280,000 deaths and 1.25 million hospitalizations.[1] We believe that vaccinating health care workers is a public health issue. Doing so will help reduce the spread of the virus, as well as help reduce the impact of the virus on the resilient but extremely over-burdened health care work force. We believe that COVID-19 mutations will be impacting this country beyond the current PHE, and thus having this measure in place for a workforce that interacts with vulnerable members of the U.S. population every year is paramount.

*d. Request for Comment on Potential Future Efforts to Address Health Equity in the Hospital OQR Program*

The Task Force appreciates the opportunity to provide comments on efforts to address health equity in the Hospital Outpatient Quality Reporting (OQR) Program.

i. *Request for Comment on Potential Future Adoption and Inclusion of a Patient Reported Outcomes Measure Following Elective THA/TKA*

On the topic of quality measures to inform decision-making and quality improvement related to Total Hip and/or Total Knee Arthroplasty (THA/TKA), the Task Force recommends the following:

- Outcome measures that assess pain and functional status three, six-, and nine-months post-procedure.
- Measures of whether the patient – together with family and/or caregivers – was engaged in decision-making using aids highly rated by the International Patient Decision Aids Standards (IPDAS) with the support of a decision coach or a health educator, if needed. One example of a decision aid provider is Healthwise, a not-for-profit corporation that provides consumer health information to patients and caregivers, which has highly rated decision aids for both hip and knee replacement, as assessed by the IPDAS (Ottawa Hospital Research Institute, 2014b; Ottawa Hospital Research Institute, 2014c). Healthwise includes information about care options—including the pros and cons of each—and how to consider a patient's values and preferences as they relate to the care options.
- Measures of ongoing engagement of patients in the discussion of care options and subsequent decisions related to the joint replacement procedure, if one is deemed appropriate.
- Public reporting of comparative quality information about surgeons, surgical facilities, rehab services, and home health services at a time when the patient still have time to make proactive decisions about his or her treatment.

*ii. Stratification of data in six performance measures by patients' dual eligibility status*

[1] https://news.yale.edu/2021/07/08/us-vaccination-campaign-prevented-279000-covid-19-deaths

As noted earlier in our comments, the Task Force favors stratifying data by race, ethnicity, and other variables that correlate to social risk factors (SRFs). While dual eligibility (DE) status can correlate with poverty, and research indicates that Dual Eligible patients are more likely to receive poorer quality hospital care than non-DE patients, the research also notes that "relying on DE proportion as a proxy for all other SRFs is potentially problematic…and assumes that DE patients across the country are identical in terms of their exposure to SRFs."[2] Given these concerns, we hesitate to fully support CMS' proposal. However, we do recognize that this is a step toward stratifying performance by available data, and may support the effort to advance health equity by allowing outpatient institutions to develop appropriate interventions to address the needs of their patient populations. If implemented, we recommend that CMS ensure stratified results are still reliable and valid. If CMS chooses to publicly report results stratified by dual eligibility, the agency should demonstrate the statistical soundness of the results prior to posting the results on Care Compare. We do continue to recommend that CMS concurrently apply resources to collecting a wide range of demographic data that allow for a more evidence-based identification of social risks factors.

*iii. Indirect estimation techniques to identify Medicare beneficiaries' race and ethnicity*

CMS seeks comment on the possibility of expanding current disparities methods to include reporting by race and ethnicity using indirect estimation, as well as on the possibility of facility collection of standardized demographic information for the purposes of potential future quality reporting and measure stratification to permit more robust equity measurement. The Task Force opposes the use of indirect estimation techniques, due to concerns that this imprecise approach may result in data inaccuracy, and because of its potential to divert resources from seeking improved methods of direct reporting. Instead, we urge CMS to rapidly and meaningfully pursue efforts to improve access to directly collected race and ethnicity data from more reliable sources (including potentially the US Core Data for Interoperability (USCDI)) and exchanged via HL7, as noted above. We also support efforts to pursue more aggressive facility-level collection of standardized demographic information, and offer the following promising practices that institutions are using to successfully boost their demographic data collection rates:

- Training all patient-facing staff – including registration staff and those doing care delivery – on how to respectfully ask patients about their background in the service of collecting demographic data, to achieve the goal of obtaining self-reported data.
- Requiring registration staff to request demographics information each time a patient enters the system, which has been shown to improve overall accuracy.

## IV. Request for Information on Rural Emergency Hospitals (XVII)

The Task Force applauds CMS for the emphasis on addressing the challenges faced by rural and critical access hospitals. Rural and critical access hospitals are essential sites of service

[2] Alberti, Philip M., Ph.D., Baker, Matthew C., MS, "Dual Eligible Patients Are Not the Same: How Social Risk May Impact Quality Measurement's Ability to Reduce Inequities," Medicine: September 18, 2020, Vol. 99, Issue 38

for millions of Americans and have been increasingly facing financial pressures that jeopardize their sustainability. According to a recent reports by the GAO and Kaiser Family Foundation, many of these sustainability issues can be traced back to changes in payer mix and declining inpatient revenue. Under a fee-for-service payment structure, these factors create an environment where hospitals must continue to support the fixed costs of maintaining inpatient service lines even as demand for these services falls because these services are a primary source of revenue.

While hopeful that the new Rural Emergency Hospitals (REHs) provider classification will allow smaller facilities the flexibility to sustain emergency and observation care for their service areas, we believe additional payment model innovation is necessary for long term sustainability. The Task force believes that payment models that intentionally decouple payment from the volume of services delivered and instead focus on building the capacity of hospitals to deliver high quality and appropriate care should be a foundational component of the CMS rural health strategy. CMS has already worked on strategies for creating sustainable funding for hospitals – including specifically rural hospitals – in the form of the Center for Medicare and Medicaid Innovations Maryland All-Payer, Pennsylvania Rural Hospital, and Community Health Access and Rural Transformation Models. **We encourage CMS to dedicate resources to continuing efforts to design non-volume dependent strategies to support rural hospitals and conduct robust stakeholder engagement to inform design efforts.**

Notably, CMS requests feedback on strategies for improving maternal health in rural communities. The Task Force is committed to improving maternal health outcomes in the United States and believes that all hospitals and providers, including REHs, have a critical role to play in addressing maternal health needs. In our opinion, **the current FFS reimbursement structures do not facilitate the most effective delivery of evidence-based maternity care. Implementing a value-based paradigm for maternity care is one critical lever to positively impact maternal health outcomes by reducing variations in care delivery.** In a response to the 2020 CMS Rural Maternal Health RFI, the Task Force urged CMS to test a multi-payer maternity care model to advance the industry's understanding and adoption of the most effective models for maternity care payment. The Medicaid program provides the greatest opportunity to test an encourage adoption of alternatives to fee-for-service for maternity payment. CMS should also expedite the approval process for Medicaid state plan amendments and waivers to implement maternity care APMs that hold states and providers accountable for improved outcomes and provide guidance about how to do so through State Medicaid Director letters. A maternal health APM should ensure clinical delivery that is aligned with evidence-based best practices and must be designed to mitigate pervasive racial and other disparities in maternal health outcomes.

**To improve maternal and infant health in rural communities, it is critical to address barriers to access and the perinatal workforce shortage in rural areas.** This includes training and reimbursement for perinatal services provided by nurses, physician assistants, midwives, doulas, and community health workers, and recruitment and development of racially and

ethnically diverse health care professionals. The COVID-19 pandemic has demonstrated the value of telehealth as an essential modality to provide access to prenatal and postpartum care services as well as perinatal support services like peer support groups and doulas. CMS could provide clear guidance to State Medicaid Directors on reimbursement for maternity services delivered via telehealth to ensure this modality is supported beyond the PHE.

The Task Force also welcomes the opportunity to provide feedback on how REHs can address the social needs of rural areas. Not unlike maternity care, REHs strategies to address the social needs of individuals living in rural areas is critical to the health and wellbeing of community residents served by the REH. REHs can address the social needs of individuals residing in the community they serve by utilizing social needs risk assessments, partnering with community-based organizations, working with community health workers (CHWs), and partnering with public health.

- **CMS should partner with federal agencies to allow for flexibilities in how federal health care dollars are spent.** Health systems are eager to offer patients ways to address social risk factors that can be detrimental to the clinical care being delivered. For example, patients with cardiac or respiratory conditions may receive the finest clinical care within the walls of the health system, but if they go home to an environment that lacks healthy food, clean air or climate control, the clinical treatment will not have its intended effect.
- CHWs have proven to improve the health outcomes of vulnerable populations; however, there is not a sustainable financing mechanism to pay CHWs for their work, with some state and local agencies relying solely on grant funding. **Several states are exploring opportunities to use Medicaid to fund CHWs and we urge CMS to reduce barriers so Medicaid can more easily pay CHWs, which would advance CMS' objective to provide more equitable care.** The Association of State and Territorial Health Officials (ASTHO) has outlined bills introduced by states that would reimburse CHWs through Medicaid.
- CMS should identify and address disparities in access to and funding for public health resources. These disparities, which have always existed, were made visible and further exacerbated, by the COVID-19 pandemic. The Task Force applauds parts of the American Rescue Plan Act of 2021 aimed at helping community partners build capacity, including increased funding for community health centers and community care, block grants for community mental health services, and the state option to provide qualifying community-based mobile crisis intervention services. **Providing local public health programs with resources and connections in the community to address the limitations of a fragmented national health system will help address unmet social needs of individuals and reduce health inequities.**

In terms of addressing the upstream social determinants of health, including the conditions in which people are born, live, learn, work, play, worship, and age, the Task Force urges REHs and other stakeholders to advocate for policies that will better address the social

determinants of health to increase opportunities for successful well-being for individuals. For example, the Task Force believes that it is not the health care system's role to build affordable housing, but if a community served by a health care system is lacking affordable housing, then such system should use its advocacy power to urge legislative bodies to improve housing opportunities. Raising the Bar: Healthcare's Transforming Role, a project funded by the Robert Wood Johnson Foundation, is developing principles and providing practical guidance for the health care sector to achieve optimal well-being for those who face the greatest barriers to health. The project is focused on defining health care's role in addressing social factors and systemic inequities inside and outside of clinical walls that affect health. **While the final project product has not yet been released, we encourage CMS to commit to these principles and refer to the lessons learned once available to the public. Additionally, the Task Force believes that a critical component to achieving equity is merging health equity metrics into the way CMS pays for care is the best way to hold REHs, and other stakeholders, accountable for improving health equity.**

V. Radiation Oncology Model

The Proposed Rule includes a notice that the Radiation Oncology (RO) Model will be implemented starting on January 1, 2022. The Proposed Rule also proposes changes to the 2020 RO Model final rule, including the removal of liver cancer from the included cancer types and brachytherapy from included radiation therapy (RT) services. The Proposed Rule also proposes reducing the discounts for professional RT services from 3.75 to 3.5 percent, and for technical RT services from 4.75 to 4.5 percent. Finally, the Proposed Rule proposes excluding hospital outpatient departments participating in the Medicare Shared Savings Program SSP or the Innovation Center's CHART model from the RO model.

The Task Force has commented on the RO Model during both the 2019 NPRM public comment opportunity, and again earlier in 2021. Both times, the Task Force recommended that CMS include stakeholders in the design of mandatory models through meaningful engagement activities. We also encouraged CMS to acknowledge the efforts of early adopters and of practices that are actively working to implement care delivery and efficiency reforms that align with CMS model goals. In terms of technical aspects of the model, the Task Force recommended both the professional and technical component discounts be reduced; that CMMI incorporate upside incentives into the model; that a glidepath be created for providers with less APM experience to increase risk over time; that a mechanism should be added to support improved coordination and the delivery of guideline concordant care (in the context of the 28-day "trigger," and finally that the requirement that participants submit clinical data elements or risk not receiving their 1% quality withhold be removed.

We are pleased to see that a reduction in the discounts is being proposed, but continue to have concerns over how the 3.5 and 4.5 percent discounts will affect RT providers, particularly those who are already providing high value care at a slim margin, given the impact of the PHE on volume and utilization of RT services. While the Task Force is not offering a specific discount

amount recommendation, several other organizations have proposed more favorable discount amounts that we encourage CMS to consider, that will not have the effect of penalizing already high-value RT providers.

Overall, however, our concern remains that the RO Model does not seem to be designed in a way that aligns with or reflects the goal of episode payment models, which, as defined by the Health Care Payment Learning and Action Network (LAN) is "to improve the quality of health care, promote smarter spending, and improve outcomes for patients resulting in better coordination and less fragmentation across the medical system." The model relies on coordination between the professional participant and the technical participant but does not provide any infrastructure for how that coordination will take place, which creates a level of confusion that could have a negative impact on patients. The Task Force also notes that the RO Model's complexity, and lack of clear financial incentives, put it at odds with the June 2021 MedPAC Report to Congress which notes "APMs' complex parameters can make it difficult for providers to forecast whether they will earn a bonus or owe a financial penalty if they participate in a model…consequently there is a risk that the complexity of models may be suppressing provider participation and limiting the effectiveness of incentives for providers to change their behavior." Finally, we wish to amplify concerns raised by other stakeholders over the RO Model's potential for exacerbating disparities in care for vulnerable populations.

We recognize that the RO Model is mandatory and thus the participation aspect is irrelevant in this case; however, our concern is that this model will not reflect the goals of value payment in general. **We ask that CMS consider these comments in its continued operations of the RO Model, and in the design of new APMs.**

## VI. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

The Task Force has been a steadfast supporter increasing transparency in health care and the need for consumer-friendly tools that allow individuals to understand the costs associated with a health care service. That said, the Task Force has a concern with the application of Hospital Price Transparency Rule (Transparency Rule) in the context of certain alternative payment model arrangements. Specifically, the Transparency Rule requires hospitals generate a machine-readable file online that includes all standard charges (specifically, gross charges, payer-specific negotiated charges, discounted cash prices, and de-identified minimum and maximum negotiated charges) for all hospital items and services. While complying with this requirement is feasible under traditional Fee-For Service based arrangements, alternative payment models built on capitated payment arrangements and episode-based payments (especially long-standing arrangements) are generally not able to be disaggregated into item or service level prices. Consequently, **we urge CMS to create a reporting option for alternative payment model arrangements that would allow for price reporting of average per-member-per-month pricing for capitated arrangements as well as average episode or bundled payment costs where applicable.**

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The Task Force appreciates the opportunity to respond to the OPPS/ASC Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to these comments.

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