MEDPAC Medicare Payment Advisory Commission

425 Eye Street, N.W. • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

August 17, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1656-P

Dear Mr. Slavitt:

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; 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," published in the *Federal Register* on July 14, 2016 (81 FR 45603–45788). 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 2017 update to the conversion factors in the OPPS and the ASC payment system.

This rule also proposes to:

- Create 25 new comprehensive APCs;

- Use cost-to-charge ratios from the cost center "implantable devices charged to patients" on the hospital cost reports to estimate costs for purposes of payment for pass-through devices;
- Allow pass-through status of devices and drugs to expire on a quarterly basis rather than at the end of calendar years;
- Combine the two payment tiers currently used in the partial hospital program (PHP) stays into a single-tier payment;
- Take steps to implement section 603 of the Bipartisan Budget Act of 2015, which requires that items and services that are covered under the OPPS to be paid under a payment system other than the OPPS if they are provided in an off-campus outpatient department of a hospital that was established after November 2, 2015;
- Add new quality measures to the Outpatient Quality Reporting (OQR) program;
- End scoring of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) pain management dimension in the Hospital Value-based Purchasing Program (VBP);
- Add seven quality measures for the ASC Quality Reporting Program (ASCQR), request feedback on a potential quality measure assessing the rate of occurrence of toxic anterior segment syndrome (TASS, a possible complication of cataract surgery), and alter the ASCQR reporting process by moving the reporting deadline earlier and providing ASCs with a 30-day period to review their quality report before it is publically reported; and
- Remove two measures and reduce thresholds for remaining measures that eligible hospitals and critical access hospitals (CAHs) must attest to under the Medicare EHR Program.

We focus our comments on the updates to the ASC conversion factor and the topics listed above.

Create 25 new comprehensive APCs
CMS introduced comprehensive APCs (C-APCs) into the OPPS in calendar year 2015. The idea of C-APCs is to combine the primary service (the service that is the reason for a patient's visit to an HOPD) and all of the adjunctive and secondary services billed on the same claim—with a few exceptions—into a single payment. For 2017 CMS proposes to add 25 new C-APCs to the OPPS.

Comments
We have always supported CMS' use of C-APCs in the OPPS because it increases the size of the payment bundles, which provides incentives for more efficient provision of care. It also increases the number of claims that can be used to set payment rates, which results in payments more accurately representing costs. Therefore, we support the proposal to add 25 C-APCs to the OPPS for calendar year 2017.

Changes to CCRs used to determine pass-through payments for devices
In the OPPS, the costs of most implantable medical devices are packaged into the payment rates of the procedures that use the devices. Therefore, there are not separate payments for most implantable devices in the OPPS. For some devices, however, providers receive special 'pass-through' payments. These are new devices for which CMS does not yet have adequate cost data to use in the method that sets the payment rates in the OPPS. Currently, devices have pass-through

status for 2 to 3 years. Giving pass-through status to new devices for a limited time allows CMS to collect the needed data for eventually including the new devices into the standard process for setting payment rates while ensuring that providers are paid adequately for the new devices. When pass-through status for a device expires, CMS estimates the cost of each device by multiplying the device charges on claims by the appropriate cost-to-charge ratios from hospital cost reports. CMS uses these estimated costs in its process for setting payment rates.

CMS determines the pass-through payment for a device by multiplying the hospital's charge for the device by the hospital's average CCR across all outpatient departments, then subtracting an amount representing the cost of current devices that are contained in the payment rate for the applicable procedure.

In 2013, CMS began using data from a new cost center on the hospital cost reports: implantable devices charged to patients. For purposes of calculating device pass-through payments, CMS has received a request to use CCRs from this new cost center in place of the average CCRs across all outpatient departments. In response, CMS has proposed to begin using the CCRs from the new cost center.

Comments
We support this proposal. Implantable devices tend to be very high-cost items for hospitals, and hospitals tend to mark up the charges on high-cost items by a smaller percentage than the charges on low-cost items. Therefore, the CCRs for high-cost items tend to be higher than the CCRs for low-cost items. Under the current method for calculating pass-through payments, the CCRs for low-cost items and the CCRs for high-cost items are averaged to create the CCR that is used to calculate the pass-through payments. Consequently, the average all-cost center CCRs that CMS uses may be too low to set accurate payments for these devices. In this rule, CMS stated that for hospitals that have a CCR for the 'implantable devices charged to patients' cost center, the median CCR is 0.3911, compared with a median hospital-wide CCR of 0.2035. Therefore, it is evident that using CCRs from the 'implantable devices charged to patients' cost center (when available) will result in more accurate estimates of devices costs.

Make pass-through payments for all pass-through devices and drugs for 3 years and expire pass-through status on a quarterly rather than annual basis
In addition to pass-through payments for devices, the OPPS has pass-through payments for drugs, biologicals, and radiopharmaceuticals (we will collectively refer to these as 'drugs' for purposes of this letter). Like pass-through devices, pass-through drugs can have that status for 2 to 3 years. For both pass-through devices and pass-through drugs, CMS currently accepts applications on a quarterly basis and begins pass-through payments on the next available OPPS quarterly update after approval for pass-through status. In contrast, pass-through status expires on a calendar-year basis rather than quarterly basis. This means that the length of a device's or drug's pass-through status depends on when during a year an applicant is approved for pass-through payment. For example, if an item begins pass-through status on April 1, it would have pass-through status for 2 years and 3 quarters, while a pass-through item that has pass-through status that begins on October 1 would have pass-through status for 2 years and 1 quarter.

CMS is proposing to allow for quarterly expiration of pass-through status so that pass-through status for devices and drugs is as close to a full 3 years as possible. This would eliminate the variability in the length of pass-through eligibility.

Comments
We agree with this proposal. It would create more equitable treatment among the devices and drugs that receive pass-through status.

Combine the two payment tiers currently used in the partial hospitalization program into a single tier
The partial hospitalization program (PHP) is a part of the OPPS and is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness. Services in the PHP are furnished in hospitals or in community mental health centers (CMHCs). Statute defines the PHP as a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential setting.

The OPPS currently has separate payment rates for PHP services provided in hospitals and for PHP services provided in CMHCs. For PHP services provided in hospitals, the OPPS payments involve a two-tiered approach: one APC (and payment rate) is assigned if three services are provided in a day (level 1 partial hospitalization) and a different APC (and payment rate) if four or more services are provided in a day (level 2 partial hospitalization). The OPPS has the same type of tiers for PHP services provided in CMHCs (level 1 and level 2 partial hospitalization), but level 1 and level 2 payment rates for hospitals are higher than the level 1 and level 2 payment rates for CMHCs.

For 2017, CMS is proposing to combine the two-tiered PHP APCs for hospitals into a single PHP APC and to combine the two-tiered PHP APCs for CMHCs into a single PHP APC. A reason that CMS cites for this proposal is that costs have become "inverted" in the two-tiered APC system for PHP services provided in hospitals. This means that the geometric mean costs for level 1 PHP services in hospitals have become higher than geometric mean costs for level 2 PHP services in hospitals. CMS attributes the inverted costs to the fact that the volume of level 1 PHP services disproportionately occurs in high-cost hospitals while the volume of level 2 PHP services disproportionately occurs in low-cost hospitals. Another reason cited by CMS is that the number of providers of PHP services has decreased, especially CMHCs. With a small number of providers, data from providers that have a high percentage of total PHP service days and unusually high or low costs per day will have a relatively strong effect on the geometric mean costs within the PHP APCs.

Comments
We support this proposal. Logic in payment rates is vital to having a meaningful payment system. Payment rates that are higher for an APC that provides fewer of the same type of services as another APC are not reasonable.

Implementing section 603 of the Bipartisan Budget Act of 2014: Treatment of off-campus outpatient departments under the OPPS

In recent years, hospitals have been acquiring freestanding physician offices, establishing these offices as provider-based departments (PBDs), and billing for their services under the OPPS. Medicare makes a separate payment for the professional services of the practitioners who provide these services under the Medicare physician fee schedule (PFS). 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 has led to a shift of billing of ambulatory services from offices to PBDs.[1,2,3,4] Because these services are paid under both the OPPS and the PFS, they result in increased Medicare spending, which leads to higher costs for taxpayers and higher cost sharing for beneficiaries.

Section 603 of the Bipartisan Budget Act of 2015 (BBA 15) prohibits certain off-campus PBDs from billing under the OPPS, which is intended to reduce program spending and beneficiary cost sharing for services provided at these locations. In this proposed rule, CMS emphasizes that the purpose of section 603 is to curb hospital acquisition of physician practices that results in additional Medicare payments for similar services.

CMS's proposal to implement section 603 has three broad parts:

- Distinguish the items and services that hospitals may continue to bill under the OPPS (the excepted items and services) from the items and services that can no longer be billed under the OPPS (nonexcepted items and services);
- Define the off-campus PBDs that are not subject to section 603 (excepted providers), meaning they are allowed to continue billing under the OPPS; and
- Establish a policy for billing and paying for the nonexcepted items and services provided in off-campus PBDs.

<u>Excepted items and services; off-campus PBDs not subject to section 603</u>

To be consistent with section 603, CMS proposes to except items and services meeting one of the following criteria:

- Items and services provided in a "dedicated ED." CMS proposes to except both emergency and non-emergency items and services that are provided in dedicated EDs.[5]

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[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[2] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[3] Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[4] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[5] A dedicated ED is defined as any department or facility of a hospital that meets at least one of the following: (1) Licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) Held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) Provides at least one-third of all of its outpatient

- Items and services provided on the campus of the hospital. This includes services provided on the main campus of the provider or the campus of a remote location that furnishes inpatient care.
- Items and services provided in an off-campus PBD before the date on which BBA 15 was enacted (November 2, 2015).

CMS addresses two issues related to the excepted status of items and services that were provided in off-campus PBDs before November 2, 2015: how relocation of an off-campus PBD affects the excepted status and how expansion of an off-campus PBD affects the excepted status.

CMS proposes that off-campus PBDs will no longer be allowed to bill under the OPPS if the off-campus PBD moves or relocates from the physical address that was listed on the provider's hospital enrollment form on November 1, 2015. Therefore, items and services provided at these off-campus PBDs would no longer be excepted. Moreover, if an excepted off-campus PBD has an address that includes multiple units, and the off-campus PBD moves from the unit it occupied on November 1, 2015 to a different unit at the same address, the off-campus PBD and the items and services it furnishes would no longer have excepted status.

CMS recognizes that there may be situations beyond a hospital's control that make it necessary for an excepted off-campus PBD to move to a different location. In response, CMS is soliciting comments on whether it should develop a limited exceptions process that would allow off-campus PBDs struck by a natural disaster or other extraordinary circumstance to relocate without losing their excepted status.

CMS is also proposing that the items and services that excepted off-campus PBDs would be allowed to bill under the OPPS would be limited to the same types of items and services that they were providing before November 2, 2015. CMS is concerned that allowing excepted off-campus PBDs to expand the types of services they provide and permitting them to bill for those services under the OPPS would enable hospitals to purchase new physician practices and add them to existing off-campus PBDs. In particular, CMS proposes to group the APCs 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 could not be billed under the OPPS.

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

CMS is seeking comment on whether it should specify a timeframe before November 2, 2015 in which services had to be billed under the OPPS for those services to have excepted status. For example, CMS could require an excepted off-campus PBD to have furnished services in a clinical

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visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

family during calendar year 2013 through November 1, 2015 in order for services in that clinical family to be excepted. However, CMS did not propose a specific timeframe.

In the event that a hospital, in its entirety, is sold to or merges with another hospital, CMS proposes that an excepted off-campus PBD would maintain its excepted status. However, the ownership of the main provider must be transferred to the new owner, and the new owner must accept the Medicare provider agreement. Therefore, if the provider agreement is terminated, the excepted status of the off-campus PBD would terminate. Finally, CMS proposes that excepted off-campus PBDs cannot be transferred from one hospital to another and maintain excepted status.

Currently, CMS is not able to use claims to identify items and services furnished by each individual off-campus PBD. Although there is a claims modifier that identifies whether a service was provided at an off-campus PBD, it does not indicate the specific location of the PBD or when it began billing Medicare. Therefore, if CMS implements its proposals regarding off-campus PBDs and items and services that are excepted from section 603, CMS would not be able to distinguish excepted items and services from those that are not excepted. In response, CMS is seeking comments on whether hospitals should be required to separately identify all individual excepted off-campus PBD locations, the date that each excepted off-campus PBD began billing, and the clinical families of services that were provided by the excepted off-campus PBD before November 2, 2015. CMS would collect this information through a newly-developed form.

Billing and paying for the nonexcepted items and services

A final issue that CMS addressed is how to pay for nonexcepted items and services that are provided in off-campus PBDs. CMS intends to provide a mechanism for making these payments, but the agency indicates there is "no straightforward way to do that before January 1, 2017."

Section 603 requires that payments for nonexcepted items and services be made under "the applicable payment system" under Medicare Part B. Section 603 clearly states that payment cannot be made under the OPPS, but it does not specify "the applicable payment system" under which payments would be made. Options include the ASC payment system, the PFS, and the clinical laboratory fee schedule (CLFS).

CMS states that many off-campus PBDs were once freestanding physician offices that hospitals acquired and that many of the services furnished by off-campus PBDs are also furnished in freestanding offices. Therefore, CMS is proposing that, for calendar year 2017, the nonexcepted services would be paid under the PFS at the nonfacility rate because the hospital would not receive a separate facility payment.[6] This would be a one-year transitional policy. However, CMS does not have a mechanism to pay off-campus PBDs for nonexcepted items and services under the PFS because there are different claims forms and processing systems for hospitals and physicians. Therefore, the physicians or practitioners who provide the items and services would bill and be paid for them, rather than the off-campus PBD. An alternative approach is for the off-campus

[6] Under the PFS, services provided in physicians' offices are paid at the nonfacility rate, and services provided in facilities such as HOPDs are paid at the facility rate. In general, the nonfacility rate for a service is higher than the facility rate.

PBDs to enroll as another provider type (such as an ASC or a physician group practice) and bill under the appropriate payment system for that provider type.

Beyond 2017, CMS believes it would be necessary to establish a new provider/supplier type for nonexcepted off-campus PBDs so they could bill under the PFS for nonexcepted items and services. CMS is soliciting comments on whether an off-campus PBD should be allowed to bill for nonexcepted items and services on professional claims under the PFS and receive nonfacility payment under the PFS, provided the PBD meets all the applicable PFS requirements. In particular, CMS seeks public comments on whether there are administrative impediments to allowing off-campus PBDs to bill in this manner. CMS also is seeking comments on whether there are other implications or considerations for allowing off-campus PBDs to bill under the MPFS, such as how the costs associated with furnishing these services might be reflected on hospital cost reports.

Comments
The acquisition of freestanding practices by hospitals and the billing of services provided in those settings under the OPPS increases the financial burden on taxpayers and beneficiaries because services furnished in freestanding offices are usually billed under the PFS at the nonfacility rate, while services furnished in off-campus PBDs are usually billed under the PFS at the facility rate for professional services and the OPPS for facility services. This results in higher program spending and higher beneficiary cost sharing without observable changes in patient care. Section 603 of BBA 15 reduces this financial burden on taxpayers and beneficiaries.

In 2012 and 2014, MedPAC recommended a different approach 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.[7,8] 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 the Congress took a different approach than ours based on whether an off-campus PBD began billing after a certain date.

We commend CMS for their effort to rigorously implement section 603. If CMS finalizes their proposed method, we believe it has the potential to reduce the financial burden on taxpayers and beneficiaries, although there would likely be substantial administrative burdens on the agency, its contractors, and providers.

In the context of implementing section 603, we agree with CMS' proposals that

- define the hospital outpatient providers that are excepted from section 603,
- define the off-campus PBDs that are subject to the restrictions of section 603, and

[7] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

- establish that services that are provided in calendar year 2017 in off-campus PBDs that are not excepted from section 603 should be billed under the PFS by the physicians or other practitioners who furnish those services.

However, we believe that CMS' proposal to limit the excepted items and services for off-campus PBDs to the items and services in the 19 clinical categories that they were providing before November 2, 2015 is unnecessarily complex. A less-complex approach is to determine how much the Medicare program had paid an excepted off-campus PBD for services billed under the OPPS during a 12-month baseline period that preceded November 2, 2015 (that is, November 2, 2014 through November 1, 2015). Beginning January 1, 2017, annual program spending for an excepted off-campus PBD for 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 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 services provided at that location. Instead, CMS would pay the nonfacility PFS rate for those services. The annual cap could be updated based on the annual updates to the OPPS payment rates. Other details of this approach include:

- If an off-campus PBD expands, billing under the OPPS would still be limited to its annual cap.
- If an off-campus PBD changes locations, it would still be subject to the annual cap, and any items or services beyond the cap would not be paid under the OPPS.
- If a hospital that has an off-campus PBD is purchased in its entirety by another hospital, the annual cap would transfer to the purchasing hospital if the provider number of the hospital being purchased does not change and the purchaser accepts the Medicare provider agreement. However, if the purchaser does not maintain the provider number and Medicare provider agreement of the hospital being purchased, the annual cap should not transfer and the exception should expire.
- If an off-campus PBD is purchased by another hospital and the purchase does not include the entire hospital, the annual cap should not transfer with the PBD to the new hospital.

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 (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.

We also have comments on three additional issues:

- Whether off-campus PBDs should be allowed to relocate in very limited situations without losing their excepted status.
- Whether CMS should specify a timeframe in which services had to be billed under the OPPS in order for a PBD to have excepted status.

- Whether hospitals should be required to separately identify all individual excepted off-campus PBD locations, the date that each excepted off-campus PBD began billing, and the clinical families of services that were provided by the excepted off-campus PBDs before November 2, 2015.

We believe that off-campus PBDs should be allowed to relocate in limited situations without losing their excepted status. Clearly, acts of nature can create situations where it is necessary for health care providers to relocate, either temporarily or permanently. We see no reason why providers that relocate for these reasons should be penalized.

As we discussed above, we think it would be beneficial for CMS to establish a specific timeframe for services to be billed to meet this exception. A reasonable timeframe is the 12-month period that preceded November 2, 2015, meaning November 2, 2014 through November 1, 2015.

Under any approach to implementing section 603, it will be essential for CMS to require hospitals to separately identify all individual off-campus PBD locations, the date that each off-campus PBD began billing Medicare, the provider number of the parent hospital and whether the provider number has changed, and the clinical families of services that were provided by the off-campus PBDs before November 2, 2015. CMS must have these data to identify the off-campus PBDs and the items and services that meet the requirements for being excepted from section 603. CMS should also make this information available to the public so that oversight agencies and policy analysts could examine the prevalence of off-campus PBDs and their mix of patients and services.

We have additional comments regarding other data related to off-campus PBDs:

- To ensure program integrity, CMS should create claims modifiers that indicate whether an item or service provided in an off-campus PBD is excepted or nonexcepted from section 603. This information would allow CMS and researchers to distinguish the nonexcepted services provided in off-campus PBDs from services provided in freestanding offices and from the excepted services provided in PBDs. In addition, CMS should seek legislative authority to impose strict penalties on hospitals that inappropriately bill for nonexcepted services under the OPPS. These claims should be subject to the False Claims Act.
- CMS should create claims modifiers to identify whether an item or service is provided in a dedicated ED and whether the dedicated ED is off-campus or on-campus. This information would enable CMS and others to analyze differences in claim volume, patient mix, and costs between off-campus and on-campus hospital EDs. In the Commission's June 2016 report, we quantify the recent growth in the number of off-campus EDs billing Medicare and highlight the inability of the Medicare program to differentiate ED claims provided in the off-campus and on-campus settings.[9]
- Because CMS has indicated that it intends to continue to view off-campus PBDs as being part of a hospital, CMS should make sure that the cost and charge data from off-campus PBDs are recorded on hospital cost reports.

[9] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Finally, CMS indicates that there is no mechanism currently available to pay an off-campus PBD under a payment system other than the OPPS. To make it possible for off-campus PBDs to bill under the PFS, CMS argues that it would be necessary to establish a new provider/supplier type.

We discourage CMS from creating a new provider/supplier type for off-campus PBDs because this would add unnecessary complexity. We understand that CMS is concerned about having a mechanism for off-campus PBDs to bill for nonexcepted items and services if there is not a new provider type. As an alternative, CMS could continue using the interim payment policy it proposed for 2017 in future years, which means that the professionals who provide the services in off-campus PBDs would bill for those services under the PFS at the nonfacility rate. This approach would obviate the need to create a new provider type. Another option, as CMS notes in the proposed rule, would be for the off-campus PBD to enroll as another provider type (such as an ASC or a physician group practice) and bill under the appropriate payment system for that provider type.

Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting (OQR) Program requires hospitals to report data on a set of quality measures specified by CMS. If they fail to do so, their OPPS payment update factor will be reduced by 2.0 percentage points in the following year. The payment update determination is not based on a hospital's performance on the set of measures required for that year, only on whether the hospital successfully reported the measures that CMS required. In the first year of the OQR program in 2008, CMS required hospitals to report on seven quality measures in order to receive the full OPPS payment update in 2009. For payment determination in 2019, the program will consist of 26 measures that will be reported by hospitals or calculated by CMS from claims data.

In this rule, CMS proposes to add for payment determination in 2020 two claims-based measures and five measures based on the Outpatient and Ambulatory Surgery Consumers Assessment of Healthcare Providers and Systems (OAS CAHPS) survey. The first claims-based measure is admissions and emergency department visits for patients receiving outpatient chemotherapy, which measures potentially preventable visits that can be attributed to a hospital that provided outpatient chemotherapy in the 30 days preceding the outcome. The second measure is hospital visits after hospital outpatient surgery, which measures any inpatient admission directly after the surgery and any unplanned hospital visits occurring after discharge and within 7 days of the surgery.

The 37-question OAS CAHPS survey was developed to assess patients' experience of care following a procedure or surgery in an HOPD or ASC. CMS began voluntary national implementation of the OAS CAHPS in January 2016. To comply with the OQR, 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.

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.[10] In a value-based purchasing (VBP) program for HOPDs, high-performing providers would be rewarded and low-performing facilities would be penalized through the payment system. The VBP program should be based on a small number of outcomes-based measures. CMS should seek legislative authority to implement this program.

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. CMS should also move quickly to eliminate process measures in the measure set that weakly correlate with health outcomes, and those that measure basic standards of care on which providers have achieved full performance (i.e., most providers report scores at or near 100 percent). Some examples of weak measures CMS should remove are influenza vaccination coverage among healthcare personnel and median time to fibrinolysis.

In regard to the proposals in this rule, the Commission supports the inclusion of outcome measures, in particular measures of potentially preventable admission and ED visits.[11] The two claims-based measures would provide useful information about hospitals' performance and could encourage hospitals to reduce adverse patient outcomes, but pay for performance would likely improve outcomes more. The Commission also supports the inclusion of patient experience results, through the OAS CAHPS, in the OQR program. The use of surveys to query patients about their experience in the health care setting is the best and often only way to examine whether high-quality, patient-centered care actually takes place.

Calculation of the proposed ASC conversion factor and the proposed ASC payment rates
CMS proposes to increase the conversion factor in the ASC payment system in 2017 by 1.2 percent. This proposed update is based on CMS's estimate of a 1.7 percent increase in the consumer price index for all urban consumers (CPI–U) minus a 0.5 percentage point deduction for multifactor productivity growth mandated by PPACA.

Comments
In the Commission's March 2016 report, we recommended that the Congress eliminate the update to ASC payment rates for 2017. This 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.

CMS bases its ASC update on the CPI–U. However, in the proposed rule for 2013, CMS noted that the CPI–U may not be an ideal index for the cost of providing ASC services because the CPI–U is

[10] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[11] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

highly weighted for housing and transportation. In an effort to identify alternatives to the CPI–U for setting ASC payment rates, CMS solicited public comments on the feasibility of collecting cost information from ASCs but has not proposed a plan to collect this information.

We agree with CMS that the CPI–U may not reflect ASCs' cost structure.[12] 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.[13,14] 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 a limited amount of cost information. 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.[15]

Proposed requirements for the Ambulatory Surgical Center Quality Reporting Program
In the final rule for 2012, CMS established the ASC Quality Reporting (ASCQR) program which required ASCs to submit quality data to CMS beginning in 2012. As a part of the ASCQR, ASCs that do not submit data on a specified set of measures have their annual payment update reduced by 2.0 percentage points. Medicare payments to ASCs are adjusted based on whether the facilities report these measures and not on their performance with respect to these measures. CMS lacks the statutory authority to establish a VBP program for ASCs that would adjust payments based on performance.

Under the ASCQR program, for payment determination in 2017 ASCs will report 11 patient safety, outcome, and process measures. In addition, for payment determination in 2018 CMS has included a mandatory claims-based measure of an ASC's seven-day risk-standardized hospital visit rate following outpatient colonoscopy. In this proposed rule for CY 2017, CMS proposes to adopt seven additional quality measures for payment determination in CY 2020 and subsequent years. Two measures—the rate at which ASCs maintain normothermia (normal body temperature) for patients having surgical procedures under general or neuraxial anesthesia for 60 minutes or more and the rate of unplanned anterior vitrectomy for patients having cataract surgery—will be reported by ASCs into CMS's web-based quality reporting tool. The five remaining measures are survey-based measures collected via the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey. CMS also requests feedback on a potential new quality measure assessing the rate of occurrence of toxic anterior segment syndrome (TASS), a possible complication of cataract surgery. In addition, CMS proposes to change the reporting process by changing the submission deadline from August 15 to

[12] Medicare Payment Advisory Commission. 2014. Comment letter on 2015 proposed rule for the outpatient prospective payment system and ambulatory surgical centers.
[13] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC
[14] 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.
[15] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

May 15 of each year for measures submitted through CMS's web-based tool and to give ASCs a 30-day period to review their quality data before it is publically reported.

Comments
The Commission continues to support the establishment of a VBP program for ASCs in which high-performing ASCs would be rewarded and low-performing facilities would be penalized through the payment system.[16] The VBP program should be based on a small number of outcomes-based measures. CMS should seek legislative authority to implement this program. The current ASCQR program could lay the foundation for a VBP program.

As the Commission has stated in previous ASC comment letters, there are several quality measures used in the ASCQR program that could be used for an ASC VBP program; in addition, modifications to the current set of measures should be made. The modifications noted in our 2016 ASC comment letter include the following:

- 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.

- 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.[17]

- CMS should eliminate its ASC facility volume measure. This measure could encourage ASCs to increase their volume to improve their performance on this measure.

- We encourage CMS to examine whether the measure of prophylactic IV antibiotic timing remains useful in the ASC setting. Quality measures are considered "topped out," and no longer useful, when performance is so high and unvarying that meaningful distinctions among providers and improvement in performance can no longer be made. CMS determined in previous years that this antibiotic timing measure was topped-out in the HOPD setting. This burden of this measure could outweigh its value within the ASCQR.

In response to the measures proposed in the CY 2017 proposed rule, we do not support adding the two chart-abstracted measures of normothermia outcomes and unplanned anterior vitrectomies. To minimize burden on providers we prefer for quality measures to be based on claims data, rather than require providers to report data abstracted from medical records. With regard to five OAS

[16] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[17] 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.

CAHPS survey measures, we support these additions to the ASCQR program because they capture patient experience results, are also proposed for use as a part of the OQR, and apply to ASCs broadly.

We support the changes proposed by CMS regarding the ASCQR reporting process. Moving the reporting deadline from August 15 to May 15 of each year is consistent with the Commission's desire to make ASC quality data available to the public as soon as possible each year in order to help patients, policymakers, and researchers compare quality among facilities. We are also supportive of the proposal to give ASCs a 30-day preview period of their quality data before it is publically reported on Hospital Compare. This change will allow ASCs to correct data errors and assist them in improving their performance as quickly as possible.

Finally, the Commission believes that the public reporting of provider-level quality data is a necessary component to a successful quality improvement program and encourages CMS to limit the opportunities ASCs are given to voluntarily suppress the public reporting of their quality data. In the fall of 2016, CMS permitted ASCs to suppress five claims-based quality measures for CY 2013 and CY 2014 from public reporting.[18] In the Commission's March 2016 report we stated that suppressing these data may distort evaluations of ASC performance and diminish the overall usefulness of these data.[19]

Proposed Changes to the Medicare EHR Incentive Program

Under the American Recovery and Reinvestment Act of 2009, eligible professionals and hospitals were able to receive incentive payments for the meaningful use of certified electronic health record technology from 2011 through 2014 through either Medicare or Medicaid. Beginning in 2015, eligible hospitals and critical access hospitals (CAHs) who do not successfully demonstrate EHR meaningful use are subject to a payment penalty each year they do not meet meaningful use requirements.

The May 19, 2016 proposed rules for the "Medicare Program: Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models" included proposals on how eligible clinicians would be evaluated on meaningful use (now referred to as advancing care information). If these proposals are finalized, the requirements would be different for eligible clinicians and hospitals.

For 2017 and subsequent years, CMS proposes to eliminate the Clinician Decision Support and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program in Modified Stage 2 and Stage 3. This will align clinical and hospital requirements. To align programs and to reduce reporting burden, CMS also proposes to reduce the thresholds of a subset of the remaining objectives and measures in Modified Stage 2 for 2017 and in Stage 3 for 2017 and 2018. For example, CMS proposes to

[18] Centers for Medicare & Medicaid Services. Quality Reporting Center. 2015. Ambulatory surgical centers have option to suppress quality data code-based measures from public release. E-mail announcement. October 23.
[19] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

change the threshold of the number of patients that view, download, and transmit information from the EHR from 5% to at least one patient.

Comment
We believe that EHRs improve care coordination, patient access to information, and patient safety, but we are not convinced it benefits patients or improves health outcomes if CMS defines and measures meaningful use of EHRs. The Commission has long had concerns about the overall meaningful use approach of paying hospitals and clinicians to purchase EHRs, and about requirements for hospitals and clinicians to report information demonstrating that they use the EHRs. A better approach, in the Commission's view, is to ensure that the payment system itself creates a business case for the use of EHRs and encourages vendors to market products that improve care and interoperability.

We believe the current meaningful use program is complex and watered-down, as exemplified in the use of weak thresholds of "at least one patient" needed to meet some of the meaningful use requirements. We believe that Congress should retire the Medicare EHR incentive program. While CMS continues with the program, we encourage them to make the program simpler with minimal reporting effort. For example, hospitals and clinicians should attest to the implementation of a certified EHR with the capabilities to protect patient health information, electronically prescribe, exchange information with other providers, provide patient electronic access, and support quality measure reporting.

Although not addressed in these proposed rules, the Commission supports CMS's proposal to require clinicians and hospitals to cooperate with the surveillance of certified EHRs, especially if the surveillance advances the connectivity of electronic health information and interoperability of health information technology.[20] We also support the attestation that providers have not willingly and knowingly limited the interoperability of EHRs. We also encourage the Inspector General to investigate parties (vendor or providers) who knowingly or willingly block HIT compatibility.

[20] Medicare Payment Advisory Commission. 2016. Comment letter on 2016 proposed rule for Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule.

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.

Sincerely,

Francis J. Crosson, M.D.
Chairman

FJC/dz/wc