September 8, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Subject: Program Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (42 CFR Parts 4-5, 410, 414, 424, and 425, [CMS 1676-P] RIN 0938-AT02)

Attention: CMS-1676-P

Dear Administrator Verma:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the draft proposed changes in the Medicare physician fee schedule for calendar year 2018. This regulation was published in the *Federal Register* on July 21, 2017 (Vol. 82, No. 139), pp. 33950-34303.

NAUH wishes to comment on two aspects of the proposed rule: the continued implementation of the site-neutral payment policy for outpatient services and payments for telehealth services.

Continued Implementation of the Site-Neutral Payment Policy for Outpatient Services

Physician Payments for Outpatient Services

For 2017, CMS introduced a new policy under which Medicare payments to hospital outpatient departments were paid under the physician fee schedule and reduced to 50 percent of the outpatient prospective payment system (OPPS) rate for hospital-based services if the services in question were delivered in off-campus, provider-based hospital outpatient departments established after November 2, 2015. CMS based this new, site-neutral payment rate – 50 percent of the OPPS rate – on its analysis of claims data for a limited set of specific factors. CMS employed a different calculation for its 2018 analysis and gained a very different outcome: another 50 percent reduction on top of last year's 50 percent reduction. At the same time CMS conceded, in the proposed rule, that its latest analysis was the best it will be able to do under the circumstances until it can study 2017 claims data.

NAUH disagrees strongly with implementing such a drastic payment reduction based on the results of this calculation that was performed, albeit out of necessity, before reliable data were available. The result of

21351 Gentry Drive, Suite 210, Sterling, VA 20166
Phone: 703-444-0989, Fax: 703-444-3029
www.nauh.org

the 2018 methodology is very different from the 2017 methodology and remains insufficient to address differences in patient mix and service mix at different types of off-campus provider-based hospital outpatient departments as well as differences in the packaging of services between the OPPS and physician fee schedules.

If nothing else, the significant changes in methodology and the resulting, drastically different payment levels suggest that CMS is still in the process of developing a clear, supportable methodology for determining what site-neutral payments should be. Under such circumstances – the enormous reduction in payments providers would suffer, coupled with the misgivings about its own choices and the underlying calculations that CMS expresses in the draft regulation – NAUH believes these hospital outpatient department payments should remain 50 percent of the OPPS rate for 2018. Providers should not be subject to such drastically different annual analyses and outcomes.

NAUH also would like to point out the planning challenges such a significant decrease in payments pose for providers. Hospitals that applied to be grandfathered under the Bipartisan Budget Act of 2015 still have not, in some cases, received a decision on those applications. In addition, some planned facilities that were considered financially viable even under 2017's reduced payments may no longer be feasible if 2017 rates are cut in half. Worse, hospitals that have not completed investment in new outpatient facilities face what they now must view as a very uncertain future and question whether even more large cuts may come in the future. Medicare wants more health care delivered on an outpatient basis and significant progress has been made along these lines in recent years, but that progress could be halted in an environment of such uncertainty. NAUH encourages CMS to restore stability to Medicare's reimbursement of outpatient care so hospitals can focus on locating their services where those services are needed and providers can focus on serving their patients. It can begin doing so by keeping 2018 reimbursement at the same 50 percent level as 2017 reimbursement.

The Ability of Facilities to Move and Retain Hospital-Based Status

As we did last year, NAUH urges CMS to consider expanding the circumstances under which hospital-based outpatient clinics can move their facilities without losing their hospital-based status. Some such circumstances – lost leases, the sale of the buildings in which they are located, and the shifting needs of hospitals' local communities – are beyond hospitals' control, and NAUH believes hospitals should not be penalized when they incur such challenges. That penalty would be even greater than it currently is, moreover, if this regulation is adopted as proposed and such providers were to face the prospect of a 75 percent cut of their fees. This would place many such facilities in great jeopardy and almost certainly result in some of them closing – closings that would greatly reduce access to care in communities, such as those many urban safety-net hospitals serve, that already have very limited access to care. The same should be true for facilities that are meeting community needs and simply need more space to accommodate the demand for their services: they should be permitted to pursue larger facilities that will enhance their ability to serve their patients without losing their hospital-based status and facing the unenviable – and perhaps, unacceptable – prospect of a 75 percent cut of their Medicare payments.

The Ability of Facilities to Expand Their Services and Retain Hospital-Based Status

Similarly, NAUH urges CMS to loosen the restrictions on the expansion of services without loss of hospital-based status. We believe it should be government policy to encourage providers to deliver more care on an outpatient basis and not to penalize it, and at times this can mean responding to a community demand that was not present, or not known, at the time a hospital-based outpatient facility was established. Consider, for example, the possibility of an outpatient facility that offers a number of services, such as neurology and orthopedics, that address pain issues and that wish to expand those

services to help patients who have become addicted to the opioids prescribed in the past to help them deal with their pain. Public policy should encourage new approaches to dealing with the opioid epidemic, but current policy on hospital-based outpatient departments could discourage the introduction of such efforts – or even penalize it. NAUH believes public policy should encourage the provision of needed care and asks CMS to consider defining circumstances under which hospital-based outpatient departments could be permitted to expand their service offerings without suffering enormous financial penalties – an unsustainable 75 percent cut in fees, if this proposed regulation is adopted – or being discouraged from attempting to address new and emerging patient needs and demands. The proposed payment decrease would not only make it impossible for providers to do more to meet their communities' needs but also may jeopardize what they are already doing to address those needs.

The goal of the site-neutral payment policy was to curb the proliferation of hospital-acquired physician practices that were being converted into outpatient departments, but the prohibition on expanding the mix of services at existing outpatient departments simply limits hospitals' ability to meet the changing needs of their communities rather than achieving the goal of the policy.

Payments for Telehealth Services

Telehealth is an excellent means of helping to address the health care needs of Medicare beneficiaries who live in geographically isolated and medically underserved areas. For the most part, telehealth has been used to serve beneficiaries in rural areas. For 2018, CMS proposes adding seven services to the list of those for which Medicare will reimburse for telehealth services. NAUH supports this proposal.

Geography, however, is not the only factor that limits access to medical services, and for this reason, NAUH urges CMS to take steps to facilitate greater use of telehealth services in non-rural areas. Specifically, there are many urban areas across the country that have been designated medically underserved areas or health professional shortage areas by the Health Services and Resources Administration. NAUH believes Medicare beneficiaries who live in such communities are no less deserving of federal policies that seek to enhance their access to care than residents of rural areas and therefore urges CMS to take steps to expand the use of telehealth services. The result, we believe, would be better, more appropriate care and very possibly even reduced overall health care costs as Medicare beneficiaries receive assistance with their medical problems in a more timely manner. For this same reason, NAUH also urges CMS to consider even greater use of telehealth, beyond both its current parameters and its expansion to medically underserved and health professional shortage areas, as we have recommended.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

* * *

NAUH appreciates the opportunity to present these comments to CMS and welcomes any questions you may have about the views we have expressed.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director