Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 2, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1601-P
P. O. Box 8013
Baltimore, MD 21244-1850

REF: CMS-1613-P

Re: Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs for 2015

Dear Administrator Tavenner,

The Catholic Health Association of the United States (CHA) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the above notice of proposed rulemaking (NPRM).

1. Expanded Packaging

CHA supports the expanded packaging proposed by CMS for 2015, but we are concerned about CMS' suggestion of expansion of ancillary service packaging in future years. The proposed rule would expand packaging to include ancillary services with a mean cost of less than $100; all prosthetic supplies; and most add-on codes. Although CHA is generally supportive of packaging, we wish to emphasize that packaging decisions must be considered cautiously and some services should not be packaged – for example, expensive and infrequently used items and services. If packaged, such items and services would add only a small amount to the payment rate, but a hospital serving a patient base that often required them would be inadequately paid for the services. Imbalances of this nature can harm both beneficiary access to important services and hospitals. It is for this reason that we oppose further packaging of ancillary services. We believe that the 2015 proposal to package only lower cost ancillary services addresses this concern, but we are disturbed by the clear indication in the proposed rule of CMS' intention to expand ancillary packaging in future years. We ask CMS to reconsider further packaging.

We also urge CMS to provide a much greater amount of impact information on its packaging proposals, including data on a hospital encounter rather than only on an individual

service basis. We request that the public be provided information showing how proposals' impacts vary by hospitals' patient mix and type of hospital. In the 2015 proposed rule, for example, very little information is provided on the proposal to package all prosthetic supplies. The rationale given in the proposed rule is inadequate because the agency argues for a policy to package prosthetic supplies used in conjunction with implanted prosthetics, stating that the non-implantable prosthetic supplies are integrally related to the implanted portion and part of the full service. From this foundation, the proposed rule then merely states that the agency believes that all prosthetic supplies should be packaged as medical supplies. Regarding the expansion to all prosthetic supplies, the proposed rule provides the public with no information about what supplies would be affected and what the impact of packaging them would be.

CHA is pleased that CMS will continue to exclude chemotherapy services from the proposed expansion of packaging of add-on services.

CHA is concerned that packaging has increased beneficiary copayments since prior to 2014, no coinsurance was applicable for lab services. We raised this concern in our comments on the 2014 proposed rule. In the 2014 final rule, CMS finalized its proposal to package lab services and stated that net beneficiary coinsurance would not increase considering all of the changes in the final rule. Despite this claim, however, the final rule's impact analysis showed total beneficiary liability for OPPS payments for 2014 increasing from 20.4 to 21.7 percent, a 1.3 percentage point increase that represents more than $650 million of additional patient liability each year. CHA requests that CMS address this problem by correcting how the coinsurance amount is determined for each APC. CMS should calculate the coinsurance amount without considering the portion of the payment rate due to the packaged lab services. Such a change would protect beneficiaries from increased out-of-pocket costs, re-establish consistency with congressional intent that lab services have no coinsurance, impose no burden on hospitals, and add a doable new calculation step for CMS as it determines the coinsurance amount.

2. Composite APCs

CMS proposes several revisions to the comprehensive APCs (C-APCs), which were finalized in the FY 2014 final rule for implementation in CY 2015. As finalized in the 2014 rule, C-APCs would have applied to 29 of the 39 device-dependent APCs. For 2015, CMS proposes to consolidate and restructure all of the 39 current device-dependent APCs into 26 C-APCs (of the total 28 C-APCs), thus eliminating use of device-dependent APCs beginning in 2015. CHA commends CMS for the changes made in the structure of C-APCs since the FY 2014 final rule, especially the refined complexity adjustment which greatly improves the identification of complex, high cost cases.

CHA is concerned, however, about CMS' proposed policies to expand C-APCs to all device-dependent APCs as well as two additional APCs coupled with the encompassing packaging policies for C-APCs. Expanding the C-APC policy to include new APCs results in lower-cost APCs being treated as C-APCs, as compared to the FY 2014 proposal when the policy applied only to 29 of the 39 device-dependent APCs, most of which involved high cost

devices. Five of the 28 C-APCs proposed for 2015 have a payment rate under $3,500. Thus, many hospital outpatient encounters will involve a non-J1 procedure from a relatively high paying APC but which is performed with and packaged into a lower paying C-APC. For example, C-APC 0622, Level II Vascular Access Procedures, has a payment rate of $2,517.04, and is a service that is frequently performed with higher paying surgeries, yet the hospital would be paid only $2,517.04 for the vascular access procedure and nothing for the surgery. CHA urges CMS to address this problem, for example, by not applying the C-APC packaging policy to these cases; or by always basing payment on the higher paying procedure even if another procedure on the claim has status code J1, and paying second and subsequent procedures based on the multiple procedure discount policy (if the primary service has status indicator T and not S). We recognize that all other services on the claim might be packaged with, and paid as part of, the C-APC consistent with the structure of C-APCs.

CHA also is concerned about the long span of days included in many C-APC claims, sometimes approaching 30 days. We recommend that CMS limit the services included in the C-APC to services that are provided on the day of the J1 procedure or no more than 2 days following the day of the J1 service, and to services provided prior to the J1 procedure during the same encounter.

Finally, CHA continues to be concerned that CMS may be under-funding the OPPS in its budget neutrality calculation. The proposed rule indicates that the costs of all services previously paid outside of the OPPS based on other payment systems were added to the OPPS base in calculating the budget neutrality scalar. The proposed rule, however, provides no information concerning how this was done and no data to allow the public to review the determination of budget neutrality. The proposed rule refers the reader to a section of the preamble purported to provide this information, but the information was inadvertently omitted. CHA strongly urges CMS to make complete data available to the public.

3. Collapsing hospital visit codes

CHA commends CMS for not finalizing its 2014 proposal to collapse Type A emergency department and Type B emergency department visits. We continue to be concerned that moving to a single code for emergency department visits could disadvantage certain types of patients and hospitals, especially since CMS has greatly expanded the scope of packaging in the OPPS. Moving to a single ED visit code could disadvantage hospitals treating severely ill or injured ED patients, or those with more complex conditions. In addition, patients with longer, more complex ED visits are the patients that likely would require more diagnostic services, lab tests and other ancillary services that CMS has packaged or proposes to package.

CHA believes that CMS must examine the combined impact of all OPPS policies on total reimbursement of all of the services provided during actual patient encounters, as represented in claims data, for particular patients and the hospitals serving them, including possible differential impacts by type hospital. In addition, both the findings and the supporting data of

these analyses should be released to the public to allow for informed comment on the proposals during a public comment period.

4. Provider-Based Clinics

In the proposed rule, CMS expresses a continuing concern with hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments. CMS proposes to collect information to analyze the frequency, type and payment for services furnished in provider-based departments in order to better understand the impact of these acquisitions on beneficiaries and on the program. Specifically, CMS proposes to collect this information by creating a HCPCS modifier to be reported on both the CMS-1500 claim form and the UB-04 form (CMS Form 1450) with every code for physicians' services and outpatient hospital services furnished in an off-campus provider-based department of a hospital.

CHA is concerned about the scope of this data collection and believes that requiring hospitals to report a HCPCS modifier at the line item level will impose a significant burden. We suggest CMS reconsider its proposal, develop a less burdensome approach, and consider testing such a new approach on subset of providers before applying it more generally.

5. Hospital Outpatient Quality Reporting (OQR) Program; Ambulatory Surgical Center Quality Reporting (ASCQR) Program

CHA agrees with CMS that the measure "OP-31: Cataract—Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery" should not be implemented for the OQR and ASCQR programs as previously finalized. However, we do not agree with the proposal to continue it as a voluntary measure. Instead we recommend that OP-31 be removed entirely from the OQR Program. As we noted in our comment letter on the CY 2014 OPPS/ASC proposed rule, this measure was designed as a physician measure, not for facility reporting, and was not specified or tested in the facility setting. As CMS has now acknowledged, it would be difficult for hospitals to obtain the information necessary to report on patient vision status before and after surgery. Moreover, the underlying purpose of the OQR and ASCQR programs is to require facility reporting on a specific set of measures in order to receive a full payment update factor, and there is no reason to identify voluntary measures within that context, which can be confusing for hospitals and ASCs.

CHA does not support the proposed addition of the claims-based measure "Facility Seven Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy" to the OQR and ASCQR programs in 2017. This measure is not yet endorsed by the National Quality Forum (NQF), and the Measure Applications Partnership indicated support on the condition that it receive NQF endorsement, noting that the NQF process would resolve a number of questions about the reliability, validity and feasibility of this measure. In general, to avoid having measures suspended or withdrawn after adoption, CHA recommends that CMS wait until the NQF has endorsed the measure and it has been tested. In this case, hospitals have had an opportunity to

consider the measure specifications as part of a post-endorsement dry-run of the measure calculations.

CHA supports the proposed removal of three "topped-out" measures from the OQR Program: OP-4: Aspirin at Arrival (NQF # 0286); OP-6: Timing of Antibiotic Prophylaxis; and OP-7: Prophylactic Antibiotic Selection for Surgical Patients (NQF # 0528). We also support the alignment of the definition of "topped out" for the OQR and ASCQR programs with the definitions used in the inpatient quality reporting and hospital value-based purchasing program.

Finally, CHA supports the decision by CMS not to require separate inpatient and outpatient hospital reporting of the measure "OP-27: Influenza Vaccination Coverage among Healthcare Personnel." The proposed rule indicates that this reporting would be submitted by CMS Certification Number (CCN), although we now understand this was further clarified in the FY 2015 IPPS/LTCH final rule. Hospitals will report this measure for all patient units within the facility's National Healthcare Safety Network Organization Identification that also share a CCN.

In closing, thank you for the opportunity to share these comments in regard to the proposed CY 2015 OPPS rule. We look forward to working with you on these and other issues that continue to strengthen the country's hospitals and health care system. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy