

September 11, 2023

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS–1793–P; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1793–P. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all, especially among vulnerable populations such as those covered by Medicaid.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs. Trinity Health is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 41% of our revenue coming from Medicare and 18% from Medicaid and uninsured patients.

Trinity Health is a strong proponent of value-based care delivery. We have 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 11 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participate in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we participated

in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals.

Trinity Health is incredibly concerned with the proposed payment update of 2.3%, which does not reflect the unprecedented increase in the cost of caring for patients— since 2019, Medicare rates have increased only 6% while Trinity Health’s cost per case has increased 14%. We urge CMS to use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.

In addition, we strongly recommend CMS not finalize the price transparency standardization policies in the proposed rule. Instead, CMS should focus on the continued development of a strong price estimator tool solution whereby a quote could be provided based on their clinical record, which drives the level of service required, and based on their insurance coverage, includes an out-of-pocket cost estimate of deductibles, coinsurance and/or copays. Further, CMS should implement price transparency policies that would focus on the advanced explanation of benefits (AEOB) required in the No surprises Act as this estimate provides patients with the most accurate estimates for their course of care, rather than the multiple overlapping price transparency policies.

Below are detailed comments on the proposed rule.

#### Payment Update for OPPS and ASC

CMS proposes to increase Medicare hospital OPPS and ASC rates by 2.3% compared to CY2023. This update is woefully inadequate and does not reflect the unprecedented increase in the cost of caring for patients and comes at a time when many non-profit health systems are struggling to stay afloat after years of COVID-related financial losses, high inflation, and increased labor expenditures. We urge CMS to provide fair payment and increase payment rates to reflect the increased cost of caring for patients. Specifically, CMS should:

- Use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.
- Establish a threshold whereby if the payment differential between what was provided and actual costs is greater than 1.5 percentage points, CMS would retroactively adjust payments for that year.
- Rebase the market baskets more frequently and at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries.

The cost of caring for patients in recent years has been significantly higher than the increase reflected in the Medicare annual payment updates. Since 2019, Medicare rates have increased 6% while Trinity Health’s cost per case has increased 14% including:

- 15% increase in labor costs.
- 17% increase in supply costs.
- 24% increase in drug costs.
- 10% increase in implant costs

To maintain access to quality care for Medicare beneficiaries, reimbursement must cover the cost of delivering care. At Trinity Health, 41% of revenue comes from Medicare. Unfortunately, Medicare payment rates have not kept up with the increased costs of delivering care across all settings. With 18% of our revenue also coming from Medicaid and patients who are uninsured, there is little room to cost-shift Medicare losses to other payers. Consequently, not-for-profit health systems, like Trinity Health, are struggling to keep service lines open to care for our communities.

In recent years, the data sources used for developing annual payment updates have not accounted for the impact of inflation, nor have they captured the staggering increase in labor costs, including contract labor, which hospitals have experienced since the start of the COVID-19 pandemic. These costs are significant— Trinity Health spent nearly \$770 million in FY22 on contract labor, a 298% increase from pre-pandemic spend.

The proposed update to the hospital market basket of 3.0 percent for FY 2024 is based in part on its projection of a 3.9 percent increase in compensation and benefits for FY 2024. CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI). Specifically, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers. There is a lag in the data that CMS uses to update the market basket annually, and the proposed update is based on historical data through third quarter of CY 2022.

The use of contract labor and overall increased labor costs have been driven by significant workforce shortages. Before the pandemic, many clinical staff were in short supply and growing closer to retirement age. According to pre-pandemic research published in 2018, healthcare was projected to be short more than 1 million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant talent pipeline. Since that time, the pandemic has only exacerbated matters, prompting a significant increase in clinician resignations and retirements; for example, more than 500,000 nurse retirements were expected in 2022. A recent analysis finds that by 2025, it is expected that the United States may have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap.

This significant and growing deficit in the workforce supply indicates that it is unlikely these increased labor costs are transitory, but rather a new normal that reflects shifting market dynamics. As talent shortages become more severe, providers are paying more to attract and retain scarce staff, and our analysis indicates it is likely that these wage increases have set a new floor. However, the BLS' ECI does not accurately reflect the increased and persistent labor costs resulting from these projected ongoing shortages.

Additionally, the productivity update included in the proposed rule assumes hospitals can replicate the general economy's productivity gains. However, in reality the critical financial pressures that hospitals and health systems continue to face have resulted in productivity declines, not gains.

#### Proposed Data for Rate Setting

To set proposed OPPS and ASC payment rates, CMS would resume using the most updated cost reports and claims data available, similar to what was finalized in IPPS. Therefore, the agency

proposes to use the CY 2022 claims data and the most updated cost report extract available from the Healthcare Cost Report Information System.

Trinity Health supports using most updated cost report and claims data available.

#### Site Neutral Payment Policies

For 2024, CMS continues to set payment for most non-grandfathered (non-excepted) services at 40% of the OPPS rate. In addition, recognizing that the site neutral payment rate for intensive cardiac rehabilitation (ICR) is inconsistent with statute, CMS proposed to pay for these non-grandfathered ICR services at 100% of the OPPS rate.

Trinity Health agrees with CMS' assessment for ICR payment. Further, as policymakers continue to examine possible expansion of site neutrality policy, we caution that any changes will worsen the existing financial crisis for non-profit hospitals and put access to essential care and services in jeopardy. We urge CMS to refrain from expanding the site neutral policy in the future and work with Congress to ensure they understand potential impacts of legislation under consideration.

Hospitals play a unique role in communities, including:

- Serving all patients regardless of ability to pay.
- Serving as a safety net for vulnerable populations.
- Ensuring the necessary resources are available to respond to local disasters.

In addition, hospitals are held to higher standards than ambulatory surgery centers (ASCs) and independent physician offices (IPOs) which leads to increased costs, including:

- Providing 24/7 access to care.
- Serving as the backup site of care for complications occurring in other settings.
- Maintaining special care capabilities (e.g. trauma, burn units, neonatal, psychiatric services, etc.).
- Being held to additional regulatory requirements that increase cost and administrative burden.

Importantly, a [recent study of Medicare fee-for-service](#) (FFS) beneficiaries by KNG Health Consulting showed that hospital outpatient departments (HOPDs) were more likely than both ambulatory surgery centers ASCs and Independent Physician Offices (IPOs) to provide care to patients who are low income, with higher incidents of chronic conditions, and more likely to be eligible for Medicare, Medicaid, and be dual eligibles.

#### Area Wage Index

As it has done in previous years, CMS proposes to adopt the final fiscal year IPPS reclassified wage index as the calendar year wage index for the OPPS. Thus, any policies or adjustments finalized in the FY 2024 IPPS final rule would be reflected in the final CY 2024 OPPS wage index. These include policies to:

- Treat rural reclassified hospitals as geographically rural for the purposes of calculating the wage index;
- Continue its policy to cap any decrease in a hospital's final wage index at 5%;

- Continue an imputed floor wage index adjustment for hospitals in all-urban states; and
- Continue its policy to increase the wage index value for low-wage hospitals.

Trinity Health recognizes the need for policies to help support rural hospitals and the communities they serve. Similar to prior years, we urge HHS and Congress to develop a comprehensive, long-term approach to help these facilities. As disparities among geographic regions and challenges faced by rural hospitals continue to grow, HHS should work with Congress to provide funding for low-wage hospitals that is not subject to budget neutrality.

Trinity Health continues to support establishing a permanent 5% floor on wage index decreases to reduce volatility in the wage index and treating rural reclassified hospitals as geographically rural for the purposes of calculating the wage index.

#### Behavioral Health

The Consolidated Appropriations Act 2023 created a new Medicare benefit category for intensive outpatient (IOP) services. The rule would create an add-on payment for IOP services furnished by opioid treatment program for the treatment of opioid use disorders starting in 2024.

Trinity Health is pleased to see CMS' continue focus on behavioral health and supports this proposal.

#### 340B Payment Policy

In the CY 2023 OPSS final rule, CMS required that hospital-based 340B-covered entities continue to use the 340B-related modifier it used previously, either the "JG" (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) or "TB" (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities) modifier.

For CY2024, CMS proposes all 340B-covered entity hospitals paid under the OPSS would report the "TB" modifier, effective Jan. 1, 2025, even if the hospital previously reported the "JG" modifier.

Trinity Health supports the proposed policy as it will lead to simplification.

#### Rural Emergency Hospital (REH) proposals

CMS outlines a series of quality measures for REH, including a chart-abstracted measure that evaluates the median time (in minutes) between arrival to and departure from the ED.

Trinity Health does not recommend CMS finalize this quality measure. Given an REH has eliminated acute care beds, there will likely be longer ED averages while awaiting transfer of patients.

#### Price Transparency

CMS proposes several changes to the hospital price transparency requirements related to standardization, new data elements, file accessibility, an accuracy and completeness affirmation, and changes to CMS's monitoring and enforcement processes. Most notably, CMS proposes requiring hospitals to use a standard format to comply with the machine-readable file requirement.

Trinity Health strongly believes that delivering people-centered care requires consumers have access to meaningful information about the price and quality of their care. Our hospitals are regularly working with patients to provide a deeper understanding of their potential out-of-pocket costs which is the information that patients find most helpful and CMS should continue to support.

We note that searching for health services is not analogous to searching for a flight via a search engine—it is more similar to auto or home repair in which a diagnostic is required to determine services needed and the cost of those services. Test results often uncover the need for additional services which are unknown at the time of scheduling.

#### *Finalize policies that are most helpful to patients*

CMS should focus on the continued development of a strong price estimator tool solution whereby a quote could be provided based on their clinical record, which drives the level of service required, and based on their insurance coverage, includes an out-of-pocket cost estimate of deductibles, coinsurance and/or copays.

In addition, there are overlapping federal price transparency policies: hospital price transparency, requirements on insurers, and policies for the No Surprises Act. Instead of these overlapping policies, CMS should implement policies that would focus on the advanced explanation of benefits (AEOB) required in the No surprises Act as this estimate provides patients with the most accurate estimates for their course of care. This estimate will be tailored to the patients' unique characteristics and expected care pathways and, in the case of insured patients, take into account their health care coverage, including where they are in their deductible. In addition, patients will automatically receive these estimates as part of their pre-care paperwork without additional effort on their part.

Further, Trinity Health supports the development and availability of ONC Health IT Certification criteria for use by Plans. We believe this will eliminate variation between Plans when accepting and ingesting good faith estimates from providers and facilities. Eliminating variation will greatly assist in reducing provider and facility administrative burden. Trinity Health also believes such criteria will help ensure that AEOB information is transmitted to patients in a consistent, uniform, and secure manner.

#### *Standardization*

The rule would require hospitals to include in the machine readable file the standard charges, including the gross charges, payer-specific negotiated rates, deidentified maximum and minimum negotiated rates, and discounted cash prices. In addition, hospitals would be required to include the contacting method used to establish the negotiated rate and how the negotiated rate should be read. CMS proposes allowing hospitals only two months to transition to this new standardized format. Trinity Health is deeply concerned about the additional burden the new requirements would place on hospitals as well as the short timeline for implementation.

The additional fields detailing the methodology (e.g., percentage, algorithm) would be incredibly burdensome to produce while meaningless for anyone outside of the hospital and insurer relationship to interpret—patients aren't using this machine readable file to obtain pricing

information. Further, the information requested would require a manual extraction for a process that can't be automated given the complexity and would take months of work and significant resources.

CMS also proposes additional data fields related to modifiers and drugs that are superfluous and burdensome to produce. CMS proposes that hospitals specify in a new field any relevant modifiers that would change the negotiated rate. Many items and services can be billed with multiple modifiers that impact the calculated payment creating an almost endless number of permutations that would need to be included in the machine-readable file if CMS finalizes this requirement. For drugs, CMS proposes that hospitals indicate the drug unit and type of measurement as separate data element, which is information already captured in the item description. Most hospital formulary exports do not align with the measurement values found in the CMS PT Data Dictionary and including these new data fields would not only create non-standardization but also significantly increase the cost to comply with the new requirements while not providing additional insights to the data users beyond what is already available in other fields.

For most services, the industry does not contract at the charge master (CDM) line item level. There is not a one-to-one match between CDM code and expected allowed amount as the rate can vary based on what other services are included on the bill. This is true for all payers--commercial, Medicare and Medicaid. No template, additional fields describing the payment methodology or attestation of accuracy will solve for this issue.

In addition, CMS underestimates cost projections of the updates. The rule estimates \$2,787/hospital, or roughly \$20 million for all hospitals combined and an additional \$10.7 million annually across all hospitals. Trinity Health expects our costs, and the costs of other hospitals to significantly exceed these estimates several times over. By way of example, Trinity Health's implementation of the previous rule was estimated to cost nearly \$20,000 for each of the 56 hospitals we operate. We expect compliance with the proposed rule to cost even more. The data extrapolation required to comply with these new standard elements is not something we can do ourselves and we will have to use a vendor to do it. We have reached out to several vendors and we have yet to find a vendor who is able to do this, which is an attestation to the complexity of what is being proposed. Additionally, the new requirements proposed in the rule would significantly increase the volume of data published in the MRF.

Trinity Health urges CMS not to finalize these data elements in the proposed standard format and instead have hospitals publish a median range by payer for typical types of encounters. In addition, we recommend CMS expand upon the shoppable services list and add account level services that would provide consumers with more information.

Given the complexity of these files, detailed guidance will be required to properly ensure that any new standard format is implemented consistently across hospitals and to avoid excessive updates to the guidance in the future. Prior to finalizing these requirements, CMS should pull together a technical expert panel that includes representation from hospitals, to determine which standard format components should be finalized. Trinity Health would be happy to participate on this panel. We urge CMS to allow hospitals up to 18 months to adopt any new standards following the release of final technical guidance.

### *Changes to Monitoring and Enforcement Practices*

CMS proposes several changes to their monitoring and enforcement practices, including requiring a hospital official to certify the accuracy and completeness of the hospital's machine-readable file. Because the industry does not set prices at the CDM line level, complying with these proposed rules will require algorithms to estimate contracted rates at the CDM line level within the MRF. Therefore, any certification of accuracy would need to be qualified to account for this estimate of payer specific negotiated rates. Trinity urges the agency not to finalize this proposal. CMS also is proposing an accuracy and completeness affirmation within the standardized file, which would serve the same purpose but would be completed during the development of the file. A second, duplicative certification after the file has been developed would be administratively burdensome with no additional use. Therefore, should CMS finalize the affirmation within the standard format, they should not require a separate attestation during the monitoring process.

CMS also proposes to allow notifications to health system leadership of any compliance activity within their system, as well as notification to the specific hospital's leadership, to better accommodate health systems with a central office responsible for compliance. Trinity Health supports this proposal.

### Price Transparency Alignment

Trinity Health appreciates CMS acknowledging the multiple price transparency requirements and requesting feedback on alignment.

As stated earlier, we recommend CMS implement policies that would focus on the advanced explanation of benefits (AEOB) required in the No surprises Act as this estimate provides patients with the most accurate estimates for their course of care and is tailored to their health needs and includes insurance information. Relying on the AEOB as the source of truth would streamline current policies and remove complexity from the patient experience by narrowing the options for patient estimates and other pricing information and ensuring those estimates are as accurate as possible. To accelerate the process and avoid unnecessary costs and duplication of effort, we recommend CMS clarify that it is the insurers' responsibility to collect and collate all the estimates from the various providers to generate the patient's estimate.

We also recommend CMS streamline the hospital machine-readable file requirements to minimize duplication of effort and the potential for conflicting information, while preserving public access to negotiated rates. Specifically, we recommend that CMS maintain the requirement that payers post all negotiated rates with providers while allowing hospitals to focus solely on chargemaster rates and cash prices. In doing so, consumers, third party vendors, researchers and other interested parties would retain access to negotiated rate information while the risk of potentially conflicting information would be reduced. This also would eliminate duplication of effort and therefore reduce unnecessary costs and burden in the health care system.

### Remote Outpatient Therapy, Diabetes Self-Management Training and Medical Nutrition Therapy

The rule would extend flexibilities through 2024 for remote therapy services (including physical therapy, occupational therapy and speech language pathology), diabetes self-Management training and medical nutrition therapy when administered via telehealth.



Trinity Health strongly supports maintaining this flexibility.

### Telehealth

The telehealth flexibilities provided during the COVID-19 pandemic greatly benefit patients, caregivers, and providers. Telehealth must become a routine part of patient care to maintain access and meet consumer expectations for convenient, person-centered, technology-supported care. Trinity Health is committed to ensuring that all patients have the ability to use telehealth services when needed, including the most disadvantaged. We urge CMS to work with Congress to implement policy changes that support the permanent continuation of telehealth flexibilities to enable an efficient and equitable health care system.

Trinity Health urges CMS and Congress work together to permanently achieve the following:

- Allow all telehealth visits to be reimbursed when originated within the patient's home or location of their choosing.
- Allow all Medicare patients access to telehealth, regardless of geographic location.
- Allow clinicians to furnish and bill with parity of payment for in-office visits across all payers and settings.
- Ensure audio-only remains a reimbursable option for physicians to care for patients who do not have audio and visual technology or capability.
- Allow coverage of the facility component of telehealth offered in a provider-based clinic.
- Reimburse providers for telehealth services in home health benefits.
- Include attribution to an ACO as evidence of an existing provider/patient relationship.
- Maintain flexibility for remote-patient monitoring and reimburse for this service, including when provided through home health.
- Allow clinicians to be reimbursed for telehealth when seeing new patients or a patient not previously seen at their practice.
- Remove limitations on frequency of services.
- Advance policies that ensure access to affordable broadband, technology resources, and telehealth services for communities of color and other underserved populations.
- Allow providers to practice across state lines and at the top of their license, including medication prescription and flexibility to allow physicians to treat their patients while in a state where they may be temporarily located.

### Proposed Changes to the IPPS Medicare Code Editor (MCE)

Beginning with the FY 2025 rulemaking, CMS would no longer address the addition or deletion of MCE edits or the addition or deletion of ICD-10 diagnosis and procedure codes for the applicable MCE edit code lists in the annual IPPS rulemakings. While this proposal was not included in the FY 2024 IPPS proposed rule, CMS is inviting public comments on the proposal to remove discussion of the MCE from the annual IPPS rulemakings, beginning with the FY 2025 rulemaking, and to address future changes or updates to the MCE through instruction to the MACs.

Trinity Health recommends CMS publish MCE edits in change request similar to the outpatient quarterly updates.

### Anti-Coagulation Management in Hospital Outpatient Department

Anti-coagulation is a high-risk therapy involving complex dosing/monitoring and ensuring patient adherence to outpatient therapy plans of care. Increasingly, hospital outpatient departments are providing anti-coagulation monitoring to assist physicians. These services may be performed by nurses or pharmacist based on physician order and dosing protocols. CMS has not provided concrete guidance on appropriate CPT/HCPCS coding for these services provided by hospital outpatient departments. Over the past several years, some MACs have provided guidance generally recommending use of CPT 99211 which does not apply under OPSS. Currently most hospitals are reporting this service using G0463 (Hospital outpatient clinic visit for assessment and management of a patient).

CPT guidance is to use the most specific code available that appropriately represents the service provided. CPT code 93793 (Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed) was created in 2018. This code accurately describes the anti-coagulation management services performed in hospital outpatient departments. OPSS status indicator B is assigned to this code.

We are requesting that CMS update the status indicator for CPT 93793 to a covered status indicator such as SI=A, S or V. The service could be paid through the physician fee schedule or under OPSS.

### OPSS and ASC Quality

The CY24 OPSS rule would implement several changes for OPSS and ASC Quality:

#### *Remove Left Without Being Seen (LWBS) measure beginning with CY2024 reporting period (2026 payment determination)*

Beginning with the CY 2024 OQR reporting period, CMS proposes to remove the LWBS measure. The measure assesses the percent of patients who leave the ED without being evaluated by a physician, advanced practice nurse or physician's assistant.

Trinity Health agrees with the removal of this measure.

#### *Modify COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with CY2024 reporting (2026 payment)*

As finalized in the FY21 IPPS rule, The rule would modify the COVID-19 Vaccination Coverage Among HCP measure to utilize the term "up to date" in the HCP vaccination definition and update the numerator to specify the timeframes within which an HCP is considered up to date with CDC recommended COVID-19 vaccines, including booster doses, beginning with CY 2024 reporting period/CY 2026 payment determination for the Hospital OQR Program.

Trinity Health supports adopting the CDC's definition of "up-to-date" for consistency but urges CMS transition from the current minimum of one week / month reporting of COVID-19 vaccination for healthcare personnel (HCP) to an annual, summary report. This would mirror that which CMS continues to require for influenza vaccination of HCP. The weekly frequency of reporting consumes considerable resources by our member hospitals with little change of data between reporting

quarters. An annual summary report will be sufficient to use data reported to continually improve protection of HCP against COVID-19.

Trinity Health disagrees with CMS' assertion that the measure changes will not impose new burden on facilities. If continued one week/month reporting is finalized, the measure will require ongoing tracking of adherence with periodically changing recommendations from CDC's Advisory Committee on Immunization Practices (ACIP). This is labor intensive and diverts use of resources from other work that is more pressing. As identified above, the current reporting of this measure is not similar to the annual influenza vaccination measure, which is a simple "yes" or "no" as to whether HCP have received their annual vaccination against influenza.

Further, we urge CMS collaborate with CDC's NHSN to be very clear about any final reporting requirement as the current requirement can be problematic from a technical standpoint if a provider picked a week in a month that crossed between two months. In this instance, reporting is not received by the CMS system and providers appear as non-compliant. Personnel entering data into NHSN under this situation are not aware that data entered is incomplete, i.e. the month in which the week began remains unreported. When the deadline for reporting the quarter in which this falls is passed the facility then unexpectedly discovers incomplete data which risks 25% APU incentive as well as loss of eligibility for other CMS performance improvement programs like Hospital Value-Based Purchasing (VBP). We recommend NHSN incorporate a real time alert to those entering this data indicating data entered is incomplete. The instructions from NHSN do include this limitation of NHSN however awareness of this and changes over time in personnel that oversee this reporting can result in missed opportunities for compliance with incentives from CMS.

Trinity Health recommends CMS communicate intent for coverage of provision of COVID-19 vaccine to patients admitted for inpatient care. Specifically, CMS should reimburse for the administration of vaccine as well as the cost of the dose of vaccine above the reimbursement of care for the reason for the patient's admission. This would also mirror current CMS policy for provision of pneumococcal and influenza vaccines during an inpatient admission and it is logical to extend this to COVID-19 vaccine now that the public health emergency (PHE) has ended.

#### *Modify Cataracts measure beginning with voluntary CY2024 reporting*

CMS proposes to standardize which survey instruments can be used for this measure.

Trinity Health has evaluated various processes for collecting and reporting this measure and our discovery has identified significant burden with this measure. When CMS assesses in labor hours the burden of this measure, CMS includes only the actual reporting through the Hospital Quality Reporting application, which is 10 minutes annually. That estimate is accurate; however, that does not represent the full burden of this measure as this measure requires gathering data from provider offices. Although the surgery is completed in the hospital setting, the evaluation of visual function pre- and post-surgery (within 90 days) is completed at the physician office. The hospital has no governance over the provider office practices, the visual assessment used, or whether there is an assessment completed pre- or post-surgery.

We strongly encourage CMS to re-evaluate this measure regarding appropriateness of reporting. If the goal is to ensure that the visual assessment is completed by the provider, then the measure

should be included in a provider-specific reporting program such as MIPS rather than a hospital reporting program such as OQR. No other OQR measure requires oversight of a data reporting process at provider offices. We urge CMS to maintain this as a voluntary measure.

*Modify Colonoscopy Average Risk measure beginning with CY2024 reporting*

The rule would change the denominator from “50-75 years receiving screening colonoscopy without biopsy or polypectomy” to “45-75 years receiving screening colonoscopy without biopsy or polypectomy.” This will align with the change in clinical recommendations.

Trinity Health supports this proposal to align with modified clinical standards.

*Readopt with modification hospital outpatient volume data on selected outpatient procedures beginning with voluntary CY2025 reporting and mandatory CY2026 reporting*

Beginning with voluntary reporting during CY 2025 with mandatory reporting beginning CY 2026, CMS proposes to readopt this measure.

This measure would increase administrative burden, we urge CMS not to finalize at this time. CMS’ strategy is to reduce manual reporting burden and utilize more efficient means. We acknowledge that volume data would be valuable to patients seeking care and that a measure based on claims data would only include Medicare FFS patients; however, we would support an eCQM to report outpatient volume. This measure requires report writers to accurately capture the data and update the reports annually as well as staff performing manual entry to submit, increasing burden to hospitals.

*Adopt the Risk-Standardized Patient-Reported Outcome-Based Performance measure following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM)*

CMS proposes to adopt this measure for the OQR and ASCQR that reports the facility-level risk-standardized improvement rate in PROs following certain procedures for Medicare fee-for-service beneficiaries aged 65 and older.

Trinity Health is implementing system-wide use of Epic EHR. Implementing PROMS at this time would be challenging as it would result in a significant use of resources while we are transitioning to Epic. Should this policy be finalized, we urge CMS to provide waivers for Trinity Health as we are mid-build for infrastructure that will improve patient care.

*Adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in adults*

Beginning with voluntary reporting in CY 2025 and mandatory reporting beginning in CY 2026, CMS proposes to adopt this electronic clinical quality measure (eCQM) into the OQR (but not ASCQR) that calculates the percentage of eligible CT scans that are out-of-range based on either have excessive radiation dose or inadequate image quality (suggesting insufficient dose) relative to evidence-based thresholds for the clinical indication for the exam.

Trinity Health supports this proposal.

RFI on Maintaining Access to Essential Medicines

CMS is seeking comment on a separate, additional payment under the IPPS for establishing and maintaining access to a buffer stock of essential medicines, with a possible adjustment under OPSS to be considered for future years.

Trinity Health supports an add on payment for hospitals to hold a buffer stock of essential medicines, as it would create a more reliable, resilient supply. We urge CMS to not apply budget neutrality policy for add on payment in either IPPS or OPSS.

Conclusion

Trinity appreciates this opportunity to comment on the CY24 OPSS proposed rule. We welcome the opportunity to serve as a resource on these issues. Please feel free to contact Jen Nading with any questions at [jennifer.nading@trinity-health.org](mailto:jennifer.nading@trinity-health.org)

Sincerely,

/s/

Jennifer Nading  
Director, Medicare and Medicaid Policy and Regulatory Affairs  
Trinity Health