Alliance for Site Neutral Payment Reform

March 29, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Secretary Burwell and Acting Administrator Slavitt,

As members of The Alliance for Site Neutral Payment Reform – a coalition formed to address payment parity across sites of service in order to decrease Medicare and commercial spending, lower taxpayer and beneficiary costs and increase patient access – we would like to share our recommendations for the Centers for Medicare & Medicaid Services' (CMS) upcoming rulemaking for Section 603 of the Bipartisan Budget Act of 2015 (BBA). This provision marks an important first step in equalizing Medicare payments across sites of service, which we believe reduces unnecessary healthcare spending and provides greater patient access. We applaud Congress and the Administration for taking this difficult, but necessary step in addressing payment parity and we urge CMS to ensure implementation of Section 603 achieves the goal of equalizing payments across sites of service.

As you know, the law establishes a site neutral payment policy for all newly acquired provider based off-campus hospital outpatient departments (HOPD). The policy would exclude any newly acquired physician practice that does not operate on the main campus of the hospital from the Outpatient Prospective Payment System (OPPS) and would align their payments with other physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS). This policy appropriately levels the playing field to ensure the exact same care is reimbursed at the same payment level despite the delivery setting. The Alliance strongly supports Section 603 and believes that CMS should fully implement the provision as Congress intended.

Congress did not intend for additional grandfathering or exemptions from Section 603.
The law clearly states that any provider based off-campus outpatient department not billing Medicare before November 2, 2015 will receive payments aligned with physician rates under the ASC PPS or PFS. HOPDs already billing Medicare before November 2, 2015 are able to continue billing at the much higher OPPS rate for the same services. Efforts are currently underway to exempt HOPDs under construction, carve out PPS-exempt cancer hospitals and grandfather additional facilities from Section 603. CMS should reject these attempts to circumvent the intent of Section 603 as they would

result in increased costs for Medicare patients, Medicare, payers and employers.

The Alliance believes that the site neutral payment policy should apply to all off-campus outpatient departments and will continue to work with Congress to expand upon the progress made in the BBA. Medicare should be paying the same payment for the same service regardless of where it is performed, what it was billing before November 2nd or whether a facility was under construction prior to enactment of BBA. This would level the playing field for all off-campus outpatient care and provide stability and simplicity for seniors. Patients should not be burdened with higher costs for similar care because a hospital purchased their physician's office on November 1st instead of November 2nd.

This is especially relevant as it pertains to cancer care. Reimbursement levels for drug administration in the HOPD are, on average, 189 percent higher than reimbursement in the physician office [1]. An even more lucrative incentive exists for PPS-exempt cancer hospitals (PCHs) with outpatient departments. As you know, PCH outpatient reimbursement is based on the OPPS system with an aggregate add-on adjustment based on PCH reported costs. This unique payment structure means that PCHs have little to no reason to reduce costs and can, in fact, collect greater Medicare revenue by increasing their costs. In 2012, the outpatient setting accounted for the majority of Medicare payments for most PCHs. According to a 2015 GAO report, Medicare payment adjustments to PCHs resulted in overall reimbursements that were 37 percent higher, on average, than payments Medicare would have made to HOPDs for the same set of services[2]. That same report recommended, that not only should PCHs be paid at a lower rate, but that "all forgone outpatient payments be returned to the Trust Fund." A Section 603 carve out for PCHs would undermine the intent of the BBA and allow PCHs to exploit the existing disparity in cancer care services through uninhibited expansion of their outpatient departments. PCH outpatient departments should be reimbursed at the same level as OPPS HOPDs under Section 603.

Congress did not intend for Medicare to continue to pay facility and professional fees under Section 603.

The intent of the site-neutral provision was to implement payment parity for services provided in the HOPD with services provided in the physician office or ambulatory surgical center. If Medicare continues to pay HOPD facility and professional fees, it will perpetuate the acquisition of community-based practices by hospitals and fail to stem healthcare marketplace consolidations. The additional fees paid to HOPDs are a large component of the disparity in payment between HOPDs and the physician office setting. In chemotherapy the payment to a hospital outpatient facility is nearly three times the rate paid to a community cancer clinic ($136 vs. $390).[3] According to a study published by The National Institute of Health Care Reform[4], the average price for magnetic resonance imaging (MRI) of a knee was about $900 in hospital outpatient departments compared to about $600 in physician offices or freestanding imaging centers. Likewise, the average hospital outpatient department price for a basic colonoscopy was $1,383 compared to $625 in community settings. For a common blood test—a comprehensive metabolic panel—the average price in hospital outpatient departments was triple the price—about $37 compared to $13 in community settings.

[1] IMS Institute for Healthcare Informatics, "Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report," May 2014.
[2] GAO, "Payment Methods for Certain Cancer Hospitals Should Be Revised to Promote Efficiency." February 2015
[3] Community Oncology Alliance
[4] Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services, The National Institute for Health Care Reform (NIHCR): Published online June 2014

Section 603 of the BBA was intended to curtail consolidation, preserve patient choice in care settings and decrease costs in the Medicare system. If Medicare continues to reimburse HOPDs at a higher rate by including facility and professional fees, the result will be larger patient co-pays for patients who receive services at HOPDs and increased costs to Medicare, businesses and taxpayers. CMS should implement Section 603 simply as an alignment of payment for provider based off-campus hospital outpatient departments with the appropriate ASC or PFS rate.

CMS Should Utilize Data from the Off-Campus Billing Modifier

In the CY 2015 Medicare Physician Fee Schedule Final Rule, CMS included a requirement for hospitals to add a modifier to claims for facility and professional services provided in off-campus HOPDs. The data that will be gathered as a result of this requirement will let CMS measure for itself the financial costs to beneficiaries and the Medicare program when physician offices are, with little change other than those associated with medical recording keeping and billing systems, converted into HOPDs. We are confident that this information will further highlight the shift of care to HOPDs and the costs of services provided in off campus hospital-based physician practices.

A recent GAO report examining trends in vertical consolidation between hospitals and physicians corroborates this claim. The December 2015 report found that the number of vertically consolidated hospitals increased from about 1,400 to 1,700, while the number of vertically consolidated physicians doubled from about 96,000 to 182,000 from 2007-2013. The study also revealed the total Medicare payment rate for a mid-level E/M office visit was $51 higher when the service was performed in an HOPD instead of a freestanding physician's office.[5] In the oncology space, the proportion of chemotherapy delivery in the office-based setting has declined from 86.5 percent to 67 percent nationally between 2005 and 2011.[6]

The Alliance believes that collecting and distributing this data will help build additional support to advance recommendations made by bipartisan lawmakers, the Administration, the Medicare Payment Advisory Commission, the Government Accountability Office and a broad group of healthcare stakeholders to expand site neutral payment policies. While Section 603 is expected to save 9.3 billion dollars over 10 years, data suggest that expanding this policy to <u>all</u> off-campus outpatient departments could save an additional 10 to 20 billion dollars - adding much needed solvency to the Medicare trust fund.

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the consideration of our comments on implementation of Section 603 of the BBA. We are happy to serve as a resource to you and welcome any questions about the issues, concerns and suggestions discussed above.

Sincerely,

The Alliance for Site Neutral Payment Reform

cc: Patrick Conway, MD, MSc
Acting Principal Deputy Administrator, Deputy Administrator for Innovation & Quality,
CMS Chief Medical Officer
Centers for Medicare & Medicaid Services

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[5] GAO, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 2015.

[6] The Moran Company, "Results of Analyses for Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2011 for Medicare Fee-for-Service Beneficiaries," May 2013