



September 6, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Proposed Rule for the Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program (CMS-1656-P)

Dear Acting Administrator Slavitt:

On behalf of approximately 425 primarily large employers, including 72 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees and their families, The National Business Group on Health appreciates the opportunity to comment on CMS' proposed OPPS changes for acute care hospitals for 2017. We applaud your leadership and that of the Secretary in continuing to transform traditional Medicare away from fee-for-service reimbursement toward alternative payment models that command value and efficiency.

Specifically, we support:

- **Implementing site-neutral payments** originally enacted as part of the Bipartisan Budget Act of 2015, which would eliminate disparate reimbursement rates for same services provided in different settings;
- **Removing the pain management dimension of the HCAHPS survey** for purposes of the Hospital Value-Based Purchasing ("VBP") Program – while the agency states there is no data to support that including the pain management dimension has led to an over-prescribing of opioids in the VBP program, our members are broadly supportive of delinking the pain score from financial incentives associated with prescribing, in light of the opioid epidemic;
- **Making certain packaging policy refinements and eliminating "unrelated laboratory tests"**, including adding new categories of packaged items and services – we agree with the agency's stance that packages encourage hospital efficiency, flexibility and long-term cost containment; and, realigning packaging to the claim level as opposed to the date of service,

which will promote consistency and ensure that items and services provided during a hospital stay spanning more than one day are appropriately packaged;

- **Adding seven measures to the Hospital OQR Program**, two of which are claims-based measures and five of which are Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures;
- **Adding seven measures to the ASCQR Program**, two of which will be collected via a CMS web-based tool and five of which are OAS CAHPS survey-based measures;
- **Updating OPPS rates by 1.55 percent**, which, after considering all other policy changes proposed under the OPPS, is estimated to result in a 1.6% payment increase for hospitals paid under OPPS in calendar year 2017 – we feel this is a reasonably modest but sufficient increase, which tracks with the overall rate of economic growth but also accounts for changes in medical practices, changes in technologies and the addition of new services, new cost data and other relevant information and factors;
- **Adding 25 new Comprehensive APCs** (each a “C-APC”) for a total of 62 C-APCs, including a bone marrow transplant C-APC and bone marrow transplant dedicated cost center;
- **Requiring a modifier on film X-ray claims** which would require hospitals to use a modifier on claims for X-rays that are taken using film, resulting in a 20% payment reduction for the X-ray service;
- **Removal of Total Knee Arthroplasty (TKA) Procedure from the Inpatient Only (IPO) List** which would increase provider flexibility for determining the best and most efficient use of hospital resources for TKA procedures; and,
- **Increasing transparency** through both the Hospital OQR and ASCQR Programs by publicly displaying data on the Hospital Compare Web site, or other CMS Web site, as soon as possible after measure data have been submitted to CMS.

What Medicare does to improve efficiency and quality will have a valuable spillover effect for our health care delivery system, the health of the population and the nation’s economy. We look forward to continuing to work with you to transition our nation’s health care system to one based on value, quality and health improvement. Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health’s Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,



Brian Marcotte
President and CEO

Addendum

Site Neutral Payments

We commend CMS' efforts to implement Section 603 of the Bipartisan Budget Act of 2015 (BBA, P.L. 114-74), to foster new alignment of reimbursement rates provided for some services performed at provider-based, off-campus hospital outpatient departments (HOPDs) with those typically reimbursed under applicable existing fee schedules for freestanding outpatient and physician offices. Through Section 603 of the BBA, Congress sought to focus payments on services, rather than the setting. As the agency well knows, the race for vertical integration in the hospital and provider communities has led to an increase of disproportionate reimbursement rates at off-campus HOPDs, which has not been linked to an increase in resources expended for same services, or an overall improvement in quality of patient care.

First, we are pleased that CMS proposes to put in place specific measures to prevent excepted HOPDs from relocating to a new off-campus location, as any such relocations might enable hospitals to move into larger facilities, acquire additional freestanding physician practices, and move those practices into OPPS-reimbursed departments, which the BBA intended to exclude. Along those lines, we are also pleased that CMS proposes to interpret this classification strictly and will include the physical address that was listed on the provider's hospital enrollment form [CMS-855A] as of November 1, 2015, which will also include any unit number associated with the physical address.

We encourage CMS to additionally consider language that would limit an excepted HOPD's ability to expand within its existing footprint as well, as we feel that the same arguments that the agency made for limiting relocation would also apply to substantial additions to an existing facility, particularly in the case of a newly constructed facility floor or wing.

Second, we support the establishment of 18 clinical families of services, and the agency's distinction that only excepted HOPDs billing within one of those 18 clinical families prior to the enactment of the BBA would be eligible for reimbursement under the OPPS on a going-forward basis. Through the establishment of these clinical families, we understand that CMS seeks to enforce equitable reimbursement for "expected items and services" provided by provider-based departments, on the basis of whether or not they are truly providing hospital-based services. To the extent that an HOPD is providing care that is not considered hospital-based, but is being reimbursed at higher levels simply by virtue of consolidation, and not because that care is linked to proportionately improved outcomes, we welcome this important clarification by the agency.

Through the Medicare Payment Advisory Commission (MedPAC), we know these disparate reimbursement payments exist within the Medicare population. For example:

- Medicare reimburses \$453 for a level II echocardiogram performed in an off-campus HOPD vs. \$189 in a doctor's office

- Similarly, Medicare reimburses \$1,383 for a colonoscopy performed in an off-campus HOPD vs. \$625 in a doctor's office

Employers have also become aware of a wide variation in site-of-service billing practices at off-campus HOPDs. While transparency tools are being made available to employees to facilitate medical shopping and encourage cost-consciousness, these efforts alone are not enough as employers search for ways to control their health benefit expenses.

This payment differential has encouraged hospitals to acquire physician practices in order to receive the higher rates. This difference in payment also increases costs for the Medicare program and raises the cost-sharing liability for beneficiaries.

With that in mind, we also encourage CMS to work with the Congress to eliminate the grandfathering of arrangements in existence prior to enactment of the BBA. Left intact, these arrangements will inhibit the growth of cost effective and innovative payment and delivery systems, such as Accountable Care Organizations (ACOs) and other alternative payment models. At a minimum, we would encourage CMS to work with the Congress to develop a scheduled phase out of these existing arrangements over a reasonable time period. Allowing existing arrangements to be grandfathered 1) raises questions of fairness, 2) could provide a regulatory protection from competition for the grandfathered entities and 3) could inhibit the growth of lower cost alternatives in the affected areas.

Removing HCAHPS Pain Management Dimension from Value-Based Purchasing Program

We support CMS's efforts to address physicians' and other stakeholders' concerns regarding pain management. Additionally, our members share the concerns that any link between scoring well on pain management and higher hospital payments may create perverse incentives to overprescribe opioids. Because some hospitals have identified patient experience as a potential source of competitive advantage, we agree that there is a legitimate concern that how a hospital rates on pain management may unduly impact its overall HCAHPS Survey scores.

Additionally, we strongly support CMS's efforts to develop an electronically-specified process measure for the inpatient and outpatient hospital settings that would measure concurrent prescribing of an opioid and benzodiazepine. Our members are acutely aware of the social and economic costs associated with substance abuse and are increasingly becoming aware of additional classes of medications of concern, such as benzodiazepines. We look forward to CMS's additional guidance on this issue, and also look forward to working with the agency and other appropriate authorities on this important public health crisis.

Changes to Packaged Items and Services

We strongly support CMS' initiatives to move away from the traditional fee-for-service reimbursement model, in favor of alternative payment models such as payment bundles and packages, among other approaches. We agree with CMS that these types of reimbursements create incentives for hospitals to furnish services most efficiently and to manage their resources

with maximum flexibility. To that end, we believe the current CMS model of aligning conditional packaging modifiers to the date-of-service, as opposed to the claim, may create circumstances where items and services provided during outpatient hospital visits that span more than one day are being paid for separately, as opposed to packaged. Thus, we support the proposal to align conditional packaging modifiers to the claim level and believe this change will more accurately capture all appropriate claim-related charges.

Related to the packaging improvements, we are also pleased to see that CMS seeks to remove the maligned modifier for separately payable laboratory tests in the proposal. Stakeholders have commented that the L1 modifier, as it is known, is operationally burdensome and confusing to report. If the proposal is adopted, it would allow all laboratory tests that appear on a claim with other hospital services to be packaged, even if ordered by a different provider for a different diagnosis than the other services.

Both of these proposals support CMS' as well as employers' strategic goals of using larger payment bundles to maximize hospitals' incentives to provide care in the most efficient manner. Packaging or bundling also encourages hospitals to effectively negotiate with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care delivery.

Expanding Hospital OCR Program Quality Measures

We support efforts to continue the emphasis of the Hospital OQR Program on quality reporting for hospital inpatient services focused on measures that have high impact and support national priorities for improved quality and efficiency of care, as well as on conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. To that end, we strongly support the new claim-based quality measures and have detailed our positions below:

Admissions and emergency department visits for patients receiving outpatient chemotherapy (OP-35)

Recognizing that cancer care is a priority area for outcome measurement, because of its combined prevalence and cost, and also recognizing that cancer patients who receive chemotherapy in a hospital outpatient department require more frequent acute care in the hospital setting and experience more adverse events than cancer patients who are not receiving chemotherapy, we agree with CMS that it is imperative to include a measure to monitor admissions and ED visits for patients that receive outpatient chemotherapy in the Hospital OQR Program. Additionally, publicly reporting results would encourage providers to improve their quality of care and lower rates of adverse events that lead to hospital admissions or ED visits after outpatient chemotherapy.

Hospital visits after hospital outpatient surgery (NQF #2687; OP-36)

Most adverse events that occur after outpatient surgery, such as uncontrolled pain, infection, bleeding, etc., which can result in unanticipated hospital visits, are often

preventable. We agree with CMS that incorporating this risk-standardized measure would provide the opportunity for providers to improve the quality of care and to lower the rate of preventable adverse events that occur after outpatient surgery.

Additionally, we also support the OAS CAHPS survey-based measures, which are focused on facilities and staff (OP-37a), communications about procedures (OP-37b), preparation for discharge and recovery (OP-37d), overall rating of facility (OP-37d); and, recommendation of facility (OP-37e). By assuring that payment mechanisms increasingly reward providers who are better performers on both quality and safety, adjusting for relevant factors, public and private payers can play an important part in improving patient outcomes. Patient-reported outcomes are an integral part in understanding how the delivery system is performing and also helps to bridge a partnership with patients.

Expanding ASCQR Program Quality Measures

Normothermia Outcome (ASC-13)

Because many surgical procedures performed at ASCs involve anesthesia, we support the proposal to adopt the normothermia outcome measure. We agree with CMS that the measure would promote improvement in patient care over time, because measurement coupled with transparency in the public reporting of the data would make patient outcomes following procedures performed under general or neuraxial anesthesia more visible to ASCs and patients. Likewise, as with the increase in transparency in Hospital OCR Program, this would have the effect of incentivizing ASCs to incorporate quality improvement activities to reduce perioperative hypothermia and associated complications where necessary.

Unplanned Anterior Vitrectomy (ASC-14)

Based on the prevalence of cataract surgery in the ASC setting, we agree with CMS that it's important to minimize adverse patient outcomes associated with cataract surgery. Therefore, we support the proposal to adopt the ASC-14 and expect that the measure will promote improvement in patient care over time, again, because measurement coupled with transparency in public reporting of the data would make the rate of this unplanned procedure at ASCs more visible to both ASCs and patients. Similarly, this visibility would incentivize ASCs to incorporate quality improvement activities to reduce the occurrence of unplanned anterior vitrectomies.

Additionally, we also support the OAS CAHPS survey-based measures (ASC-15a-e), which will establish a baseline for a standardized collection of information on the patient's overall experience for surgeries or procedures performed within an ASC. Currently, no such standard exists. And while some ASCs are conducting their own surveys and reporting these results on their Web sites, others are not, and there is no method for meaningful comparisons across ASCs. We strongly support the collection of this data, in a uniform and patient-friendly manner, and its subsequent publication in a transparent and easy-to-read manner.

Removal of Total Knee Arthroplasty (TKA) Procedure from the Inpatient Only (IPO) List

We agree that total knee arthroplasty (TKA) or total knee replacement, CPT code 27447 (Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)), which has traditionally been considered an inpatient surgical procedure, could now be performed on an outpatient basis.

When this procedure was initially listed as IPO, it was considered highly invasive and required at least 24 hours of post-operative care. Since 2000, as CMS points out, the average hospital stay for this procedure has been reduced from 4.6 days in 2000, to 2.8 days in 2016, due in large part to medical innovation. With advances in minimally invasive techniques, improved perioperative anesthesia, alternative postoperative pain management, and expedited rehabilitation protocols, we feel that it's imperative to minimize unnecessary inpatient hospitalizations that could expose patients to a host of hospital-acquired conditions and infections.

While we understand certain patients will require inpatient admission for TKA procedures, absence from the IPO list does not preclude the procedure from being performed on an inpatient basis. However, IPO listed procedures must be performed on an inpatient basis in order to qualify for Medicare payment, which removes provider flexibility in determining the best course of treatment for a patient. Given that IPO list status of a procedure has no effect on the Medicare Physician Fee Schedule (MPFS) professional payment for the procedure, it seems to make perfect sense to remove the TKA from being listed as an IPO procedure.