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September 8, 2017

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: File code CMS-1678-P**

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit comments on CMS's proposed rule entitled: "Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs," published in the *Federal Register* on July 20, 2017 (82 FR 33558–33724). We appreciate your staff's ongoing efforts to administer and improve the payment system for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs), particularly considering the agency's competing demands.

As you know, the outpatient prospective payment system (OPPS) classifies services provided in outpatient departments into ambulatory payment classification (APC) groups. Each APC group has a relative weight, which is an indexed measure of the resources needed to furnish a service. The OPPS determines payment rates for APCs as the product of the relative weights and a conversion factor. The ASC payment system largely uses the APCs and relative weights from the OPPS, but uses a different conversion factor to obtain payment rates. This proposed rule is similar to its predecessors in the sense that it documents changes in the composition of some APCs and proposes changes to the relative weights based on analysis of claims and cost report data. The rule also estimates the calendar year 2018 update to the conversion factors in the OPPS and the ASC payment system.

This rule also:

- Proposes to set the OPPS payment rates for nonpass-through, separately payable drugs provided in hospitals participating in the 340B drug pricing program at 22.5 percent below each drug's average sales price (ASP – 22.5 percent);
- Proposes to not set any limit on clinical service line expansion or volume increases in off-campus provider-based departments that are excepted from section 603 of the Bipartisan Budget Act of 2015;

- Proposes to remove six quality measures from the Hospital Outpatient Quality Reporting (OQR) Program;
- Proposes to remove three quality measures from the Ambulatory Surgical Center Reporting (ASCQR) Program and add three new quality measures to the program;
  - Percent of patients who have ophthalmic anterior segment surgery that are diagnosed with toxic anterior segment syndrome,
  - Rate of unplanned hospital visits within seven days after an orthopedic ambulatory surgical center procedure, and
  - Rate of unplanned hospital visits within seven days of a urologic procedure;
- Seeks comment on whether CMS should account for social risk factors in the OQR and ASCQR programs and what social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure;
- Solicits comments on the update factor for the ASC payment system, with interest in data from ASCs that would help determine whether the ASC payment system should continue to be updated by the consumer price index for all urban consumers (CPI-U) or by an alternative factor such as the hospital market basket, Medicare Economic Index (MEI), a blend of update factors, or other mechanism;
- Seeks comment on whether the Secretary should collect cost data from ASCs to use in determining ASC payment rates and comment on information related to ASC costs for items such as drugs, employee compensation, rent, and other inputs;
- Seeks comment on whether ASCs should bill on an institutional claim form rather than a professional claim form.

We focus our comments on the update to the ASC conversion factor and the topics listed above. We do not comment on the update to the OPPS conversion factor because the proposed update in this rule is largely consistent with the update that the Commission recommended in our March 2017 Report to the Congress. In contrast, the proposed update to the ASC conversion factor differs from the Commission’s recommendation to provide no update.<sup>1</sup>

### **Payment rates for nonpass-through separately payable drugs purchased under the 340B Drug Pricing Program**

The 340B Drug Pricing Program allows some hospitals and other health care providers (covered entities) to purchase “covered outpatient drugs” at discounted prices from drug manufacturers. Covered outpatient drugs include prescribed drugs and biologics other than vaccines. The 340B discounts for these covered drugs are substantial. According to the Health Resources and Services Administration (HRSA)—which administers the 340B program—the intent of the 340B program is to allow the covered entities to stretch scarce federal resources as far as possible to provide more care to more patients.

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<sup>1</sup> Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

By statute, drug manufacturers that participate in the 340B program cannot sell drugs to covered entities at prices that exceed formula-based ceiling prices.<sup>2</sup> HRSA calculates a 340B ceiling price for each covered outpatient drug as the difference between the drug's average manufacturer price (AMP) and its unit rebate amount (URA). HRSA calculates URAs using a statutory formula that varies based on whether the drug is a single-source or innovator, multiple-source drug (that is, a brand name drug); a noninnovator multiple-source drug (a generic drug); or a clotting factor or exclusively pediatric drug.

In a May 2015 Report to the Congress, the Commission estimated the average discount on 340B drugs, which is the average difference between how much non-340B providers pay for these drugs minus how much 340B providers pay.<sup>3</sup> The Commission estimated an average discount of 22.5 percent. Because of data limitations, we view this estimate of the average discount as conservative—we believe the actual discount is greater.<sup>4</sup> Using data on actual prices, the Office of Inspector General estimated the aggregate discount to be 33.6 percent of ASP in 2013.<sup>5</sup>

In this proposed rule, CMS expresses concern about the growth in the number of providers participating in the 340B program and the high and growing prices of several separately payable drugs covered under Part B. CMS believes it is time to consider whether it is appropriate to continue to pay a rate of ASP+6 percent to hospitals that acquire drugs at the discounted rates under the 340B program. In response, CMS proposes to pay 340B hospitals for nonpass-through drugs that are separately payable under the OPSS at a rate of ASP–22.5 percent. This proposal would exclude drugs that have pass-through status and vaccines.

CMS believes that the Commission's lower bound estimate of the average discount—22.5 percent—adequately represents the average minimum discount that a 340B hospital receives for separately payable drugs. CMS's stated goal is to make Medicare payment for separately payable drugs more aligned with how much hospitals pay to acquire these drugs. CMS believes that section 1833(t)(14)(A)(iii)(II) of the Social Security Act allows the Secretary to make adjustments, as necessary, to the payment rates for nonpass-through drugs covered under the OPSS that are otherwise payable at a rate of ASP+6 percent.

CMS states that it does not believe that Medicare beneficiaries should be liable for copayment rates that are tied to the current rate of ASP+6 percent when the actual purchase price for the hospital is much less than ASP. Therefore, CMS proposes that beneficiaries' copayment rates would be based on ASP–22.5 percent for 340B drugs. In addition, CMS proposes to make this policy budget neutral within the OPSS. To obtain budget neutrality, CMS would make proportional increases to the payment rates for other items and services under OPSS to offset the reduced payment rates for 340B drugs. However, CMS is soliciting comments on whether all or

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<sup>2</sup> Covered entities that participate in HRSA's Prime Vendor Program often pay less than the ceiling price.

<sup>3</sup> Medicare Payment Advisory Commission. 2015. *Report to the Congress: Overview of the 340B drug pricing program*. Washington, DC: MedPAC.

<sup>4</sup> We view our result of an average discount of 22.5 percent as a lower bound on the actual average discount because: We used average sales price (ASP) as a proxy for AMP and ASP is generally lower than AMP; we did not have data on each drug's best price; and we did not have enough information to determine an inflation rebate for each drug.

<sup>5</sup> OIG, HHS. 2015. Part B payments for 340B-purchased drugs. Washington, DC: OIG.

part of the savings generated by the 340B payment policy should be used to increase payments for specific services paid under the OPSS, or under Part B generally. CMS is particularly interested in how the offset could be targeted to hospitals that treat a large share of indigent patients.

### *Comments*

The Commission recommended in a March 2016 Report to the Congress that payment rates for all separately payable drugs provided in 340B hospitals should be reduced by 10 percent of the ASP.<sup>6</sup> This policy allows beneficiaries to share in the savings on 340B drugs through lower spending on coinsurance. We also recommended that the program savings from these reduced payment rates should be directed to the Medicare-funded uncompensated care pool, which would target hospitals providing the most care to the uninsured, and in that way benefit indigent patients. Finally, to make sure that dollars in the uncompensated care pool actually go to the hospitals providing the most uncompensated care, the Commission recommended that payments be distributed in proportion to the amount of uncompensated care that hospitals provide.

The benefits of our March 2016 recommendation are threefold:

- It allows beneficiaries to share in the savings from the 340B program.
- It better targets resources to hospitals that provide the most uncompensated care. Currently, the 340B program is not well targeted to hospitals that provide high levels of uncompensated care. For example, we find that 40 percent of 340B hospitals provide less than the median level of uncompensated care.
- It allows the 340B hospitals to still make a profit on the covered drugs.

We believe that legislation would be needed to implement the part of our recommendation that directs the savings to the uncompensated care pool because current law would require that the savings be retained within the OPSS to make it budget neutral. In summary, if unable to implement our recommendation administratively, we encourage CMS to request that Congress enact the legislation necessary to allow CMS to implement the Commission's recommendation. Legislation would also allow CMS to apply the policy to all separately payable drugs, including those that are separately payable as a result of their pass-through status.

### **Section 603 of the Bipartisan Budget Act of 2014: Limiting service line expansion or volume increases in excepted off-campus PBDs**

Section 603 of the Bipartisan Budget Act of 2015 (BBA 15) prohibits certain provider-based departments (PBDs) that are located off a hospital campus (off-campus PBDs) from billing under the OPSS. Section 603 further specifies that these off-campus PBDs must bill under "the applicable payment system," which CMS has established as the Medicare physician fee schedule (PFS).

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<sup>6</sup> For most non-pass-through, separately payable drugs, the sequester reduces the OPSS payment rate from ASP + 6 percent to about ASP + 4.3 percent. Therefore, the OPSS payment rate under our recommendation would be about ASP – 5.7 percent.

The Congress passed this legislation in response to hospitals acquiring freestanding physician offices, establishing these offices as PBDs, and billing for their services under the OPSS. Medicare makes separate payments for the professional services of the practitioners who provide these services under the PFS and for the facility services under the OPSS. In many cases, a physician's practice that is purchased by a hospital stays in the same off-campus location and treats the same patients. The acquisition of freestanding offices led to a shift of billing of ambulatory services from offices to PBDs.<sup>7,8,9,10</sup> Because these services are paid under both the OPSS and the PFS, they result in increased Medicare spending, which leads to higher costs for taxpayers and higher cost sharing for beneficiaries.

To be consistent with section 603, CMS distinguished the items and services that hospitals may continue to bill under the OPSS (the excepted items and services) from the items and services that can no longer be billed under the OPSS and must be billed under the applicable payment system (nonexcepted items and services). A category of excepted items and services that CMS has discussed extensively are those provided by excepted off-campus PBDs, defined as those billing under the OPSS before the date that the Congress enacted BBA 15: November 2, 2015. In particular, CMS expressed concern in the proposed rule for 2017 that allowing these off-campus PBDs to expand the types of items and services they provide and permitting them to bill for them as excepted items and services under the OPSS would enable hospitals to purchase new physician practices and add them to existing off-campus PBDs. In response, CMS proposed to group the APCs in the OPSS into 19 clinical families. Excepted items and services would be limited to those in the same clinical families that the off-campus PBD provided before November 2, 2015. Other items and services would not be excepted and could not be billed under the OPSS.

Therefore, if an off-campus PBD expanded so that it provided items and services that it did not provide before November 2, 2015, those items and services would not be excepted. However, if an off-campus PBD increased the volume of items and services in one or more of the clinical families that it was providing before November 2, 2015, the increased volume would have excepted status.

After consideration of public comments that CMS received, CMS stated in the final rule for CY 2017 that it would not finalize its proposal that would use 19 clinical families to limit the items and services excepted under section 603. Consequently, there is no restriction in place to limit the extent to which an excepted off-campus PBD can expand the volume of excepted items and services. In this rule, CMS proposes to continue for CY 2018 to place no limit on clinical service line expansion or volume increase on off-campus PBDs that are excepted under section 603.

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<sup>7</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>8</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>9</sup> Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>10</sup> Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

*Comments*

In 2012 and 2014, MedPAC recommended an approach different from the approach later detailed in section 603 to address the issue of the higher Medicare payments that result from hospitals converting freestanding offices into off-campus PBDs. Our approach would identify services that meet a certain set of criteria. For services that meet these criteria, the OPPS payment rates would be adjusted so that total Medicare payments are the same whether the service is provided in a freestanding office or an HOPD.<sup>11,12</sup> Because our recommended approach does not distinguish between on-campus and off-campus PBDs, it would be less complex to administer than the policy in section 603. However, we recognize that with section 603 of BBA 15, the Congress took a different approach than ours based on whether an off-campus PBD began billing after a certain date, and CMS must implement that approach.

In the proposed rule for CY 2017, CMS proposed an approach for implementing section 603, including the use of 19 clinical families to limit the items and services excepted under section 603. In a comment letter on the CY 2017 proposed rule, the Commission expressed concern that CMS's proposed approach to 19 clinical families was unnecessarily complex, and discussed an alternative approach.<sup>13</sup> Under this alternative, CMS would determine how much the Medicare program had paid an off-campus PBD for items and services billed under the OPPS during a 12-month baseline period that precedes November 2, 2015. Beginning January 1, 2017, annual program spending for an off-campus PBD for items and services billed under the OPPS would be capped at the amount paid to that PBD during the baseline period. Over the course of a year, the hospital would bill for items and services provided at the off-campus PBD under the OPPS. When the hospital reaches the annual cap for that location, CMS would no longer pay OPPS rates for items and services provided at that location. Instead, CMS would pay the nonfacility PFS rate for those items and services. The annual cap could be updated based on the annual updates to the OPPS payment rates.

We believe this approach meets the intent of section 603 by curbing the ability of hospitals to benefit financially from purchasing freestanding physician practices and converting them to off-campus PBDs. We acknowledge the challenges of implementing our approach. CMS would have to require hospitals to report the amount of OPPS payments received by each excepted off-campus PBD during the baseline period (such as 11/2/2014 through 11/1/2015) because CMS was not collecting data on payments made to each individual PBD during that period. To help assure the accuracy of these data, CMS could selectively audit hospitals. Despite these challenges, we believe it would be easier for CMS to administer our preferred approach than the proposed system that would use 19 clinical families to limit the items and services excepted under section 603.

In its effort to implement section 603 of BBA 15, we believe that CMS should be diligent in limiting excepted items and services. CMS's decision to not implement any policy that restricts expansion of excepted items and services provided by excepted off-campus PBDs undermines the

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<sup>11</sup> Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>12</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>13</sup> Medicare Payment Advisory Commission. 2016. Comment letter on 2017 proposed rule for the hospital outpatient prospective payment system and the ambulatory surgical center payment system.

goal of section 603 of BBA 15. Therefore, CMS should implement policies that put greater restrictions on excepted items and services than the policy implemented for CY 2017 and proposed for CY 2018. We continue to believe that the policy that the Commission presented in our comment letter on the CY 2017 proposed rule and repeated in this letter is the best policy to address this issue, within the constraints of section 603 of BBA 15.

### **Hospital Outpatient Quality Reporting Program and Ambulatory Surgery Center Quality Reporting Program**

The Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgery Center Quality Reporting (ASCQR) programs require hospitals and ASCs to report data on a set of quality measures specified by CMS. If they fail to do so, their annual update factors will be reduced by 2.0 percentage points in the following year. The payment update determination is not based on the hospital's or ASC's performance on the set of measures required for that year, only on whether they successfully reported the required measures. CMS lacks the statutory authority to establish a value-based purchasing (VBP) program for ASCs that would adjust payments based on performance.

The OQR program currently consists of 26 measures that will be reported by hospitals or calculated by CMS from claims data. In this rule, CMS proposes to remove for payment determination in CY 2020 two process measures reported by hospitals: 1) median time to pain management for long bone fracture; and 2) hospital outpatient volume data on selected outpatient surgical procedures. For payment determination in CY 2021, CMS proposes to remove four more process measures reported by hospitals: 1) median time to fibrinolysis; 2) aspirin at arrival; 3) door to diagnostic evaluation by a qualified medical professional; and 4) safe surgery checklist use.

Under the ASCQR program, ASCs currently report 14 patient safety, outcome, and process measures. In this proposed rule, CMS proposes to adopt three additional quality measures for payment determination in CY 2021 or CY 2022 and subsequent years. One measure—the number of ophthalmic anterior segment surgery patients diagnosed with toxic anterior segment syndrome within two days of surgery—will be reported by ASCs into CMS's web-based quality reporting tool. The other two measures are CMS calculated, claims-based measures that assess all-cause, unplanned hospital visits occurring within seven days of ASC procedures 1) orthopedic; and 2) urology. CMS also proposes to remove a total of three measures for the CY 2019 payment determination and subsequent years. These three measures are process or utilization measures reported to CMS by ASCs: 1) prophylactic intravenous antibiotic timing; 2) safe surgery checklist; 3) ASC facility volume data on selected procedures.

For both the OQR and ASCQR, CMS proposes to delay making the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey mandatory for all hospitals and facilities. Under the proposal, hospitals and facilities can continue to voluntarily collect and report OAS CAHPS results to CMS in CY 2018, as they have done since January 2016. The 37-question OAS CAHPS survey was developed to assess patients' experience of care following a procedure or surgery in an HOPD or ASC. To comply with the OQR and ASCQR, hospitals and ASCs must work with a survey vendor to distribute and collect survey

results from a sample of patients. CMS will use the survey results to calculate the following five OAS CAHPS measures for each outpatient facility and ASC: 1) about facilities and staff; 2) communication about procedure; 3) preparation for discharge and recovery; 4) overall rating of facility; and 5) recommendation of facility. However, CMS reports that more analysis is needed on the OAS CAHPS survey data that hospitals and facilities have voluntarily reported. CMS proposes to collect and analyze an additional year of data to ensure that the OAS CAHPS is reliable, valid, and not unduly burdensome for providers before the survey is mandatory.

CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs. CMS has also been monitoring and awaiting results from the National Quality Forum's (NQF) 2-year trial period in which quality measures seeking endorsement are assessed to determine whether risk adjustment for selected social risk factors is appropriate. At the end of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures. As CMS continues to consider the analyses from these reports and awaits the results of the NQF trial on risk adjustment for quality measures, the agency seeks public comment on whether and how to incorporate social risk factors in Medicare programs, including the OQR.

#### *Comments*

In general, the Commission supports value-based purchasing (i.e., pay for performance) approaches over pay-for-reporting, and in fact has recommended such a program for ASCs.<sup>14</sup> In VBP programs for HOPDs and ASCs, high-performing providers would be rewarded and low-performing facilities would be penalized through the payment system. The VBP programs should be based on a small number of outcomes-based measures. CMS should seek legislative authority to implement these programs.

Over the past few years, the Commission has become increasingly concerned that Medicare's current quality measurement programs rely on too many clinical process measures that are, at best, weakly correlated with health outcomes of importance to beneficiaries and the program. Process measures are also burdensome for providers to report, while yielding limited information to support clinical improvement. Therefore, the Commission supports CMS's proposal to remove six process measures from the OQR, and three process measures from the ASCQR. In past comment letters, we have encouraged CMS to examine the usefulness of two of those ASCQR process measures (prophylactic intravenous antibiotic timing and ASC facility volume) because it could encourage ASCs to increase their volume to improve their performance on this measure. CMS should continue to eliminate process measures that weakly correlate with health outcomes, as well as those that measure basic standards of care on which providers have achieved full performance (most providers report scores at or near 100 percent). Some examples of weak measures CMS should remove are influenza vaccination coverage among health care personnel, and patients left without being seen.

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<sup>14</sup> Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.



The Commission supports including the two claims-based, outcome measures proposed for the ASCQR: 1) hospital visits after orthopedic procedures in ASCs, and 2) hospital visits after urologic procedures in ASCs. We do not support inclusion of the toxic anterior segment syndrome (TASS) measure in the ASCQR because it is a self-reported outcome measure that may be at risk of subjectivity and manipulation by the reporting facility. In addition, we believe the TASS measure is narrowly limited to a small segment of the ASC industry, and we prefer quality measures that apply more broadly to various types of ASCs.

As stated in previous ASC comment letters, there are several modifications to the current set of ASCQR measures that the Commission believes CMS should make. First, the current measure on hospital transfer or admission after a procedure should be expanded to include patients who return home after the ASC procedure but are admitted to a hospital shortly thereafter because of a problem related to the procedure. Including these patients in the measure would enable CMS to more comprehensively track patients who experience serious complications or medical errors related to an ASC procedure. Second, CMS should develop a surgical site infection (SSI) measure that applies to common ASC procedures. Researchers have found that lapses in infection control practices were common among a sample of ASCs in three states.<sup>15</sup>

The Commission believes that Medicare quality programs should also include patient experience measures, such as the OAS CAHPS survey measures. The use of surveys to query patients about their experience in health care settings is the best and often only way to examine whether high-quality, patient-centered care actually takes place. We understand that CMS needs more information and time to produce a valid and reliable implementation of the OAS CAHPS, but we encourage CMS to continue its work to include patient experience measures in the OQR and ASCQR as soon as feasible.

In December 2016, ASPE released the “Social Risk Factors and Performance under Medicare’s Value-based Purchasing Programs” report to the Congress, which was mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The report provides empirical analysis of the effects of six social risk factors (dual eligibility, residence in low-income areas, Black race, Hispanic ethnicity, rural residence, and disability) on the nine Medicare quality payment programs including the Hospital Readmission Reduction (HRR) program. The report included two main findings:

1. Beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they saw, and dual eligibility status was the most powerful predictor of poor outcomes among the social risk factors.
2. Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

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<sup>15</sup> Schaefer, M. K., M. Jhung, M. Dahl, et al. 2010. Infection control assessment of ambulatory surgical centers. *Journal of the American Medical Association* 303, no. 22 (June 9): 2273-2279.

ASPE simulated the effect of three different potential policy solutions to account for social risk factors in each of the Medicare programs:

- adjust quality and resource use measures,
- stratify providers into groups by proportion that are at-risk, and
- create separate payment adjustments.

MedPAC supports the second solution of using peer grouping or stratification.<sup>16</sup> This approach is straightforward to implement, since no additional measure-level research is needed (that is, working with measure developers to run new risk-adjustment models). The stratification report also does not minimize incentives to improve for providers with high shares of beneficiaries that have social risk factors and does not “mask” (or hide) actual provider performance. Instead, providers would compare their unmasked performance (the rate would still have been adjusted for differences in patient age, sex, and comorbidities) with providers with similar risk factors. For example, risk-adjusted readmission performance would be compared for hospitals with similar shares of low-income patients, and payment would be adjusted based on whether hospitals met performance targets in their peer group.

### **Proposed ASC conversion factor, ASC payment rates, ASC cost reporting, and the ASC billing process**

CMS proposes to increase the conversion factor in the ASC payment system in 2018 by 1.9 percent. This proposed update is based on CMS’s estimate of a 2.3 percent increase in the CPI–U minus a 0.4 percentage point deduction for multifactor productivity growth mandated by PPACA. CMS is seeking comment on the update factor for the ASC payment system, with interest in data from ASCs that would help determine whether the ASC payment system should continue to be updated by the CPI–U or by an alternative factor such as the hospital market basket, Medicare Economic Index (MEI), a blend of update factors, or some other mechanism. In addition, CMS is seeking comment on whether the Secretary should collect cost data from ASCs to use in determining ASC payment rates. Finally, CMS requests comment on whether ASCs should bill on the institutional claim form (UB-04) rather than the professional claim form (CMS-1500).

#### *Comments*

In the Commission’s March 2017 report, we recommended that the Congress eliminate the update to ASC payment rates for 2018.<sup>17</sup> The Commission’s recommendation was based on our indicators of payment adequacy for ASCs, which are positive, and the importance of maintaining financial pressure on providers to constrain costs. Therefore, the Commission believes the proposed 1.9 percent increase to ASC payment rates is unnecessarily high. The Commission does understand that the method for arriving at the proposed 1.9 percent update is mandated by law.

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<sup>16</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>17</sup> Medicare Payment Advisory Commission. 2017. *Report to Congress: Medicare payment policy*. Washington, DC: MedPAC.

CMS bases its ASC update on the CPI-U, and for several years the Commission has commented that the CPI-U likely does not reflect ASC's cost structure, both in comment letters on proposed rules and in reports to the Congress. In the 2013 proposed rule, CMS noted that the CPI-U may not be an ideal index for measuring the change in the cost of providing ASC services because the CPI-U is highly weighted for factors that have a relatively small effect on ASC costs such as housing and transportation. In addition, CMS solicited public comments on the feasibility of collecting cost information from ASCs but has not proposed a plan to collect this information. At that time and in subsequent comment letters, the Commission concurred with CMS's assessment of the CPI-U.<sup>18</sup>

The Commission has also recommended in several reports to Congress (the first being March 2009) and comment letters on OPPS/ASC proposed rules that ASCs should be required to submit cost data.<sup>19</sup> This would facilitate a more accurate annual update to ASC payment rates. Using data from a Government Accountability Office (GAO) survey of ASC costs, we found that ASCs have a different cost structure than hospitals and physicians' offices.<sup>20,21</sup> Given our past findings, and that it has been more than 10 years since the GAO collected cost data from ASCs, CMS should begin collecting new cost data and use that information to examine whether an existing Medicare price index is an appropriate proxy for the cost of these facilities or an ASC-specific market basket should be developed.

We believe it is feasible for ASCs to provide cost information to CMS annually because ASCs typically keep records of their costs for filing taxes and other purposes. Moreover, other small providers such as hospices and home health agencies collect and submit cost data annually. To minimize the burden on ASCs and CMS, CMS could require all ASCs to submit streamlined cost reports or require a random sample of ASCs to respond to annual surveys.<sup>22</sup> In addition to more traditional Medicare cost reporting variables such as payments and costs by payer type, this cost reporting device should collect cost data for items such as drugs, medical supplies (including costly implantable devices), medical equipment, employee compensation, building expenses (such as rent), and other professional services (such as legal, accounting, and billing services).

Finally, CMS should transition ASCs to billing through an institutional claim form, rather than through the professional claim form. The ASC payment system is closely tied to the OPPS. CMS has established a policy to base ASC relative weights and payment rates on APC groups and OPPS relative weights. However, because hospitals and ASCs use different claim forms to bill Medicare,

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<sup>18</sup> Medicare Payment Advisory Commission. 2014. Comment letter on 2015 proposed rule for the outpatient prospective payment system and ambulatory surgical centers.

<sup>19</sup> Medicare Payment Advisory Commission. 2009. *Report to the Congress. Medicare payment policy*. Washington, DC: MedPAC.

<sup>20</sup> Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

<sup>21</sup> Government Accountability Office. 2006. *Medicare: Payment for ambulatory surgical centers should be based on the hospital outpatient payment system*. GAO report: GAO-07-06. Washington, DC: GAO.

<sup>22</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

CMS is not able to implement some OPPS payment policies to the ASC payment system, such as comprehensive APCs. To fully align OPPS payment policies with the ASC payment system, ASCs and hospitals should use the same claim form.

However, having ASCs bill using the facility claim form should be delayed for two reasons. First ASCs should be given time to implement a system for submitting cost data. ASCs should not be required to begin using a new claim form while they adjust to submitting cost data. Second, the facility claim form requires information that ASCs may not currently be structured to submit. For example, the facility claim form requires providers to record information such as charges and service codes by revenue centers. ASCs may not be structured in a way that allows them to record information by revenue center. ASCs should be given time to make the necessary adjustments.

### **Conclusion**

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.  
Chairman

FJC/dz/wc