NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

September 24, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject:42 CFR Parts 416 and 419 [CMS-1695-P], RIN 0938-AT30, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs: Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model

Attention: File Code CMS-1695-P

Dear Administrator Verma:

I am writing on behalf of the National Association of Urban Hospitals to convey our views on the proposed Medicare outpatient prospective payment system regulation for 2019 that was published in the *Federal Register* on July 31, 2018 (Vol. 83, No. 147, pp. 37046-37240).

NAUH would like to address three aspects of the proposed regulation:

- quality data reporting proposals
- modifications to site-neutral payments
- proposed changes in ambulatory surgical center payments

We address each of these issues individually below.

Quality Data Reporting Proposals

In this proposed regulation, the Centers for Medicare & Medicaid Services (CMS) calls for reducing the number of quality measures hospitals must report to CMS. Those reductions include measures that are considered duplicative, those that CMS considers "topped out," and those for which CMS considers the cost of reporting to be greater than the benefits of the quality measure.

NAUH appreciates CMS's proposal to reduce the data reporting requirements we now face and wishes to express our support for this proposal.

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Modifications to Site-Neutral Payments

Contrary to the administration's general and laudable trend toward removing unnecessary administrative burdens, the proposed outpatient prospective payment system rule contains three provisions associated with site-neutral payments that would increase administrative complexity rather than reduce it while reducing programmatic consistency in the application of Medicare outpatient payment policy.

Under the site-neutral payment system, off-campus provider-based departments are paid under the physician fee schedule rather than the hospital outpatient prospective payment system. This policy applies to new off-campus provider-based departments while existing off-campus provider-based departments are exempt.

The 2019 rule proposes to further delineate when site-neutral payments will be applied at a service-specific level. The result would be that rather than having two payment policies in place, there would now be six, depending on when the department opened, whether it provides 340B drugs, whether it provides clinic visits and whether it was grandfathered but began providing a different mix of services after a point in time not definitively stated in the proposed rule.

NAUH believes the additional administrative complexity associated with this approach outweighs the potential for these proposals to achieve their policy goals.

It is not services but institutions that must establish and interact with billing systems, anticipate revenues, and determine how (and whether) they will be able to address the unmet health care needs they identify in their communities. All of this becomes exceedingly complex when institutions are treated not as cohesive entities but as patchworks of different service lines.

Clinic Rates for Services at Exempted Off-Campus Provider-Based Departments

The proposed rule contains a provision that the Secretary would use her authority under 1833(t)(2)(F) to reduce the rates paid to exempted off-campus provider-based departments to match the site-neutral version of the rate – essentially removing the site-neutral exemption for a single type of service provided at exempted departments. The basis of this authority is to "develop a method for controlling unnecessary increases in the volume of covered OPD services."

NAUH disagrees with the idea that reducing reimbursement for clinic visits is an effective method for controlling unnecessary increases in the volume of covered outpatient services. Although similar services can be safely provided in more than one setting, CMS's conclusion that providing care in the more expensive setting is unnecessary presumes that the patients who require these services have access to both types of settings. In reality, the opposite is often true: urban safety-net hospitals that operate off-campus provider-based departments often do so because they are attempting to address a need in their communities. Rather than increasing the volume of unnecessary services, the payment differential enables safety-net providers to create access to necessary services in communities where these services would otherwise be unavailable in any setting. NAUH asks CMS not to "throw out the baby with the bathwater" by cutting reimbursement for necessary outpatient department services just because there may be circumstances where an alternative setting might be available.

In NAUH's view, the proposed regulation for 2019 takes the site-neutral payment policy too far, and in so doing it ultimately could jeopardize access to vital forms of care for entire urban communities.

The recent practice of reducing payments even to exempted hospital-based, off-campus facilities is harmful: harmful to those practices, harmful to the hospitals that own and operate those practices, and harmful in the long run, NAUH believes, to many of the patients these practices serve. NAUH continues to object to Medicare reimbursing non-excepted, provider-based physician practices at physician fee schedule rates. These rates fail to reflect the hospital-related costs associated with such practices – costs such as maintaining emergency departments, operating laboratories, offering comprehensive radiology services, complying with regulatory requirements not imposed on independent physician practices, and much more. These are valid costs that benefit entire communities, and further reducing these payments, as proposed in this regulation, would jeopardize major parts of the health care infrastructure that every urban community – and every community, for that matter – truly needs.

Proposed Changes in Extension of Clinical Families of Services in Hospital-Based Facilities

In the past, CMS proposed paying Medicare physician fee schedule rates when hospital-based off-campus facilities expand their services in response to patient and community needs. Faced with considerable opposition from the provider community, CMS relented and agreed to apply the exemption from the site-neutral policy at a facility level rather than at a level specific to "service families." NAUH supported this decision because we believe it would be inappropriate to limit excepted departments' ability to update their service mix to meet community needs, especially when the site-neutral payment rate is calculated as a percentage of the outpatient prospective payment system rate and does not reflect the specific mix of services as they would be reimbursed under the physician fee schedule.

In the proposed regulation, however, CMS proposes reversing this relatively new policy. NAUH opposes this proposed change because we believe it is contrary to the public's clear interest in introducing important changes in the delivery of medical care when those changes will improve or save lives. This proposal creates for safety-net hospitals the same challenges as the site-neutral clinic proposal. Specifically, it increases administrative complexity while restricting hospitals' ability to target identified needs in challenged communities. NAUH believes it is not effective public policy to limit safety-net providers' ability to pursue their missions simply to reduce the potential of undesired behaviors among a few actors – particularly at a time when there is no evidence that any such undesired action has occurred. NAUH urges CMS to reconsider this proposal and continue to pay outpatient prospective payment system rates to exempted hospital-based, off-campus physician practices for expanded services.

Proposed 340B Changes

In addition to proposing to pay exempted departments as if they were non-exempted for certain services, the rule proposes paying non-exempted departments as if they were exempted for 340B-purchased prescription drugs. This requirement would actually pay hospital outpatient departments less than non-hospital setting practices (assuming both settings are dispensing 340B-covered drugs) while at the same time widening the gap in costs between the two settings. NAUH opposes this proposal.

The idea behind the 340B program is to help improve access to high-cost drugs for low-income patients. If off-campus provider-based physician practices are serving enough low-income patients to qualify to participate in the 340B program, what possible public policy rationale could there be for reducing these payments? Is the goal of the 340B program no longer to enhance access to high-cost drugs for low-income patients? If CMS's concern in this situation mirrors that of its overall concern about the 340B program – that is, questioning how providers use the savings derived from the 340B discounts – there are better ways of addressing that concern than by cutting off patients in need. NAUH urges CMS not to respond to its concerns about how 340B savings are used by jeopardizing the health of low-income 340B participants. If provider-based physician practices continue to meet the eligibility requirements for 340B participation then they should continue to be eligible to participate in that program.

Through this proposed regulation, CMS already proposes equalizing Medicare physician payments for outpatient care delivered outside of hospitals. By permitting non-hospital-based physician practices to continue participating in the 340B program if they meet the eligibility criteria, however, this proposal would result in the incongruous, inappropriate, and – in NAUH's view – indefensible situation in which private physician practices, with their greatly reduced cost structure and very limited role in their communities' health care infrastructure, could potentially end up being paid more than hospital-affiliated medical practices if those private practices are eligible to participate in 340B. NAUH can think of no public policy rationale either for eliminating 340B discounts for hospital-based facilities or for continuing to extend them to private physician offices when those discounts are no longer available to hospital-based physician practices. For these reasons, NAUH urges CMS not to adopt the changes it has proposed for the 340B program.

Proposed Changes in Ambulatory Surgical Center Payments

NAUH objects to the proposal to bring ambulatory surgical center fees closer to those paid to hospitals for outpatient services. Ambulatory surgical centers are fundamentally different providers than hospitals, free of many of hospitals' regulatory and financial responsibilities while also, significantly, free of the civic institutional responsibilities inherent in being part of a community's health care infrastructure. Ambulatory surgical centers have far fewer administrative requirements, must comply with fewer data reporting requirements, face fewer licensing requirements, and are subject to fewer government inspections. In addition, they are surprisingly free of any role or responsibility in a community other than making money for their owners: they avoid providing costly, unprofitable services such as mental health care or delivering babies; they do not operate laboratories; they have minimal radiology equipment, if any. They do not provide emergency services at all: if their own patients experience emergencies, in fact, they are often unable to provide the full extent of assistance they need, depending instead on hospitals to provide emergency care. When a community suffers a fire or a natural disaster, no one takes patients to the nearest ambulatory surgical center. As the nation watched in recent weeks as communities on the east coast dealt with the effects of Hurricane Florence, there were no reports of injured patients being rushed to nearby ambulatory surgical centers for care. Ambulatory surgical centers are spectators in this vital part of the health care infrastructure of the communities in which they are located.

In the end, ambulatory surgical centers' costs are less than those of hospitals because they do not have hospitals' administrative and overhead costs and do not have to contribute to helping to pay for those costs. They do not contribute to the preservation of their communities' health care infrastructure and never step into a breach to provide a service their community needs that otherwise is unavailable. Bringing hospitals' payments for outpatient surgical procedures closer to what Medicare pays ambulatory surgical centers will, over time, erode communities' health care infrastructures, and their health care safety nets, by depriving hospitals of the resources they need to meet their communities' health care needs by providing services that no one else will provide because they are not sufficiently lucrative. Unless the federal government is prepared to intervene and provide – and fund – those services that no one else will provide, NAUH believes Medicare should continue paying its share of the cost of those services and not attempt to equate the work done by hospitals with that done by ambulatory surgical centers by treating them as equals – because in no way are these very different types of health care providers equals.

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.

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NAUH appreciates the opportunity to present these comments to CMS and invites questions about the concerns we have raised.

Sincerely,

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Executive Director