ALLIANCE FOR
SITE NEUTRAL
PAYMENT REFORM

September 6, 2016

VIA ELECTRONIC SUBMISSION THROUGH **www.regulations.gov**

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1656-P)

Dear Acting Administrator Slavitt:

As members of the Alliance for Site Neutral Payment Reform, we appreciate the opportunity to comment on the Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1656-P) as published on July 14, 2016 in the *Federal Register*.

The Alliance for Site Neutral Payment Reform is a coalition of patient advocates, providers, employers and payers advocating for payment parity across site of service in order to decrease Medicare and commercial spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs and increase patient access.

Section 603 of the Bipartisan Budget Act of 2015 (BBA) establishes a site neutral payment policy for all newly acquired off-campus outpatient provider-based departments (off-campus PBDs). This provision, estimated to save $9.3 billion over a 10-year period, marks an important first step in equalizing Medicare payments across site of service, will reduce unnecessary healthcare spending and provide greater patient access to care. 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. We applaud CMS' proposed implementation of Section 603 and would like to share specific comments in the following areas.

Relocation of "Excepted" Off-Campus (PBD)
The Alliance agrees with CMS' interpretation that the BBA provided "excepted" status to off-campus PBDs as they existed on the date of enactment and thus prohibits relocation of "excepted" facilities. Allowing relocation for "excepted" off-campus PBDs would provide an avenue for these entities to purchase additional physicians practices and move into larger facilities while continuing to charge patients and Medicare higher costs.

Stemming consolidation in the healthcare marketplace was a key driver in the creation of Section 603 as policymakers are recognizing the negative effects that hospital acquisition of independent physician practices has on healthcare costs and access to care. A recent report from the Government Accountability Office (GAO) 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 rates for a mid-level E/M office visit are $51 higher when performed in a hospital outpatient department (HOPD) instead of a freestanding physician's office.[1]

Section 603 of the BBA was intended to curtail consolidation, preserve patient choice in care settings and decrease costs in the Medicare system. The Alliance encourages CMS to include its proposed policy on the relocation of "excepted" off-campus PBDs in the final rule.

Service Expansion in an "Excepted" Off-Campus (PBDs)

The Alliance commends CMS' proposed restriction on the scope of services "excepted" off-campus PBDs are able to furnish and bill at the higher OPPS rate. CMS correctly surmises that allowing "excepted" facilities to expand beyond their current scope of services will perpetuate the acquisition of community-based practices by hospitals and fail to achieve the BBA's intent of curtailing consolidation and achieving savings in the Medicare system.

Payment differentials in Medicare have put community clinics at a direct disadvantage in the delivery of the same care provided in hospital outpatient departments, resulting in a significant shift of outpatient care from the community setting to the HOPD. In oncology, reimbursement levels for drug administration in the hospital outpatient department are189 percent higher than reimbursement in the physician office[2] providing a lucrative incentive for hospitals to purchase community cancer clinics, change their Medicare designation and charge patients and Medicare higher costs. Data illustrating this shift shows the proportion of chemotherapy delivery in the physician office-based setting declined from 84% to 54% nationally between 2004-2014.[3] Patients, Medicare and taxpayers are on the hook for these increased costs.

CMS does not prevent "excepted" off-campus PBDs from expanding the services available at their facilities. Appropriately the proposed policy will reimburse new service lines beyond the clinical family of services offered at the facility after the November 2, 2015 enactment date at the same level for the same services provided in freestanding clinics.

Provider Based Status Rules

As CMS references in the proposed rule, the process for hospitals to attest that their provider-based facilities meet requirements for receiving higher OPPS payments is currently voluntary. OIG recently reviewed CMS' oversight of provider-based billing and released a report with its findings and recommendations. OIG reviewed 50 hospitals that had not voluntarily attested for all of their off-campus provider-based facilities and found that more than three-quarters of those hospitals owned

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[1] GAO, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 2015.
[2] The Moran Company, "Results of Analyses for Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2011 for Medicare Fee-for-Service Beneficiaries," May 2013.
[3] Milliman, "Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014," April 2016.

off-campus facilities that did not meet at least one requirement[4] for higher OPPS reimbursement. Medicare often pays over 50 percent more for services performed in provider-based facilities than for the same services performed in freestanding facilities[5]. With Medicare patients responsible for copayments of 20%, the increased cost to both patients and Medicare for services provided at non-compliant facilities could be substantial. The Alliance recommends CMS institute mandatory attestation for all hospital provider-based facilities to protect patients and Medicare from overpaying for services provided in non-compliant facilities.

Data from the Off-Campus Billing Modifier

The Alliance supports the requirement for hospitals to add a modifier to claims for facility and professional services provided in off-campus provider-based facilities included in the CY 2015 Medicare Physician Fee Schedule Final Rule. 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 record 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 provider-based facilities.

According to MedPAC's March 2015 Report to Congress, from 2012 to 2013, the use of Medicare services provided in a hospital outpatient setting, which includes provider-based facilities, increased by nearly 4 percent, and over the past seven years, the cumulative increase was 33 percent. This increase was due, in part, to hospitals purchasing freestanding facilities and converting them to provider-based facilities.[6]

The Alliance believes that CMS' collection and distribution of this data will help build additional support to advance efforts to expand site neutral payment policies.

Proposed Payment Policy for CY 2017

CMS is proposing items and services furnished in off-campus PBDs be paid under the Medicare Physician Fee Schedule (MPFS) in 2017. As CMS collects comments on developing a new payment policy for off-campus PBDs, the Alliance encourages CMS to explore the creation of a single outpatient payment fee schedule to reimburse for all outpatient care. Ensuring Medicare pays the most appropriate amount for the same service regardless of the setting has support from bipartisan lawmakers, the Administration, MedPAC, GAO, OIG and a broad group of healthcare stakeholders. Beginning in 2017, depending on the setting, outpatient care will be paid under the OPPS, MPFS or ASC. Medicare patients will continue to navigate a complex payment system with varying copayment amounts for services depending on whether that service is provided in an "excepted" off-campus PBD, freestanding physician office or an ambulatory surgical center. Creating a single outpatient schedule will provide vital transparency and certainty for patients, as well as simplify billing and reimbursement for providers and CMS.

The Alliance believes that the site neutral payment policy should apply to <u>all</u> 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. CMS estimates that implementation of Section 603 will save Medicare $330 million in

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[4] OIG, "CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain," June 2016
[5] MedPAC, Report to the Congress: Medicare Payment Policy, March 2011
[6] MedPAC, Report to the Congress: Medicare Payment Policy, March 2015

2017 alone while data suggest that expanding this policy to all off-campus provider-based facilities could save an additional 10 to 20 billion dollars[7] - adding much needed solvency to the Medicare trust fund. Patients should not be burdened with higher costs for similar care solely because a hospital purchased their physician's office on November 1st instead of November 2nd.

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the consideration of our comments on the Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1656-P). 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

[7] CBO, Proposals for Health Care Programs—CBO's Estimate of the President's Fiscal Year 2016 Budget, March 2015