



September 24, 2018

VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1695-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model (CMS-1695-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) 2019 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1695-P) as published on July 31, 2018 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.

The Alliance commends CMS for expanding site neutral payment policies in the 2019 proposed rule and continuing momentum toward ensuring the exact same service is reimbursed at the same rate despite the setting. In the proposed rule, CMS appropriately builds upon policies enacted over the past two years to reimburse all newly built and newly acquired off-campus provider-based departments (PBDs) at the Physician Fee Schedule (PFS)-equivalent payment rate and limit relocation and change of ownership of excepted PBDs. While these policies are a step in the right direction, CMS accurately notes that the majority of off-campus PBDs continue to receive the full OPPS payment. The Alliance fully supports CMS' proposals to implement site neutral payments for outpatient clinic visits and services in new clinical families of services furnished at **all** off-campus PBDs and encourages CMS to continue to explore opportunities to implement site neutral payments for all clinically appropriate outpatient services.

Proposal to Control for Unnecessary Increases in the Volume of Outpatient Services

CMS proposes to institute the PFS-equivalent rate for clinic visit services performed at excepted off-campus PBDs to control unnecessary volume increases in the outpatient setting for these services. The Alliance strongly supports payment parity for Evaluation & Management (E&M) services performed at all off-campus PBDs.

While the Alliance supports site neutral payments across all outpatient services, we are encouraged by CMS' efforts to align payments for the most commonly billed service: E&M office visits. Currently, Medicare pays \$51 more for a basic E&M visit when it is performed in a hospital outpatient department (HOPD) than in a physician's office. Those costs add up. According to a recent MedPAC analysis, Medicare spent an additional \$1.6 billion and patients were out an extra \$400 million in out-of-pocket costs in 2015 due to higher payment rates for E&M visits in HOPDs.

CMS correctly recognizes that payment differentials between the OPPS and the PFS have incentivized hospitals to acquire freestanding physician practices to gain access to higher reimbursement rates. Between 2012 and 2015, the number of physicians employed by hospitals grew by 49 percent nationwide. From July 2014 to July 2015 alone, the number of hospital owned practices grew by approximately 18,000.¹ These acquisitions have resulted in a costly shift in site of service from the physician-office setting to the higher paid HOPD. In a three-year period, hospital-based E&M visits per beneficiary grew by 22 percent, compared with a -1 percent decline in the physician-office setting.²

While the proposed site neutral payment policy for E&M services in the rule is a needed step in the right direction, the Alliance urges the agency to examine other opportunities to further payment parity in the outpatient setting. Data demonstrates that HOPDs drive up volume for several other common outpatient services:

- Patients receive more chemotherapy administration sessions on average when treated in the HOPD. Chemotherapy days per beneficiary were an estimated 9 to 12 percent higher in the hospital outpatient department than the physician office setting.³
- Differences in utilization of chemotherapy drugs and services between hospital outpatient departments and physicians' offices resulted in an estimated increase in Medicare and Medicare beneficiary payments of \$167.28 million. Over 93 percent of the additional payments were related to chemotherapy and other chemotherapy-related drugs.⁴
- Cardiac imaging procedures resulted in higher payments for a 3-day episode (217 percent) and 22-day episodes (80 percent) when performed in a HOPD compared to a physician's office.⁵
- For certain cardiology, orthopedic and gastroenterology services, employed physicians were 7 times more likely to perform services in a HOPD setting than independent physicians resulting in additional costs of \$2.7 billion to Medicare and \$411 million in patient co-pays over a three-year period.⁶

The Alliance strongly supports CMS' proposal to equalize payment rates between HOPDs and freestanding physician practices for E&M visits. This proposal is a step toward ensuring patients receive the right care in the right setting and will result in Medicare savings totaling \$610 million and beneficiary

¹ Physicians Advocacy Institute: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017

² MedPAC: Report to Congress; March 2017

³ The Moran Company: Cost Differences in Cancer Care Across Settings; August 2013

⁴ BRG: Impact of Medicare Payments of Shift in Site of Care for Chemotherapy Administration; June 2014

⁵ Avalere: Medicare Payment Differentials Across Outpatient Settings of Care; February 2016

⁶ Avalere, PAI: Physician Practice Acquisition Study: National and Regional Employment Changes, October 2016

savings of \$150 million in 2019 alone. The Alliance is encouraged by the Administration's attention to the negative consequences payment disparities between outpatient settings has on marketplace consolidation, patient access to care and volume of services performed in HOPDs and urges CMS to continue to evaluate all options available to bring payment parity across clinically appropriate outpatient services.

New Clinical Families of Services at Excepted Off-Campus Provider-Based Departments (PBDs)

The proposed rule includes a proposal to reimburse new clinical families of services at excepted off-campus PBDs at the PFS-equivalent rate. This proposal was included in the CY 2017 rulemaking process but was not included in the final rule. The Alliance appreciates CMS revisiting this policy and urges CMS to finalize it for CY 2019.

The Alliance agrees with CMS that stemming consolidation in the health care marketplace was the primary goal in the creation of Section 603 of the Bipartisan Budget Act of 2015 (BBA). Congress recognized the negative effects that hospital acquisition of independent physician practices was having on health care costs and access to care and included Section 603 to curb this practice. The Alliance believes that allowing excepted off-campus PBDs to continue to reap higher reimbursement levels for new services defies the BBA's intent of curtailing consolidation and achieving savings in the Medicare system and will only perpetuate the acquisition of community-based practices by hospitals.

Most off-campus PBDs are not subject to Section 603 and therefore are able to take advantage of higher payment rates for a wide variety of services, including: chemotherapy: \$281 vs. \$136⁷; cardiac imaging: \$2,078 vs. \$655; colonoscopy: \$1,383 vs. \$625; even a basic blood test costs \$24 more when performed in a HOPD.⁸ Given the significant payment disparities for certain services, hospital systems have been gobbling up certain specialties. According to a study in Health Affairs examining hospital-physician consolidation by specialty, cardiology and oncology practices had the highest rates of growth in vertical integration, increasing by about 34 percent from 2007 to 2017.⁹ When access to community-based care is impacted, patients and Medicare are on the hook for increased health care costs. Implementing site neutral payments for new clinical families of services helps remove an incentive for hospitals to purchase physician practices.

It is important to note that CMS' proposal would not prevent excepted off-campus PBDs from expanding the services available at their facilities. New clinical families of services would simply be reimbursed at the more appropriate PFS-equivalent rate rather than the higher OPPS rate. **The Alliance urges CMS to finalize payments for new clinical families of services at excepted off-campus PBDs at the PFS-equivalent rate.**

Opportunities to Further Site Neutral Payments

The Alliance applauds CMS for its site neutral proposals and encourages the agency to take further action to ensure payment parity across sites of service.

While implementation of BBA marked an important step toward payment parity for outpatient care, it also created an additional layer of complexity for patients. 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

⁷ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 (CMS-1676-P)

⁸ NIHCR: Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services, Published online June 2014

⁹ Health Affairs: Hospital-Physician Consolidation Accelerated in the Past Decade in Cardiology, Oncology; July 2018

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.

Section 603 of the 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 which is in line with the Administration's proposal in the fiscal year 2019 budget. **The Alliance urges CMS and the Administration to take further regulatory action 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.**

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the consideration of our comments on the Calendar Year (CY) 2019 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1695-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