Sept. 8, 2017

Ms. Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W.

Room 445-G

Washington, DC 20201

Comments submitted electronically at <http://www.regulations.gov>

**File Code: CMS–1678-P - Medicare Program: Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule**

Dear Ms. Verma:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems effective Jan. 1, 2018. As proposed, this rule is projected to increase Medicare fee-for-service (FFS) OPPS payments to Michigan hospitals by an estimated $33 million, or 1.6 percent, in 2018. This minimal increases fail to cover annual inflationary cost increases. **This impact** **excludes the negative impact resulting from the further reduction in payment for outpatient services provided at non-grandfathered off-campus hospital outpatient departments (HOPDs) and the significant payment cuts proposed for drugs purchased under the 340B drug pricing program.** When these two major changes are included, Michigan hospitals will actually realize a net decrease in Medicare OPPS payments in 2018 compared to 2017. On a long-term basis, it is not sustainable for our hospitals to continue providing the necessary access and services to Medicare beneficiaries and other Michigan residents.In addition, absent Congressional action, through fiscal year 2025, hospitals remain subject to the 2 percent payment sequestration reduction which cuts nearly $42 million from Medicare OPPS payments to Michigan hospitals annually.

Since Medicare OPPS payment rates have historically failed to cover the cost of providing care, we believe this increase in inadequate. Based on the latest data available, Medicare FFS OPPS payments are approximately 15 percent less than Medicare **allowable** cost, which is approximately 20 percent less than financial statement cost. These negative Medicare margins result in the commercial payers and Michigan’s employers paying higher health insurance rats to cover the unreimbursed cost of Medicare services.

The MHA’s comments focus on the proposed changes related to:

* Reduction in payments for drugs purchased through the 340B drug pricing program
* Additional cuts to site-neutral payments for “non-grandfathered” off-campus hospital outpatient departments (HOPDs)
* Removal of Total Knee Arthroplasty (TKA) procedures from the inpatient only list
* Packaging of low-cost drug administration services
* Coding edits for brachytherapy insertion procedures
* Payment reductions for X-rays taken using computed radiography technology
* Claim edits for partial hospitalization program (PHP) services
* Hospital Outpatient Quality Reporting Program (QRP) changes

**340B Payment Reductions**

**The MHA opposes the CMS’ proposal to reduce Medicare Part B payments for drugs acquired through the 340B drug pricing program.** The CMS proposes to pay for separately payable, non-pass-through drugs purchased through the 340B program based on the average sales price (ASP) less 22.5 percent rather than the current rate of ASP plus 6 percent. Nationally, the CMS has estimated that this proposal would cut payments for 340B drugs by $900 million in 2018. The CMS proposes to implement this cut in a budget-neutral manner by increasing the OPPS conversion factor. We believe that the CMS lacks statutory authority to impose such a significant payment cut for 340B drugs that dramatically reduces payments to and effectively eviscerates the benefits of the 340B program for hospitals. This proposed policy would shift funding from hospitals providing access to vulnerable Medicare patients to those that do not have the same patient load. **Rather than inappropriately punishing 340B hospitals, we urge the CMS to address the core issue of skyrocketing pharmaceutical costs**. In addition, we believe that the proposed cuts undermine the Congressional intent and purpose of the 340B program which was created to permit safety net hospitals that provide care to a high number of low income and uninsured patients to utilize the financial benefit of the 340B program to maintain or increase access to and provide a more comprehensive array of health care services. For example, hospitals use the 340B savings to:

* Provide financial assistance to patients unable to afford their prescriptions;
* Provide clinical pharmacy services, such as disease management programs or medication therapy management;
* Fund other medical services, such as obstetrical services, diabetes education, oncology services and other ambulatory services;
* Establish additional outpatient clinics to improve patient access;
* Create new community outreach programs; and
* Offer free vaccinations for vulnerable populations.

**Site Neutral Payments**

Section 603 of the Bipartisan Budget Act of 2015 required that the CMS develop a new payment methodology for Medicare services provided at off-campus hospital outpatient departments (HOPDs). Only certain facilities are “grandfathered” and continue to be paid under the Medicare OPPS including:

* Items and services provided in a dedicated emergency department (E/D).
* Items and services provided by an off-campus HOPD that meets all of the following requirements:
  + The HOPD provided and submitted bills for covered outpatient department services under the Medicare OPPS before Nov. 2, 2015;
  + The items and services are furnished at the same location that the HOPD was providing such services as of Nov. 1, 2015;

For 2017, the CMS adopted the Medicare physician fee schedule (PFS) as the applicable Part B payment system for most non-grandfathered facilities and set payment rates for most services at 50 percent of the Medicare OPPS payment rate. For 2018, the CMS proposes to reduce this payment rate further to 25 percent of the OPPS rate. **The MHA opposes this reduction as it penalizes HOPDs and assumes that the care provided in the off-campus HOPD setting is the same as that provided in a physician office.** We believe that the CMS short-sighted policies on the relocation of non-grandfathered off-campus HOPDs is unreasonable. This policy is punitive for hospitals that are modifying their physical locations and service mix to better address the needs of their patients. Along with the American Hospital Association (AHA) and others, we will continue to urge the CMS to provide payments that are adequate to cover the costs of providing care so that hospitals and health systems can continue to serve as the access point for community care.

**Inpatient Only List**

On an annual basis, the CMS updates procedures that are reflected on the Inpatient Only (IPO) List. For 2018, the CMS proposes to remove total knee replacement (TKA), CPT code 27447, from the IPO list. **The MHA opposes the removal of TKA from the IPO list since we do not believe it is clinically appropriate for the outpatient setting and have concerns that it will jeopardize the success of the Comprehensive Care for Joint Replacement (CJR) and Bundled Payment for Care Improvements (BPCI) programs**. While they may be performed successfully on an outpatient basis for non-Medicare patients, we do not believe it is appropriate for the Medicare population for the following reasons:

1. Nearly 50 percent of all Medicare beneficiaries live with four or more chronic conditions and one-third have one or more limitations in activities of daily living that limit their ability to function independently. These factors often make a simple procedure much more complicated.
2. Spinal anesthesia is often used for TKAs and waiting for full sensation to return can take hours.
3. Pain management, particularly in the immediate postoperative period, remains a challenge which is best controlled in the inpatient setting especially given the opioid epidemic the U.S. is currently facing.

If the CMS opts to finalize the removal of TKA from the IPO list, we urge the CMS to modify the CJR and BPCI program initiatives especially since the CMS has noted in the past that problems may arise if TKA is removed from the IPO list and not properly addressed.

In addition, the CMS seeks comments on whether the partial and total hip arthroplasty should be removed from the IPO list. **The MHA also opposes the removal of PHA/THA from the IPO list and urges the CMS to exercise caution if it contemplates this change in the future.** **Similar to our comments on TKA, we do not believe it is clinically appropriate to remove PHA/THA from the IPO list and are further concerned that it could put the success of the CJR and BPCI programs in jeopardy.**

**Proposed Packaging of Low-Cost Drug Administration Services**

For 2018, the CMS proposes to conditionally package payment for low-cost drug administration services when these services are performed with another service. This policy would package the cost of APCs 5691 (Level I Drug Administration) and APC 5692 (Level 2 Drug Administration) into a primary service when these APCs are billed on the same claim as another primary service. **The MHA recommends that the CMS not finalize this proposal to conditionally package payment for Level 1 and 2 drug administration services since we believe that additional analysis must be completed.**

Contrary to the CMS’ statement in the proposed rule, the proposed approach would not “promote equitable payment between the physician office and hospital outpatient department”. The CMS asserts that hospitals currently receive separate payment for clinical visits and a drug administration service, while physicians are not eligible to receive payment for an office visit when a drug administration service is also provided. As indicated in the AHA’s letter, this statement is incorrect. Medicare does allow physicians to be paid for both an office visit and drug administration services in certain circumstances. Since all drugs are separately payable in the physician office setting, unlike the OPPS, the proposed expansion of packaging to include most Level 1 and 2 drug administration services, as well as the increased packaging of higher cost drugs, actually increases the differences in reimbursement between the physician office and hospital outpatient department. **The MHA recommends that the CMS not finalize this policy and instead continue to provide separate payment for all drug administration services.**

**Brachytherapy Insertion Procedures**

The CMS proposes to implement a code edit for claims with brachytherapy services that will require the brachytherapy application HCPCS code 7778 to be included on the claim with the brachytherapy insertion procedure (HCPCS code 55875). For the following reasons, **the MHA opposes the adoption of this edit since we believe it will be burdensome for hospitals when the insertion procedure is not performed during the same encounter:**

* + There are clinical and other reasons when a patient may receive the brachytherapy treatment at a later date than the brachytherapy insertion procedure. Holding claims to combine the codes would introduce additional administrative burdens.
  + In some instances, the procedures are done at different facilities within the geographic region making it impossible for the codes to be reported on the same claim.
  + To ensure accurate coding, some billing systems already have a soft edit to flag these cases. If the edit is overridden, it often is for one of the reasons above.

**Changes to Payment for X-rays Taken Using Computed Radiography Technology**

The CMS proposes to implement a non-budget-neutral provision of the Consolidated Appropriations Act of 2016, which reduces OPPS payment for X-rays taken using computed radiography technology by 7 percent for services provided in 2018 through 2022, and by 10 percent for services provided in 2023 and subsequent years.

To implement this provision, the CMS proposes a new modifier that would be reported on claims for X-rays that are taken using computed radiography technology/cassette-based imaging. **The MHA is concerned about the impact of these payment reductions especially on rural hospitals that lack the resources to have the latest technology and urge the CMS to not apply these reductions for X-rays provided by rural hospitals.**

**Partial Hospitalization Program**

In the proposed rule, the CMS continues to express concern that providers may be providing too few services to Medicare beneficiaries enrolled in partial hospital programs (PHPs). Specifically, in order to be eligible for PHP, a beneficiary must require a minimum of 20 hours-per-week in services per the plan of care and reiterates its view that a typical PHP beneficiary should receive five to six hours of services per day. However, the CMS describes an analysis conducted that assessed the intensity of PHP services provided in which if found that the majority of PHP patients did not receive at least 20 hours of PHP services per week. As such, the CMS seeks comments on the advisability of applying a payment requirement conditioned on a beneficiary’s receipt of a minimum of 20 hours of therapeutic services per week. The CMS also seeks comments addressing the need for exceptions to such a policy and the types of occurrences or circumstances that would cause a PHP patient to not receive at least 20 hours of PHP services per week, particularly where payment is still appropriate.

We understand that the PHP benefit is designed as an intensive benefit requiring physician certification that the patient requires a minimum of 20-hurs-per-week of therapeutic services. We agree with the CMS that it is critical to ensure that patients eligible for PHP services receive the appropriate intensity of services. We also share the CMS’ concerns about the possibility that its policy decision in 2017 to replace the previous two-tiered PHP APCs with the single-tiered PHP APCs (which pays providers for providing three or more services per PHP service day) could provide a financial incentive to reduce patient intensity of services. However, the data needed to assess whether and what extent this is occurring will not be available until the 2019 OPPS proposed rule. As a result, the MHA believes that it would be premature to implement a claims edit conditioning payment on the provision of 20-hours of therapeutic services per week. In addition, we are concerned that a claims edit that is overly strict could result in inappropriate changes and perhaps reduced access to the PHP benefit. **The MHA opposes the proposed use of a claims edit conditioning payment on the provision of 20 hours of therapeutic services per week. Instead, we urge the CMS to work with hospital and community mental health center PHP providers during 2018 in order to develop a more comprehensive plan to address the CMS concerns about the intensity of services.**

Recent input received from a Michigan free-standing inpatient psychiatric facility (IPF) indicates that they expect that the proposed changes will reduce their Medicare OPPS payments by over $100,000 in 2018 when their costs for psychiatry and nursing services have increased more than 10 percent in recent years. This facility competes in the local labor market with area acute care hospitals and struggles to recruit and retain staff, particularly registered nurses.

**Hospital Outpatient Quality Reporting Program**

In the proposed rule, the CMS proposed to remove six measures from the outpatient quality reporting program (QRP), with two measures removed starting with the CY 2020 payment determinations, which are based on 2018 provider performance. In addition, the CMS proposes to remove four other measures beginning with the CY 2021 payment determinations, based on 2019 provider performance. The CMS also proposed to delay implementation of the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures proposed for adoption in the 2017 OPPS final rule.

Consistent with the AHA, the MHA is supportive of the CMS proposal to remove the six measures and appreciate the CMS’ efforts to remove measures that provide little meaningful information on quality of care and that fail to support the ongoing hospital quality improvement efforts. However, we believe that the CMS could do more to remove measures that fail to encourage improvements in hospital quality. First, the CMS should remove all six rather than two measures for the 2020 outpatient QRP.

There are several other measures that meet the same criteria as those addressed here and should be considered for removal. For example, the measure Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival, OP-2, was finalized for removal from the FY 2019 inpatient QRP since it focuses on a relatively narrow aspect of care and improvement in the measure does not result in better patient outcomes. If removal of this measure was deemed appropriate in the inpatient setting, it should likely be considered for removal in the outpatient setting.

The MHA, along with the AHA and others, agree with the CMS that the implementation of the OAS CAHPS is premature and appreciates the CMS’ proposal to delay the survey-based measures pending further analysis and modification. If the CMS is intent on implementing the OAS CAHPS in future years, we urge the CMS to use the delay to address critical implementation issues. In addition, the MHA encourages the CMS to pursue endorsement by the National Quality Forum (NQF) before requiring the OAS CAHPS by hospitals.

In addition, the MHA supports principles outlined in the AHA’s OPPS comment letter for future measures to be included in hospital payment and performance systems.

Again, the MHA appreciates this opportunity to provide input to the CMS. We believe that our suggested changes regarding implementation the site neutral policy would more closely represent Congressional intentions. In addition, our recommended changes would have a positive impact for hospitals and all patients they serve. Please contact me at 517-703-8603 or via email at [mklein@mha.org](mailto:mklein@mha.org) with any questions.

Sincerely,



Marilyn Litka-Klein

Vice President, Health Finance

Policy and Health Delivery