Illinois Health and Hospital Association

September 13, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: CY 2023 Outpatient Prospective Payment System Proposed Rule (CMS-1772-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year (CY) 2023 Outpatient Prospective Payment System (OPPS) proposed rule.

Illinois hospitals have faced unprecedented challenges over the past two and a half years. Our providers and their colleagues have confronted wave after wave of COVID-19 surges, a pattern that White House officials now predict is unlikely to end in the short-term. Front-line providers have seen their colleagues understandingly burn out and leave the medical field in droves, particularly among registered nurses and allied staff, exacerbating a labor shortage that predates the COVID-19 pandemic. And constant economic uncertainty looms, with inflation remaining high and supply chain interruptions constantly threatening to impede hospitals' abilities to serve their patients and communities.

With these challenges in mind, we ask the Centers for Medicare & Medicaid Services (CMS) to consider our comments below. We understand the limitations of CMS' authority, and appreciate that certain issues are out of the agency's control. However, we are concerned that some of the overarching initiatives coming from CMS over the past few years may force our hospitals to cut service lines or otherwise curtail access to the care our communities deserve.

There is a growing disconnect between how hospitals are paid and how CMS governs the Medicare program. Many of CMS' policies in recent years have pushed to modernize the Medicare program, incentivizing the use of integrated technologies and instilling important patient protections that increase transparency and work to drive down out-of-pocket costs. At the same time, many of CMS' longstanding payment methodologies are based on the very concepts that these policies push against. And while modernizing hospital infrastructure is a goal we and our members share with CMS, it requires resources and funding that the federal government is not providing.

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When the Medicare program reimburses hospitals below cost while simultaneously squeezing private payer reimbursement, it cannot expect providers with negative margins to quickly invest in and implement costly policies.

Thus, we strongly urge CMS to reexamine portions of this proposed rule and finalize policies and payment updates that better reflect the economic and logistical realities hospitals currently face.

Proposed CY 2023 Rate Update

We are disappointed with CMS' proposed CY 2023 OPPS rate update. After accounting for all proposed payment and policy changes and the sequestration reduction, we estimate that Illinois hospitals will realize a 0.73% increase in OPPS payments compared to CY 2022. This rate update is painfully inadequate given the current fiscal realities faced by our hospitals.

In this proposed rule, CMS relies on IHS Global Inc.'s fourth quarter 2021 forecast to calculate the market basket update. The fourth quarter 2021 forecast is based on historical data through the third quarter of 2021. Using these data, CMS proposed a market basket update of 2.7%.

We recognize that CMS intends to update this methodology in the final rule using IHS Global Inc.'s second quarter 2022 forecast. Similar to the Inpatient PPS (IPPS) final rule, we expect to see a slight increase in the final rate update due to the use of more updated data. However, it is clear that the methodology used by CMS in updating rates does not track with real-time costs of providing healthcare.

Consider a January 2022 analysis by Kaufmann Hall which found a 20.1% increase in hospital expenses per patient from 2019 to 2021.[1] This includes a 36.9% increase in per patient cost on drugs, a 19.1% increase in per patient cost on labor, and a 20.6% increase in per patient cost on supplies compared to pre-pandemic levels. All of these estimates vastly outpace the proposed CY 2023 rate update from CMS.

At the same time, inflation is currently at 8.5%.[2] CMS' proposed CY 2023 market basket update does not come close to keeping pace with inflation. Inflation and COVID-related price hikes are on top of a Medicare program that only reimburses hospitals at about 88% of cost in Illinois. CMS's rate update will clearly only widen this gap between cost and reimbursement, further increasing reliance on private payers and threatening providers' ability to meet the growing needs of the Medicare population.

A recent analysis from McKinsey & Company demonstrates three challenges to effectively meeting patient care needs that the U.S. healthcare system will face by 2025. These include a decreased supply of the registered nurse workforce, increased inpatient demand from or

[1] American Hospital Association. Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health systems. April 2022. Available from: https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf. Accessed Sept. 7, 2022.
[2] U.S. Inflation Calculator. Available from: https://www.usinflationcalculator.com/inflation/current-inflation-rates/#:~:text=The%20annual%20inflation%20rate%20for,10%20at%208%3A30%20a.m. Accessed Sept. 7, 2022.

related to COVID-19, and continued work setting shifts and increased demand due to a growing and aging population.[3] Supporting this analysis, there were 11,700 job postings in Illinois as of the second quarter of 2022, including nursing, allied health, pharmacy, and therapy positions.[4] And hospital outpatient departments are the very setting to which care is shifting, along with home health and community-based providers.

Finally, the latest data indicate decreases in productivity, not gains.[5] This calls into question the appropriateness of the Affordable Care Act mandated productivity adjustment that automatically decreases the market basket update. Hospitals simply have not seen an increase in productivity over the last two years, and given the extreme and uncertain circumstances in which our hospitals are currently operating, we question the appropriateness of the productivity adjustment moving forward.

Given this evidence, it is clear that CMS' rate update is inadequate as proposed. This is primarily because the market basket is a time-lagged estimate that uses historical data to predict the future. When historical data are no longer a good predictor of future changes, the market basket becomes obsolete. Indeed, as we saw with the IPPS final rule, using more recent data results in a more accurate rate update, including a market basket that was well above what CMS originally proposed.

IHA urges CMS to do everything within its statutory authority to increase payments to OPPS hospitals. **Specifically, we suggest CMS reassess the data and methodology used for the annual market basket update, and formulate a rate update that better reflects the fiscal reality hospitals currently face. Additionally, we ask CMS to eliminate the productivity adjustment for CY 2023, and work with Congress to assess the relevance of this adjustment twelve years after the passage of the Affordable Care Act.**

Data Used for CY 2023 OPPS Rate Setting

IHA supports CMS' proposal to use CY 2021 claims data and June 2020 Healthcare Cost Report Information System (HCRIS) extract cost report data in setting CY 2023 rates. We evaluated the financial impact of using the most recent full year of cost report data for rate setting, and it is clear that COVID-19 significantly impacted these data. Using the most recent year of data results in an estimated 0.41% increase in OPPS payments relative to CY 2022, which decreases to -1.64% after accounting for sequestration. Such an update would have significant negative impacts on hospital finances, threatening their ability to secure much needed labor and continue providing the high quality services our communities depend on. Thus, **we strongly support CMS' proposal to forgo its customary data methodology, and instead use the June 2020 HCRIS extract for CY 2023 rate setting purposes.**

[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce
[4] American Hospital Association. 2022 Q2 Health Care Jobs Report. Region 5. Accessed Sept. 6, 2022.
[5] U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. https://www.bls.gov/news.release/pdf/prod2.pdf.

340B

IHA is pleased that the U.S. Supreme Court reversed CMS' unlawful reimbursement policy for drugs acquired through the 340B program. We support CMS reverting to its prior drug payment policy to reimburse for all drugs, including 340B-acquired drugs, at average sales price (ASP) plus 6%. Additionally, in response to CMS' request for information on how to apply the Court's decision to CYs 2018 through 2022, we suggest the following:

1. **Promptly repay any hospital the difference between ASP plus 6% and what they were actually paid for drug claims as a result of CMS' unlawful reimbursement policy for CYs 2018 through 2022; and**
2. **Hold the entire hospital field harmless for this illegal policy for CYs 2018 through 2022, meaning no recoupment of funds received during this period.**

Given the Court's decision, we believe CMS should pursue a straight-forward path of truing up hospitals that were unlawfully underpaid during CYs 2018 through 2022. Additionally, it would be unfair and unprecedented for CMS to decide to recoup funds from 340B and non-340B providers alike in an effort to address budget neutrality concerns from CYs 2018 through 2022. The OPPS statute is clear that budget neutrality applies prospectively, not retrospectively. Nowhere does the OPPS statute reference budget neutrality in connecting with retrospective changes.

And in fact, while CMS frequently implements retroactive fixes to its prospective payment systems, it has not coupled these fixes with a retroactive recoupment of prior payments. For example:

- The U.S. Department of Health and Human Services (HHS) retroactively adjusted payment rates to several rural hospitals without offsetting recoupments to achieve budget neutrality in 2007 (71 *Federal Register* 67960, 68010 (Nov. 24, 2006)).
- In 2015, CMS realized that OPPS payments in 2014 and 2015 were too high after it began packaging clinical diagnostic laboratory tests into OPPS payments rather than paying for them separately using the Clinical Laboratory Fee Schedule. Upon recognizing the error, CMS reduced the conversion factor beginning in 2016 to prevent further overpayments going forward, but it did "not recoup 'overpayments' made for CYs 2014 and 2015" (80 *Federal Register* 70298, 70354 (Nov. 13, 2015)).
- Under the IPPS, CMS can revise a wage index in response to an adverse judicial decision without any need for corresponding changes to achieve budget neutrality (42 CFR§ 412.64(l)).

Recouping overpayments caused by CMS' unlawful reimbursement cuts will unfairly affect a wide variety of hospitals, including those that serve our most vulnerable citizens such as rural sole community hospitals, children's hospitals, safety net hospitals, and critical access hospitals (CAHs). These are entities that are simultaneously experiencing financial strain due to the

unaddressed, egregious actions of pharmaceutical companies withholding 340B drug discounts, requiring the use of certain pharmacies, or mandating the use of white-bagging for 340B-acquired drugs.

For example, one rural Illinois 340B hospital launched an outpatient oncology clinic to meet the needs of its community, and anticipated using 340B savings to fund the clinic. Due to pharmaceutical company-imposed limitations regarding the use of contract pharmacies, anticipated 340B savings have severely decreased and the hospital must now find other financial resources to fund the clinic.

If CMS claws back payments made to these and other 340B-covered entities, it will exacerbate the financial strain currently imposed by pharmaceutical companies and will almost certainly be requiring the repayment of dollars that have already been spent bringing important healthcare services to the communities served by these providers.

Finally, we urge CMS to rectify underpayments without reprocessing claims or reopening and re-auditing past Medicare cost reports. Pursuing either of these practices will slow the repayment process, unnecessarily burdening providers when CMS and Medicare Administrative Contractors (MACs) can ascertain what is owed based on previously processed claims and finalized cost reports. Further, Medicare beneficiaries should not be affected by this policy change, and reprocessing claims risks inappropriate rebilling beneficiaries for copays or coinsurance.

In conclusion, IHA supports CMS' proposal to reinstate the lawful reimbursement for 340B-acquired drugs at ASP plus 6%. The Court was clear that CMS' policy was unlawful, and by extension the decision should apply to all years during which CMS discriminated between 340B and non-340B acquired drugs. Therefore, we urge CMS to **expeditiously repay 340B providers that were unlawfully underpaid between CYs 2018 through 2022.** Further, **CMS should move forward without recouping any perceived overpayments caused by CMS' unlawful reimbursement cuts, particularly as there is no precedent for such actions.** Finally, we urge CMS to rectify 340B payments without unnecessarily burdening hospitals, and potentially beneficiaries, by reprocessing claims or re-auditing Medicare cost reports.

Prior Authorization

IHA appreciates the HHS Secretary's authority under section 1833(t)(2)(F) of the Social Security Act to develop methods for controlling unnecessary increases in the volume of covered outpatient department (OPD) services. CMS has grown its prior authorization process since it was created under the CY 2020 OPPS final rule, with the proposed addition of facet joint injections and nerve destruction services in CY 2023 totaling eight OPPS service categories subject to the Medicare fee-for-service prior authorization process.

IHA does not question CMS' need for oversight of the Medicare program. We agree it is important that CMS monitor the outpatient space as demand for outpatient services rise and

the Medicare population grows. However, we are concerned that the general expansion of prior authorization requirements is impacting patient care.

Illinois hospitals face prior authorization requirements across payers: Medicare fee-for-service, Medicare Advantage, Medicaid, and all private payers. When utilized correctly, prior authorization is an important patient safety tool that ensures patients receive medically necessary care. Unfortunately, payers increasingly use prior authorization solely as a cost containment tool, resulting in patients being *denied* medically necessary care. This problem was recently highlighted in a report[6] from the HHS Office of Inspector General which found that 13% of prior authorization denials for Medicare Advantage enrollees and 18% of denied payment requests did in fact meet Medicare coverage rules.

This is just one example of inappropriate prior authorization denials that impede access to medically necessary healthcare. But access issues are also caused by the process itself. As the number of services subject to prior authorization grows, providers are forced to delay care as they wait for payers to approve prior authorization requests. Further, prior authorization creates confusions for patients and providers, with some hospitals dedicating entire teams to prior authorization issues. In an effort to keep up with changing rules, hospitals must divert resources away from patient care simply to ensure medically necessary care is furnished in a timely fashion.

The problems accompanying prior authorization processes have not gone unnoticed by legislators. Congress is currently considering H.R. 8487[7], a bill that would impose requirements on Medicare Advantage plans to better streamline the prior authorization process and provide protections for beneficiaries and providers. Additionally, states across the country, including Illinois, have seen an uptick in prior authorization legislation in an effort to better oversee the use of this tool by private payers and Medicaid managed care organizations.

If CMS moves forward with this proposal and continues to expand the OPPS prior authorization policy to include additional services in the coming years, it should also **ensure proper safeguards are in place to safeguard Medicare beneficiaries' access to medically necessary care.** One way to do this is to ensure CMS only applies prior authorization to services that are truly vulnerable to unnecessary overutilization, and then continue to monitor those service categories to ensure that prior authorization is used appropriately. Further, CMS should explore requiring electronic approvals across all payers, thereby increasing the speed of the prior authorization process and curtailing unnecessary delays in care provision. Finally, **we ask CMS to explore its authority in mandating consistency in prior authorization policies across payers.** Hospitals are held accountable for patient outcomes and administrative processes, but payers are often given much more leeway. Having uniform standards across payers would ensure both

[6] U.S. Department of Health and Human Services Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization requests Raise Concerns About Beneficiary Access to Medically Necessary Care. OIE-09-18-00260. April 2022. Available from: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf. Accessed Sept. 7, 2022.
[7] 117th Congress. H.R. 8487. Available from: https://www.congress.gov/bill/117th-congress/house-bill/8487/text?r=1&s=1. Accessed Sept. 7, 2022.

providers and payers play by the rules and furnish only medically necessary care. This would also cut down on the administrative burden providers experience from having to learn and comply with myriad policies across various payers.

Site-Neutral Payment Policy

IHA supports CMS' proposal to exempt grandfathered (excepted) off-campus provider-based departments (PBDs) at rural sole community hospitals (SCHs) from the site-neutral payment reduction policy for outpatient clinic visits. We agree with CMS' assessment that rural SCHs are often the only source of care in their communities. As such it is important to ensure rural SCHs and their affiliated off-campus PBDs have adequate resources to maintain staffing levels and supply sufficient access to healthcare for their communities.

We continue to be concerned that CMS' site-neutral payment policy may generally impede healthcare access for other communities. We fully support CMS' continued analysis of access and utilization data, and urge CMS to look at utilization in conjunction with other programs focused on the underserved as it did with rural SCHs. These include but are not limited to special CMS compensation designations (e.g. Medicare-Dependent Hospitals, Low Volume Adjustment Hospitals), and provider types that focus on underserved individuals and communities such as 340B providers and high disproportionate share providers.

In that vein, **we urge CMS to consider exempting rural hospitals with fewer than 100 beds as it suggested in this proposed rule from its site-neutral payment policy.** There may also be other criteria CMS should assess when considering how this payment policy affects access. In addition to rural SCHs, CMS may want to examine access data related to urban SCHs. CMS might also consider exempting hospitals that serve a certain percentage of uninsured or underinsured individuals, as these providers rely on adequate funding to meet the needs of their patients and communities.

Many Illinois off-campus PBDs provide access to healthcare in communities that have historically been underserved and experience large disparities in health outcomes. We know that low reimbursement can lead to provider or service line closures, particularly in areas where patients predominantly rely on Medicare or Medicaid for insurance. Underserved communities, which the Biden administration is appropriately focused on, suffer the most from reimbursement cuts. Thus, **we urge the agency to diligently examine potential unintended consequences of this site-neutral payment policy, particularly because off-campus PBDs are well-positioned to meet the growing demand for outpatient services.**

Remote Outpatient Mental Health Services

Illinois hospitals have quickly adapted to the use of telehealth for furnishing mental health services during the COVID-19 public health emergency (PHE). Indeed, patients have also embraced telehealth, with a Dec. 2021 HHS study showing a 63-fold increase in Medicare

telehealth visits between 2019 and 2020,[8] and a Kaiser Family Foundation study showing an increase in telehealth visits for mental health and substance use disorders from 11% in March-Aug. 2019 to 39% in March-Aug. 2021.[9]

IHA appreciates and supports CMS' proposal to continue paying for mental health services furnished to Medicare beneficiaries via telehealth with the originating site restrictions removed until 151 days following the end of the COVID-19 PHE. Similarly, we agree that it is in the best interest of patients and providers to continue covering mental health diagnosis, evaluation, and treatment services available via telehealth to beneficiaries in their homes as hospital outpatient department services.

However, we are concerned with CMS' assumption that hospitals do not accrue the same costs when beneficiaries receive care in their home. While it is true that many upfront costs of providing mental health services via telehealth are "fixed" and already paid for, there are other telehealth characteristics that introduce fiscal variability. These include routine costs such as electronic medical record maintenance and equipment upgrades, as well as more dynamic issues, such as labor costs, as demand for mental health services currently outpaces supply.

Additionally, the requirement for an in-person visit once every 12 months may ultimately disrupt a patient's treatment plan. Many patients that receive mental health services via telehealth live far away from the physical hospital location. For example, many Chicago-area hospitals provide mental health services via telehealth to patients that live in Southern Illinois. Requiring a patient to make a trip that is several hours long by car may interrupt treatment if the patient decides it is too difficult to keep the in-person appointment.

Given increasing demand for mental health services and a plethora of fiscal and logistical variables, we urge CMS to reconsider using the Physician Fee Schedule, and instead use OPPS payment rates to reimburse hospital outpatient departments for mental health services delivered via telehealth. We also ask CMS to reconsider the requirement for an annual in-person visit. We believe this is an area of healthcare that has been historically underfunded and understaffed, thus leading to stark inequities in terms of access and utilization across Illinois communities. At a minimum, we expect CMS to monitor this space and make reimbursement and policy adjustments as appropriate to ensure it fulfills the Administration's goals of ensuring equitable access to mental health services.

Non-Opioid Pain Management Drugs

IHA supports CMS' 2019 policy to unpackage and pay separately for certain non-opioid pain management drugs that function as surgical supplies in the Ambulatory Surgical Center (ASC) setting. In 2020, opioid overdoses in Illinois increased 33% compared to 2019, with 2,944 opioid

[8] Centers for Medicare & Medicaid Services. New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic. Dec. 3, 2021. Available from: https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic. Accessed Sept. 6, 2022.
[9] Kaiser Family Foundation. Telehealth has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic. Mar. 15, 2022. Available from: https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/. Accessed Sept. 6, 2022.

overdose fatalities.[10] By reimbursing certain non-opioids separately at ASP plus 6%, CMS is ensuring that there are no financial incentives to utilize opioids in place of a non-opioid alternative and is doing its part to help providers curb opioid misuse.

That is why IHA appreciates CMS' annual evaluation of this policy and eligible non-opioid pain management drugs. We support CMS' proposal to add Dextenza to the list of non-opioid pain management drugs functioning as a surgical supply that should receive separate payment in the ASC setting in CY 2023.

We also strongly urge CMS to amend this payment policy, and apply it to non-opioids functioning as surgical supplies in the hospital outpatient department setting as well. In 2020, Illinois' opioid overdose fatalities were more than twice the number of fatal motor vehicle accidents and homicides. And yet these shocking numbers find Illinois in the middle of the pack when ranked against other states on overall drug overdose fatality rates. Clearly this is a national issue that requires more governmental action, and extending this policy to hospital outpatient departments is logical and appropriate in light of the Administration's goals to address the opioid epidemic.

Rural Emergency Hospitals (REHs)

Illinois hospitals eligible to convert to the REH provider type are still considering whether it is fiscally advisable for them to do so. IHA thanks CMS for providing REH payment information in this proposed rule, as this information is essential for our hospitals as they consider converting to an REH.

We are generally pleased with the proposed facility payment and reimbursement for outpatient department services typically paid under the OPPS at OPPS rates plus 5%. We urge CMS to continue considering challenges associated with the provision of healthcare services in rural communities as it monitors access to and utilization of REH services. **Specifically, for services not paid at OPPS rates plus 5%, CMS should monitor access over the next several years to identify areas where additional reimbursement may be necessary to ensure equitable access for rural residents.**

Additionally, we support CMS' use of Medicare claims data to determine the monthly facility payment for REHs. However, we urge CMS to publish a more detailed methodology of these calculations, particularly in light of rising labor and supply costs. As we have seen across the PPS payment rules for FY and CY 2023, the market basket update is often inadequate in terms of covering the Medicare costs hospitals face. To that end, we encourage CMS to consider additional methodologies when updating the facility payment each year.

We support CMS' proposal to codify that items and services furnished by off-campus PBDs of REHs are not applicable items and services under sections 1833(t)(1)(B)(v) or (t)(21) of the Act.

[10] Illinois Department of Public Health. IDPH Opioid Data Dashboard. Available from: https://dph.illinois.gov/topics-services/opioids/idph-data-dashboard.html#:~:text=Opioid%20overdoses%20in%20Illinois%20increased,twice%20the%20number%20of%20homicides. Accessed Sept. 6, 2022.

We urge CMS to finalize this payment policy for all REHs, regardless of the REH's provider type prior to converting. We agree with CMS that the purpose of the REH is to ensure adequate access to healthcare services in underserved communities. Maximizing allowable reimbursement will better ensure REHs remain open and serving their communities.

More expert input is necessary to create and implement the REH quality reporting program (REHQRP), and we appreciate CMS' request for comments in this area. In reviewing the outpatient measures proposed for the REHQRP by CMS, it is clear that current reporting practices vary across these measures for small rural and critical access hospitals. For example, 74.7% of small rural hospitals reported data for OP-4, compared to only 46.2% of CAHs.

It is not only important that CMS ensure REHQRP measures reflect the services REHs typically provide, but also that they are streamlined to maximize efficiency and the appropriate use of REH staff time and expertise. To that end, we urge CMS to work closely with the National Quality Forum (NQF) to select and verify measures for the REHQRP. Analyzing data and soliciting advice from the National Advisory Committee on Rural Health and Human Services is also paramount, and we urge CMS to continue working with them to develop the REHQRP. Finally, **we believe REHQRP Medicare measures should align with quality measures required by other payers to the extent possible, particularly Medicaid.**

Finally, the sooner CMS can provide further guidance, the more likely our small rural and critical access hospitals will be able to make sound decisions regarding REH conversion. Our providers are committed to ensuring healthcare access in the rural communities they serve, and we look forward to working with our members and CMS to provide the right care, in the right place and at the right time for years to come.

Outpatient Quality Reporting (OQR) Program

IHA supports CMS' proposed change to the measure Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31/ASC-11) for both the OQR and ambulatory surgical center quality programs. Changing this measure from mandatory to voluntary reporting is an appropriate response to the concerns CMS has heard regarding reporting burden amidst national staffing shortages.

IHA also supports CMS' proposed realignment of the OQR reporting timeline. Aligning OQR reporting requirements with other quality reporting programs, including the inpatient quality reporting program, makes sense from a logistical and resource allocation perspective, and we appreciate CMS' efforts in this area.

Finally, in response to CMS' request for comments on adopting an OQR measure that tracks the volume of outpatient procedures, we suggest CMS reconsider adopting Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26). We agree it is important to track service utilization and quality in the outpatient space given the continued shift toward outpatient procedures. However, it does not make sense for CMS to utilize a measure that was

removed in CY 2018 because there was a "lack of evidence to support this specific measure's link to improved clinical quality."

We also believe CMS should adhere to requirements for the NQF to review and endorse all measures implemented across various Medicare quality programs. The NQF did not review nor endorse OP-26, and we expect CMS to go through that process for any volume measure it formally introduces to the OQR program in the future.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

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