



*A Passionate Voice for Compassionate Care*

December 29, 2016

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

REF: CMS-1656-IFC

**Re: Medicare Program: Payment to Non-excepted Off-Campus Provider- Based Department of a Hospital; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital**

Dear Mr. Slavitt,

The Catholic Health Association of the United States (CHA) is pleased to submit these comments to the Centers for Medicare and Medicaid Services (CMS) on the calendar year (CY) 2017 Hospital Outpatient Prospective Payment System (OPPS) final rule and the Interim Final Rule with Comment (IFC) establishing Medicare payment under the Medicare physician fee schedule (MPFS) for new off-campus provider-based departments (PBD) that are subject to section 603 of the Bipartisan Budget Act of 2015 (section 603).

We appreciate your staff's ongoing efforts to administer and improve Medicare's payment systems for outpatient hospital services, especially considering the agency's many competing demands and limited resources. As we discuss in greater detail below, CHA is grateful for the many changes that CMS made in the CY 2017 OPPS final rule in response to public comments on the agency's proposed implementation of section 603. In the CY 2017 OPPS final rule, CMS also included an IFC where it established a new MPFS that would apply only in off-campus PBDs of hospitals that are not excepted from section 603. In the final rule and the IFC, CMS specifically requested public comments on:

- The MPFS payment rates for non-excepted items and services furnished and billed by non-excepted off-campus PBDs, and

- The potential limitation on clinical service line expansion or volume of services by non-excepted off-campus PBDs.

Below, we address these specific issues as well as review the changes that CMS made in the final rule in response to public comments including those from the CHA.

### **Current and Future Payment to PBDs Subject to Section 603**

When a physician provides a service in the office, Medicare's payment to the physician is at the non-facility MPFS rate which recognizes that the physician incurs direct and indirect expenses (the cost of the office) for the service. If the physician provides that same service in a hospital, Medicare's makes payment to the physician as a lower MPFS facility rate to reflect that the physician no longer incurs the direct costs of furnishing the service. Those direct costs are incurred by the hospital. The hospital also has indirect institutional costs which are analogous (although higher because the hospital must meet health and safety regulations that do not apply to physician offices) to the indirect office costs incurred by the physician. The hospital is compensated for both these direct and institutional costs through its payment under the OPFS.

Under the proposed rule, CMS would have made payment only to the physician at the higher non-facility MPFS rate when a service is furnished in a non-excepted off-campus PBD. CMS proposed not to make any separate facility payment to the hospital for non-excepted services furnished during CY 2017. Under CMS' proposal, hospitals could either seek compensation for their expenses from the physician or separately enroll as a non-institutional provider that would seek payment using a practitioner claim rather than an institutional claim.

CHA opposed the proposal to leave hospitals unpaid and raised several concerns including the lack of details about reimbursement under the MPFS for a number of specific services ("incident to" services, Part B drugs, laboratory services, the technical component of diagnostic tests, observation services, and partial hospitalization services). In the final rule, CMS did not finalize its proposal and instead adopted a policy to pay for outpatient hospital services at a special MPFS rate equal to 50 percent of payment under the OPFS that will be applicable only to PBDs subject to section 603. **CHA is pleased that CMS has abandoned its proposal to provide no payment to non-excepted off-campus PBDs and will reimburse such PBDs at no less than 50 percent of the OPFS rate in 2017.**

CHA suggests the payment for non-excepted off-campus PBDs should be greater than 50 percent of the OPFS rate. First, CMS did not make any adjustment for packaging differences between the OPFS and the MPFS. Further, CMS' analysis uses only the portion of the MPFS payment that accounts for the direct costs of the service and does not include any amount for indirect costs that the hospital would continue to incur when a service is furnished in an off-campus PBD subject to section 603. We believe CMS' analysis should use the full non-facility practice expense payment rather than the difference between the non-facility and facility practice expense

payment so that the hospital is paid an amount for all of its costs, not just its direct costs. If CMS' analysis accounted for packaging differences and used the full non-facility practice expense payment, we believe the MPFS as a percent of OPSS payment would be higher than 50 percent.

CMS indicates in the IFC that the percentage reduction for CY 2017 is a transitional policy subject to adjustment should CMS have better data in the future. **CHA urges CMS to maintain this percentage at 50 percent (or higher) and not reduce the percentage of the OPSS payment paid to non-excepted off-campus PBDs.** CHA member hospitals provide services to low income and rural communities. We are concerned that section 603 already will affect potential access to health care by lessening our members' ability to meet the changing needs of the communities they serve. Reducing payment to hospitals further can only lessen access to needed services in these vulnerable communities.

For 2019 and subsequent years, CMS indicates that it is considering continuing its current methodology (a special MPFS rate that is a percentage of the OPSS payment) or paying based on the MPFS itself. The IFC indicates that where CMS will pay based on the MPFS, payment will equal Medicare's full non-facility practice expense payment for technical component and "incident to" services where payment is not made under the physician fee schedule in the facility site. In other cases, Medicare's payment would equal the difference between the MPFS' non-facility and facility payment.<sup>1</sup>

In Table X.B.1 of the IFC, CMS provides the MPFS payment amounts that would be used for 22 services if CMS adopted a policy to pay non-excepted off-campus PBDs using the MPFS. For those services where Medicare would pay the full non-facility practice expense payment, the reductions could be as much as 82 percent (CPT code 93017). For services where Medicare pays the difference between the non-facility and facility MPFS amounts, the reductions would be even higher and the payments would be clearly insufficient. For example, Medicare would pay a non-excepted off-campus PBD only \$0.36 for CPT code 90834 (Psychotherapy, 45 minutes). Paying \$0.36 for 45 minutes of use of a hospital outpatient department is clearly unreasonable and insufficient.<sup>2</sup>

Hospital outpatient clinic visits are the most commonly furnished services in off-campus PBDs. While Medicare uses CPT codes to pay for clinic visits under the MPFS, it uses G0463 to pay for outpatient clinic visits. The discussion in the rule<sup>3</sup> suggests that if CMS were to use the MPFS to pay for the most commonly furnished clinic visits, payment could decline from \$102.12 to \$29.02 for 99214 and to \$21.86 for 99213—respective reductions of 71 and 79 percent respectively. We believe reductions of this magnitude would set the rates well below the hospital's costs of providing outpatient clinic visits and would be inadequate.

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<sup>1</sup> 81 FR 797928, November 14, 2016.

<sup>2</sup> 81 FR 79724-79725, November 14, 2016

<sup>3</sup> 81 FR 79723

CHA's primary concern is that whatever payment methodology CMS chooses to implement for services in non-excepted off-campus PBDs results in adequate payment for the essential services provided. Based on the discussion in the IFC, we believe the current methodology of making payment based on a percentage of the OPSS is more likely to produce adequate payment to maintain access to health care services in the vulnerable communities that are served by CHA hospitals.

### **Use of the Institutional Claim Form and the 340B Drug Program**

In our November 14, 2016 comment letter to CMS, CHA expressed concern about the proposed rule's possible effect on continued eligibility of non-excepted PBDs for the 340B program. Regulations from 1994 implementing the 340B drug discount program state "the outpatient facility is considered an integral part of the "hospital" and therefore eligible for section 340B drug discounts if it is a reimbursable facility included on the hospital's Medicare cost report."<sup>4</sup> The CY 2017 OPSS final rule states "services provided at non-excepted off-campus PBDs will continue to be reported on the hospital cost report."<sup>5</sup> **CHA is pleased that CMS will allow hospitals to use the institutional claim form to bill for non-excepted PBD items and services, which will therefore be reported on the hospital cost report. This will allow for both continued 340B eligibility and appropriate cost reporting.**

### **Partial Hospitalization Services**

CHA was particularly concerned about the proposed rule's requirement that partial hospitalization services would only be paid in non-excepted off-campus PBDs if the PBD abandoned its status as a hospital outpatient department and enrolled as a Community Mental Health Center (CMHC). Partial hospitalization services are important to patients suffering from mental illness who represent some of our most vulnerable and neediest patients. **We thank CMS for allowing a non-excepted off-campus PBD to retain its hospital status and be paid based upon the CMHC rate rather than having to enroll as a CMHC in the final rule. Further, we appreciate CMS's decision to pay for partial hospitalization at the CMHC rate which is 58 percent rather than the 50 percent of the OPSS rate as CMS is doing with all other outpatient services provided in a non-excepted off-campus PBD.**

### **Proposed Qualification Date for Excepted Status**

An off-campus PBD "that was billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015" (the date of enactment) is excepted from section 603 and may continue to be paid under the OPSS. CMS proposed that a facility must have submitted a bill before November 2, 2015, to qualify for excepted status. CHA and others

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<sup>4</sup> 59, FR 47886, September 19, 1994.

<sup>5</sup> 81 FR 79718, November 14, 2016.

commented that the statute only requires a hospital to have furnished a service prior to the statute's enactment date to qualify for the exception.

**As requested in the public comments, CMS adopted a policy to base the exception on the date a service is furnished rather than the date a bill was submitted. CHA thanks CMS for considering our public comments and those of others in making this change in the final rule.**

### **Proposed Relocation Policy**

CHA objected to CMS' proposal that an excepted off-campus PBD would lose its excepted status if it moved or relocated from the physical address (including a change in the unit number of the address) listed on the provider's hospital enrollment form as of November 1, 2015. In the final rule, CMS would allow an excepted off-campus PBD to relocate in the limited instances of extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building code requirements, or significant public health and public safety issues, that necessitate moving to a new building (either temporarily or permanently) without losing its excepted status.

CHA is grateful that CMS has provided at least some flexibility with respect to relocation in the final rule. However, we remain concerned that excepted PBDs may need to relocate for other reasons than those provided in the final rule and should be allowed to do so without loss of their excepted status. For instance, in the proposed rule, we indicate that a landlord fully aware that an excepted off-campus PBD will lose its excepted status if it moves is in a strong position to demand far higher rents or concessions than would otherwise have been the case during normal lease negotiations. In such a situation, our efforts to serve the needs of communities, including the poor, the uninsured and the medically underserved, would be hindered by a policy that inadvertently favors a landlord over a tenant. CHA continues to question whether CMS has authority under Section 603 to impose restrictions on the ability of an off-campus provide to relocate to another address, as discussed in our September 6, 2016 comment letter.

In the final rule, CMS indicates "exceptions to the relocation policy will be evaluated on a case-by-case basis by the appropriate CMS Regional Office." **CHA requests that CMS instruct the Regional Offices to use their flexibility to recognize the needs of the communities served by our hospitals when deciding whether to allow an excepted off-campus PBD to relocate without losing its excepted status.**

### **Proposed Expansion of Services Policy**

CMS proposed to limit expansion of services in an excepted off-campus PBD within the "clinical families of services" it furnished before the enactment date of section 603. CMS did not finalize this policy and will allow off-campus PBDs excepted from section 603 to expand the number of services they provide. **CHA thanks CMS for considering the public comments on this issue**

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**and not finalizing its proposal that would limit expansion of services in excepted off-campus PBDs.**

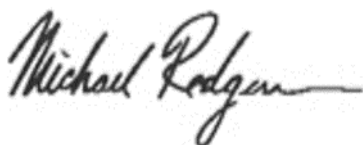
In the IFC, CMS requested comment on how either a limitation on volume of services, or a limitation on lines of service would work in practice. CHA reiterates the comments that we made on the proposed rule that:

- We believe the 603 statute makes excepted off-campus PBDs completely outside of the reach of section 603;
- A limit on service expansion will create confusion and undue burden for those excepted off-campus PBDs that begin to provide services in a new “clinical family” and would therefore have to bill under two different payment systems; and
- A limit on service expansion will hinder hospitals ability to meet the changing medical needs of their communities. Hospitals must also be able to adapt to changes in technology or best practice guidelines in the absence of large changes in payment depending on the services they choose to provide.

If CMS were to adopt a limitation on service expansion, CHA remains concerned that the policy would limit patient access to quality care in many areas and would result in the inefficient increase in emergency department visits, including at main providers, when an off-campus outpatient department would be far better suited to efficiently meet those health care needs. **CHA continues to oppose a limitation on service expansion in excepted off-campus PBDs and urges CMS not to adopt such a policy in the future.**

In closing, thank you for the opportunity to share these comments in regard to the CY 2017 OPPI final rule and the CY 2017 IFC implementing section 603. We look forward to working with you on these and other issues to continue to strengthen our nation’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