ALLIANCE FOR
SITE NEUTRAL
PAYMENT REFORM

September 11, 2017

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

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Calendar Year (CY) 2018 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1678-P)

Dear Administrator Verma:

As members of the Alliance for Site Neutral Payment Reform, we appreciate the opportunity to comment on the Calendar Year (CY) 2018 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1678-P) as published on July 20, 2017 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 sites 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 and choice.

In November 2016, CMS finalized several site neutral payment policies within its 2017 OPPS Final Payment Rule. The Alliance commended CMS's implementation of Section 603 of the Bipartisan Budget Act of 2015 (BBA), specifically adoption of the Medicare Physician Fee Schedule (PFS) as the applicable payment system for nonexcepted off-campus provider-based departments (PBDs) and limiting the relocation and change of ownership of off-campus outpatient departments not covered by the site neutral law. These policies represent important progress toward leveling the playing field to ensure the exact same service is reimbursed at the same rate when clinically appropriate care is delivered across different settings. The Alliance thanks CMS for its previous efforts and encourages CMS to consider the following recommendations to help further lower costs for patients, provide savings and stability to the Medicare program and promote competition in the health care marketplace.

Apply Site Neutral Payment Policies to All Off-Campus PBDs

While passage of BBA marked an important step toward payment parity for outpatient care, it also created an additional layer of complexity for patients. Beginning this year and depending on the setting, outpatient care delivered at an off-campus PBD could be covered under the OPPS, PFS or ASC payment

rules. This forces Medicare patients to navigate multiple payment systems with varying copayment amounts for the same services depending on whether that service is provided in an excepted off-campus PBD, nonexcepted off-campus PBD, PPS-exempt cancer hospital, freestanding physician office or an ambulatory surgical center. This system is overly-complex and complicated. Both patients and Medicare should be paying the ***same*** amount for the ***same*** service regardless of where it is performed.

BBA was estimated to save $9 billion over 10 years, but substantial Medicare savings remain. Our own internal analysis estimates extending the BBA's site neutral policy to all off-campus PBD services where a comparable service exists under the PFS or ACS would save approximately $33 billion over 10 years. The Alliance urges CMS and the Administration to work with Congress to provide vital transparency and certainty for patients and solvency for the Medicare program by applying the site neutral payment policy to all clinically appropriate off-campus PBD services.

Limit Service Line Expansion for Excepted Off-Campus Provider-Based Departments (PBDs)
The proposed rule invites comment on proposals to limit clinical service line expansion or volume increases at excepted off-campus PBDs. The Alliance strongly supports a restriction on the scope of services excepted off-campus PBDs can furnish and bill at the higher OPPS rate and urges CMS to move forward with this policy.

Stemming consolidation in the health care marketplace was the primary goal in the creation of the BBA's Section 603 as Congress began to recognize the negative effects that hospital acquisition of independent physician practices is having on health care costs and access to care. Allowing excepted off-campus PBDs to continue to expand beyond their current scope and volume of services will only 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 policies that support higher reimbursement in the hospital outpatient setting encourage the acquisition of office-based physician practices, further restricting patient access to care in the lower cost community setting. Since 2008, community cancer clinics have experienced a 172 percent increase in consolidation into hospitals, which has resulted in a 30 percent shift in the site of service for chemotherapy administration from the physician-office setting to the costlier hospital outpatient setting. Alarmingly, hospitals aren't just looking to take advantage of the 104 percent payment differential on cancer treatment,[1] they are aiming to dominate entire marketplaces through the acquisition of independent physician practices. A recent study by Avalere found hospital ownership of physician practices increased to one in four in 2015 when 13,000 physician practices alone were acquired in a six-month period from July 2014 to January 2015.[2] When access to community-based care is impacted, patients and Medicare are on the hook for increased health care costs.

CMS accurately notes that a proposed limitation on service line expansion would not prevent excepted off-campus PBDs from expanding the services available at their facilities as some have argued. New services would simply be reimbursed at the more appropriate PFS rate rather than the higher OPPS rate. **The Alliance urges CMS to propose and finalize policies restricting the range of items and services excepted off-campus PBDs can bill at the OPPS rate.**

[1] Hospital Outpatient Prospective Payment - Final Rule with Comment and Final CY2017 Payment Rates (CMS-1656-FC)
[2] Avalere, PAI: Physician Practice Acquisition Study: National and Regional Employment Changes, October 2016

Require Attestation for All Off-Campus PBDs

Currently, CMS does not require hospitals to attest that their off-campus provider-based facilities meet requirements for receiving higher OPPS payments. Just last year, the Office of the Inspector General (OIG) reviewed CMS's oversight of provider-based billing and found that more than three-quarters of the 50 hospitals reviewed, that had not voluntarily attested for all their off-campus provider-based departments, owned off-campus facilities that did not meet at least one requirement for higher OPPS reimbursement.[3] Medicare often pays more than 50 percent more for services performed in excepted off-campus PBDs than for the same services performed in freestanding facilities. With Medicare patients responsible for copayments of 20 percent, the increased cost to both patients and Medicare for services provided in non-compliant facilities could be substantial. **The Alliance recommends CMS institute mandatory attestation for all excepted off-campus PBDs to protect patients and Medicare from overpaying for services provided in non-compliant facilities.**

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the consideration of our comments on the Calendar Year (CY) 2018 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1678-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
www.siteneutral.org

[3] OIG, "CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain," June 2016