MHA
MISSOURI HOSPITAL ASSOCIATION

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U. S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201-0007

Re: 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 its 148 member hospitals, the Missouri Hospital Association offers the following comments regarding the Centers for Medicare & Medicaid Services' hospital outpatient prospective payment system and ambulatory surgical center payment system proposed rules for fiscal year 2017. We appreciate the opportunity to do so.

APPLICATION OF SECTION 603 — PAYMENT TO CERTAIN OFF-CAMPUS OUTPATIENT DEPARTMENTS OF A PROVIDER

However one may view the merits or demerits of the policy set by Section 603 of the Bipartisan Budget Act of 2015, the process of enacting it was not afforded the normal care and due diligence generally given to legislative initiatives. It was enacted three days after first being unveiled as part of a conference committee accord, with the payment change affecting billing status as of the date of enactment. Hospitals with pending development projects involving their off-campus hospital outpatient departments watched their government upend the apple cart regarding their plans for ensuring the financial viability of the projects. Without warning, a new and unexpected payment rubric was imposed on projects already underway. Recognizing the challenge of that action, more than half of the U.S. House of Representatives and Senate signed a joint letter calling for CMS to use its regulatory authority to provide some flexibility in the implementation of Section 603. CMS' response is reflected in this proposed regulation. Essentially, the answer is "no."

CMS augments the damage done by Section 603 by further tightening the restrictions limiting the availability of OPPS payment to off-campus, provider-based hospital outpatient departments. If a hospital is sold in its entirety, its exempted off-campus, provider-based outpatient department services would retain its exemption. Otherwise, any change in ownership incurs the loss of the OPPS payment. Similarly, any relocation of services will be accompanied by a reimbursement reduction. This seems certain to curtail or at least impede relocations that otherwise would be done to improve the efficiency of service delivery or convenience to Medicare enrollees. Also, the proposed rule limits the availability of OPPS reimbursement to those types of services being delivered at the time of enactment, with an administratively burdensome requirement to document that any added services are in the same clinical family of services as was offered before this new standard.

MHA recommends that the final rules not compel the loss of OPPS payment eligibility for an otherwise qualified off-campus HOPD based on:

- change of ownership to another qualified hospital
- relocation of the HOPD facility, or
- changes in the type or volume of services it provides

There is nothing in Section 603 which mandates the additional restrictions imposed by the proposed rules.

CMS also is proposing to use the Medicare Physician Fee Schedule as the basis for the majority of non-exempted items and services provided in an off-campus HOPD during calendar year 2017. This will limit or eliminate reimbursement to non-exempted HOPDs for laboratory, imaging, chemotherapy, surgical and other reasonable and necessary services. CMS states that this is a one-year “fix” to allow CMS to continue to explore operational changes needed to permit non-exempted HOPDs to bill and be paid for Medicare services under a Part B payment system other than the OPPS beginning in CY 2018. It is no “fix” at all, but a 12-month evasion of the agency’s responsibility to pay for services rendered to Medicare enrollees. CMS should not hold clinics hostage due to lack of operational structures to make payments for services necessary to treat Medicare beneficiaries. CMS has the authority and precedent to delay implementation to effect the operational changes needed to ensure that these services will be paid. It should do so.

RURAL SOLE COMMUNITY HOSPITAL ADJUSTMENT

MHA applauds CMS for proposing to continue the rural adjustment paid to certain rural sole community hospitals. This adjustment helps hospitals continue to offer needed outpatient services to those in rural areas.

PACKAGED OUTPATIENT AND UNRELATED LABORATORY SERVICES

CMS is proposing to change the packaging logic from date of service to claim-based. Due to some outpatient claims spanning multiple dates of services, MHA believes that CMS should continue to package services based on date of service and not apply the logic on a per-claim basis.

CMS also is proposing to eliminate the unrelated laboratory test modifier that allows hospitals to receive payment for normally packaged laboratory tests. Laboratory tests which are unrelated to the other services provided for that day should be separately payable. MHA recommends that CMS remove this proposed requirement in the final rule.

HOSPITAL INPATIENT PPS VALUE-BASED PURCHASING PROGRAM — PAIN MANAGEMENT

MHA supports CMS' proposal to remove the pain management dimension questions within the Hospital Consumer Assessment of Healthcare Providers and Systems survey for the purposes of calculating the inpatient PPS value-based payment program payment adjustments. While unsubstantiated, some have suggested that the pain management questions create an incentive for hospitals to encourage the use of opioids for pain control. By eliminating these questions from the VBP program, concern about this potential effect is resolved. MHA asks CMS to consider suspending public reporting of the measures while alternative metrics are developed for FY 2018.

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

MHA suggests that the proposed Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems survey is too long. We recommend shortening the 37-question survey to narrow its focus based on the goals of the national quality strategy.

CMS mentions in the proposed rule that it is developing an eCQM to capture the proportion of patients 18 and older who have an active prescription for an opioid and an additional opioid or benzodiazepine prescribed during the encounter. As Missouri is the only state that has not authorized the creation of a prescription drug monitoring system, MHA recognizes and supports the value of this measure.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

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