Regulatory Education and Action for Patients

• Seeking Common Ground

September 6, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 21244-1850

Re: CMS-1601-P: Medicare and Medicaid Programs; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals

Dear Administrator Tavenner:

The Regulatory Education and Action for Patients (REAP) Coalition would like to thank you for the opportunity to comment on the proposal entitled "Medicare and Medicaid Programs; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals" (the Proposed Rule), which was published in the *Federal Register* on July 19, 2013.[1]

REAP is an umbrella coalition comprised of patient advocacy groups whose goal is to strengthen current relationships and build new relationships with government agencies that have responsibility for Medicare, Medicaid and the implementation of health reform provisions of the Patient Protection and Affordable Care Act.[2] The unique experience and expertise of each REAP member organization allows REAP to present the patient voice in a cross-disciplinary manner. As such, REAP, through its member entities, expects to provide input on key healthcare regulatory proposals from a collective perspective that has not heretofore been characterized in comments submitted by other more disease-focused healthcare advocacy groups.

For ease of review, we have divided our recommendations and comments on the 2014 Hospital Outpatient Prospective System (HOPPS) Proposed Rule by topic. Our comments address site-of-service

[1] 78 *Fed. Reg*. 43533 (July 19, 2013).
[2] Pub. L. 111-148.

parity, supervision and condition of payment requirements for outpatient therapeutic services, and the structure of the *Hospital Compare* website.

Site-of-Service Payment Parity

REAP supports policy changes that would, where appropriate, establish payment parity between hospital outpatient departments (OPDs) and physician offices because parity would, in our view, enhance patient access and reduce patient costs. Our view is consistent with recommendations in the June 2013 MedPAC report to Congress.[3] In that report, MedPAC supported aligning payments across all ambulatory care delivery settings for those services that are performed in physician's offices more than 50 percent of the time, are infrequently provided in emergency rooms, involve average patient severities that are no greater in the hospital outpatient setting than in freestanding offices, and do not involve significant differences in resources as a result of packaging under the HOPPS.[4] We concur and urge CMS to move toward implementation of the MedPAC parity recommendations.

The reality is that higher payments for items and services furnished in OPDs can lead to the closure of physician practices and/or the consolidation of practices with hospitals, which are often in more densely populated urban areas – areas that tend to be less accessible to many rural residents. The shift in the site of delivery of cancer care recently[5] illustrates the point. Eight years ago, 87 percent of cancer care occurred successfully in cost-effective community oncology practices,[6] but by 2011 Medicare beneficiaries received nearly a third of their outpatient chemotherapy services in hospital-based OPDs.[7] Not surprisingly, a 2011 study also showed that hospital-based chemotherapy costs Medicare $6,500 more per beneficiary, and seniors pay $650 more in out-of-pocket spending per patient annually when they receive care in an OPD rather than a physician office.[8] The story is the same with many other physician specialties.

In our view, the higher Medicare allowables and associated higher beneficiary copayments that can attach to many services when they are delivered in hospital-base OPDs instead of a physician office fail to add perceptible value to the care patients receive. Recent news articles make it clear that individuals with commercial insurance are beginning to come to the same conclusion and challenge the added costs associated with facility fees when hospitals attempt to impose them.[9] The 2014 Physician Fee Schedule

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[3] MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013), available at www.medpac.gov/documents/Jun13_EntireReport.pdf.

[4] *Id.* at 37.

[5] *See* Community Oncology Alliance, Community Oncology Practice Impact Report, *The Changing Landscape of Cancer Care* (June 25, 2013) (showing that 469 oncology groups have entered into contractual relationships with a hospital, such as a professional services agreement, or been acquired outright by a hospital in the past 6 years) *available at* http://www.communityoncology.org/UserFiles/Community_Oncology_Practice_Impact_Report_6-25-13F.pdf.

[6] Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2001 for Medicare Fee-for-Service Beneficiaries; The Moran Company (May 2013), available at https://media.gractions.com/E5820F8C11F80915AE699A1BD4FA0948B6285786/01655fe9-7f3d-4d9a-80d0-d2f9581673a1.pdf.

[7] *Id.; see also* Community Oncology Alliance Practice Impact Report (June 25, 2013) (showing that since 2008 1,338 community cancer centers have closed, consolidated or reported financial problems), available at http://www.communityoncology.org/UserFiles/Community_Oncology_Practice_Impact_Report_6-25-13F.pdf.

[8] K. Fitch and B. Pyenson, Milliman Client Report, Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy (Oct. 19, 2011), available at http://publications.milliman.com/publications/health-published/pdfs/site-of-service-cost-differences.pdf.

[9] Hospital charges bring a backlash: patients objecting; adds scrutiny, The Boston Globe (March 11, 2013), available at www.bostonglobe.com/lifestyle/health-wellness/2013/03/10/patients-surprised-high-medical-bills-challenge-hospital-overhead-charges/EY2x6KTiPLiGXpSCyskKM/story.html.

Proposed Rule also cites similar articles questioning the additional costs when care is received in a hospital-based OPD.[10]

MedPAC also concluded in its June 2013 report that there is no justification for automatically paying hospitals higher rates for services that can be delivered safely and effectively in a physician's office just because hospitals incur higher costs to operate around the clock, offer emergency room services, sometimes treat higher acuity patients and are subject to survey and certification by Medicare or other accrediting organizations. REAP agrees because, we, like MedPAC, think that building subsidies into OPD payments to cover a hospital's indirect expenses associated with standby services and the like fails to target the added resources appropriately to those services. It also distorts pricing for outpatient ambulatory services that require the same level of resource commitment regardless of the site of service. It seems more logical for Medicare to develop ambulatory care payment methodologies that are site neutral and then to compensate hospitals for the unique services they do provide through a separate hospital overhead payment based on cost report data, in a manner similar to outlier payments currently provided by Medicare to qualifying hospitals.

For these reasons, we urge CMS to embrace MedPAC's recommendation to work expeditiously toward the establishment of site-of-service payment parity whenever appropriate. We also applaud CMS' plan to collect data on services furnished in off-campus hospital OPDs because we expect such data collection to be a meaningful first step toward a reduction in the payment disparities between OPD and physician office settings. We encourage CMS to use the collected data to assess whether such facilities actually qualify for provider-based status and, if they do, to determine whether site-of-service payment parity should be established between various OPDs (e.g., medical oncology department, cardiology department, etc.) and physician offices offering the same range of services.

Supervision Requirement for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals

The 2009 HOPPS Rule required direct supervision of all therapeutic services billed as an "incident-to" physician service in a hospital OPD regardless of the hospital's size. CMS interpreted this requirement as meaning that the supervising physician had to be physically present in the OPD when the "incident-to" service was rendered. Because of intense advocacy efforts on the part of the American Hospital Association and representatives of Critical Access Hospitals (CAHs) and other small rural hospital providers, CMS delayed enforcement of the direct supervision policy through the end of 2013 for CAHs and rural hospitals with fewer than 100 beds. It also conceded that the supervision requirement could be met by non-physician practitioners working within the scope of their licenses. Moreover, the supervising practitioner was only required to be "immediately available," not physically present in the OPD. CMS also designated certain services as suitable for either two-tiered or general supervision.

[10] 78 *Fed. Reg.* 43282, 43301 (July 19, 2013).

Now, under the Proposed Rule, CMS would end its direct supervision enforcement moratorium for CAHs and small rural hospitals paid under HOPPS. REAP is opposed to this proposed change in the *status quo* and favors instead extending the enforcement delay. CMS has not outlined, nor have we become aware of, any safety or quality concerns resulting from the enforcement moratorium that would justify the reduced access to care in many rural communities that will result from the proposed supervision policy change. The number of physicians and non-physician practitioners providing services in rural areas is already inadequate to meet the current needs of many communities, much less the added demands the direct supervision requirement would impose. It seems likely to us that implementing the direct supervision policy in CAHs and small rural hospitals is likely to leave those facilities with little choice but to limit OPD hours and/or to close programs. Given the anticipated increase in demand in 2014 as the Affordable Care Act health insurance marketplaces come on line, the individual mandate becomes a reality, and Medicaid expansion takes hold in more than half the states, we strongly urge CMS to rethink this proposal and to extend the direct supervision enforcement moratorium for CAHs and small rural hospitals at least until it can assess the adequacy of the healthcare workforce in rural communities over the next several years.

New Condition of Payment for Outpatient Therapeutic Services

Under the Proposed Rule, it would become a new condition of payment that individuals furnishing outpatient therapeutic services and supplies "incident-to" the services of a physician or qualified non-physician practitioner in a hospital OPD must do so in compliance with applicable state laws. The intent of this proposal is to ensure that such services are performed by qualified individuals who meet each state's minimum standards for education and training. The change will also provide Medicare with recourse under its payment rules when they do not. This proposal addresses a patient safety issue, and we see it as way to ensure more consistent provision of high-quality care, not just to Medicare beneficiaries, but to all patients regardless of payer. The proposed new payment requirement seems particularly important in light of our recommendation that CMS forego the implementation of the direct supervision policy for CAHs and small rural hospitals. It is critical to ensure that ancillary personnel are properly trained, experienced, and potentially – in some states – even licensed given that they will be expected to work relatively independently in CAHs and small rural hospitals where many outpatient therapeutic services will not be subject to a direct supervision requirement if the current enforcement moratorium is extended.

The *Hospital Compare* Website

REAP supports making data collected under the Outpatient Quality Reporting (OQR) program available on the *Hospital Compare* website. Access to quality performance data can be a powerful tool for consumers trying to make an informed choice between healthcare service providers. We recognize that the statutory provision which underlies public reporting of OQR data merely requires that hospitals be given the opportunity to preview data to be posted before its public release,[11] and we know that CMS' current practice provides for such a preview opportunity. Accuracy, fairness, and reliability necessitate more. We urge CMS to enhance the preview process by building in a dispute resolution procedure so that hospitals can challenge and CMS can correct inadvertent errors before OQR data are posted. Errors do happen and a dispute resolution process seems particularly appropriate in the case of hospital OQR data given the role that CMS expects the data to play in informing prudent consumer

[11] Social Security Act §1833(f)(17)(E).

"shopping." The fact that OQR data can be made publicly available whether or not it has been validated for payment purposes also argues for such a process.[12]

REAP members also encourage CMS to ensure that the *Hospital Compare* website remain user friendly, even though it must present data that can be complicated and potentially confusing if not well structured. As such, it is essential not only that information published on the *Hospital Compare* site be accurate and fair, but also that it be impartial and presented in plain English at a sixth-grade reading level. The site should use a simple format that is easy to navigate and unencumbered with graphics that will slow down Internet operations so that consumers can easily view the information on smart phones or other mobile devices, which are often used by many, especially those with lower incomes, as personal computers. We also encourage CMS to ensure that the *Hospital Compare* website will automatically translate into languages other than English that are commonly spoken throughout the United States, such as Spanish, for use by those with limited English proficiency. CMS has already established appropriate rules governing website translation design for Medicare Part D, and it should routinely apply those standards to any website designed to inform the public about the quality or availability of healthcare services and/or health insurance options.[13]

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Again, we appreciate the opportunity to share our perspective on the Proposed Rule with you. REAP members stand ready to answer questions and provide any additional information about the patient groups for whom we advocate.

Sincerely,

Alpha-1 Association
Alpha-1 Foundation
American Kidney Fund
Cancer Support Community
C-Change
COPD Foundation
Cutaneous Lymphoma Foundation
Epilepsy Foundation
HealthHIV
Kidney Cancer Association

[12] 78 *Fed. Reg.* at 43645/
[13] *See* Medicare Prescription Drug Benefit Manual, Chapter 2, Section 30.7.

Leukemia & Lymphoma Society
LUNGevity Foundation
National Osteoporosis Foundation
National Patient Advocate Foundation
Prevent Cancer Foundation
Retiresafe
Sisters Network
Susan G. Komen for the Cure
Us TOO International Prostate Cancer Education and Support Network
Zero - The Project to End Prostate Cancer