HAP Comments—Outpatient Prospective Payment System
Proposed Rule for Calendar Year 2017

SECTION 603 SITE-NEUTRAL POLICIES

The 2017 Outpatient Prospective Payment System (OPPS) proposed rule proposes to implement the site-neutral provisions of the Bipartisan Budget Act of 2015. Section 603 of the Bipartisan Budget Act (P.L. 114-74) imposes “site-neutral” payment policy impacting new off-campus provider-based hospital outpatient departments (HOPD). In the rule:

• Beginning January 1, 2017, new provider-based, off-campus outpatient departments no longer will be paid under the CMS OPPS. Payment would be made under another “applicable payment system.”
• A new provider-based, off-campus outpatient department is defined as an entity, not on the main campus of a hospital and located more than 250 yards from the main campus that executed a CMS provider agreement and billed for a covered HOPD service after the date of enactment of the budget agreement, November 2, 2015.
• A grandfather clause preserves payments for excepted off-campus provider-based HOPDs that were billing for Medicare outpatient services before November 2, 2015.
• Excepted items and services are:
  – All items and services furnished in a dedicated emergency department (DED) whether or not they are emergency services
  – Items and services furnished and billed by an off-campus, provider-based HOPD prior to November 2, 2015
  – Items and services furnished in a hospital department within 250 yards of a remote location of the hospital

In general, HAP is very concerned about the proposed rule. In May, a majority of both the U.S. House and U.S. Senate sent letters to CMS urging reasonable flexibility in the implementation of the Section 603 policy. Seventeen members of the Pennsylvania delegation signed on to the U.S. House letter and the U.S. Senate letter. The proposed rule, as written, does not present workable policies. At worst, it provides no payment for hospitals for services provided, and at best, it firmly freezes time at November 2, 2015 for outpatient services provided. The proposed policy will be damaging to the progress of off-campus clinical care, which ultimately may affect access to important services for the populations hospitals serve.

Key Site-Neutral Provisions:

• Grandfather Date: The November 2, 2015 enactment date provided little to no advanced notice of a payment change that would have a significant impact on financial projections for hospitals and health systems that were in the process of planning or executing the creation of new HOPDs or altering the footprint of an existing facility. Many Pennsylvania hospitals that were mid-project when the budget agreement was enacted are now faced with the very difficult decisions of whether to continue with a
project that may no longer be financially feasible under the new payment policies. This has the potential to severely impact the ability of hospitals and health systems to meet the needs of their communities.

**HAP requests that all possible measures are taken to ensure appropriate consideration for facilities that were/are under development at the time of enactment.**

- **Hospital Payment:** For calendar year (CY) 2017, CMS proposes the Medicare Physician Fee Schedule (MPFS) to be the “applicable payment system” for the majority of non-excepted items and services furnished in an off-campus, provider-based HOPD. Physicians furnishing such services would be paid at the non-facility rate under the MPFS for services they are permitted to bill. Off-campus, provider-based HOPDs would not receive reimbursement for services provided such as nursing, imaging, chemotherapy, and surgical services. Hospitals may continue to bill for services that are not paid under the OPPS, so long as the requirements to bill under that payment system are met. This payment proposal would be a one-year transitional policy while CMS continues to explore operational changes that would allow an off-campus, provider-based HOPD to bill Medicare for its services under a Part B payment system other than the OPPS beginning in 2018.

In short, the rule proposes no payment for hospitals for 2017, as CMS needs to explore how to operationalize payment under a new payment system. This means that for an entire year, hospitals running off-campus HOPDs will not receive appropriate payment for services provided, and will need to assume the expense of staff and resources at these locations if they are intending to continue to provide services in these locations—thus meeting the needs of their communities. As an alternative, hospitals will have to orchestrate appropriate contracting with physicians in order to share in the professional reimbursement paid through the MPFS, which will be reimbursed at non-facility rates.

It is unacceptable and unreasonable to provide no payment to hospitals for services they provide to Medicare beneficiaries.

Also of significance, there is an extremely limited amount of time between the issuing of the final OPPS rule and implementation two months later. Developing and negotiating contracts with a large number of physicians that are compliant with Stark, anti-kickback, self-referral, and other similar laws will take significant time and effort. And, CMS has indicated the need for data collection. The regulatory timeline will not provide sufficient time for CMS to develop and test a system to gather information from hospitals, or for hospitals to properly report the data.

**CMS must provide appropriate hospital compensation for services provided by hospital outpatient departments utilizing hospital resources.**
HAP urges CMS to delay implementation until a reasonable methodology for payment is developed—at least one year.

Finally, as the American Hospital Association presented in the legal analysis it submitted to CMS, this policy presents very significant legal compliance concerns for hospitals under the Stark law and the Anti-kickback statute.

- **Circumstances Negating Excepted HOPDs**

  - **Relocation and Rebuilding**: The proposed rule sets strict limitations for the relocation and rebuilding of current excepted HOPDs. Specifically, a grandfathered, off-campus, provider-based HOPD will lose its excepted status if it changes its physical location (as of November 2, 2015)—going so far as to say that if the suite number changes, the HOPD will lose its excepted status.

    CMS is also seeking input regarding circumstances where relocating/rebuilding should be permitted.

    There are a number of valid and appropriate reasons that a HOPD may need to relocate/rebuild, including but not limited to adapting to new state and federal laws, lease issues, obsolete facilities, and natural disasters. **This provision should be implemented with the flexibility to consider the individual circumstances for which relocation or rebuilding may be required. An exception process should include provider attestation only. Written approval should not be required.**

  - **Expansion of Services**: The proposed rule states that additional items and services beyond those within the “clinical families of services” furnished and billed prior to that date will not be eligible for OPPS payment. This provision is fraught with issues, including CMS’ inability to identify the services currently being provided by excepted HOPDs. The proposed rule also fails to mention large categories of clinical families of services, for example, drugs and new technology services. The proposal creates complicated billing processes in the event that a patient encounter involves both excepted and non-excepted services.

    **It is imperative that this proposal be re-evaluated, as applying this provision in such a limited manner will handicap hospitals and health systems from adapting to meet the ever-changing needs of the populations they serve and keeping up with the rapid pace of technological advances in medicine.** The proposed approach is contrary to many other recent CMS efforts that focus on population health, including efforts to leverage the outpatient setting to provide cost-effective care.
**Change of Ownership:** If a hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from the prior owner, the off-campus, provider-based HOPD may maintain its grandfathered status under the other rules outlined in the regulation. Individual grandfathered off-campus provider-based HOPDs cannot be transferred from one hospital to another.

This provision is particularly troubling for the rural parts of our state. In the event that a rural community hospital, faced with financial hardship, is forced to close inpatient beds, this provision may hinder efforts to preserve health care in the community by selling HOPD assets to a different hospital or health system.

**HAP urges CMS to allow HOPDs to be transferred and maintain excepted status.**

**HOSPITAL VALUE-BASED PURCHASING PROGRAM**

The rule proposes removing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) pain management questions from the scoring methodology. HCAHPS, a patient satisfaction survey required by CMS for all hospitals, is used as a significant component of the scoring for hospitals under the value-based purchasing program.

The survey includes questions related to pain management, including asking patients if they need medicine for pain, how often their pain was well controlled, and if the hospital staff did everything they could to help with pain.

As the country faces an opioid epidemic, CMS acknowledged in the proposed rule that these questions may create pressure for hospital staff to prescribe opioids in order to please patients for purposes of ensuring positive scores on the HCAHPS and therefore has suggested removing these questions from the scoring so as to “mitigate even the perception that there is a financial pressure to overprescribe opioids.”

**HAP supports the decision to remove these measures from inclusion in the scoring for the value-based purchasing program for hospitals.** HAP and Pennsylvania hospitals agree that pain management is a key area of focus and will continue to be regardless of the removal of these measures from the program.

It is assumed that these measures will continue to be required under the Inpatient Quality Reporting (IQR) program, and the HCAHPS STAR rating calculation, both displayed publically. In the absence of removal from these programs, the possibility of feeling financial incentive or pressure to over-prescribe as a means of keeping patients happy is still present. **HAP urges CMS to expand the exclusion of the pain management questions from both the IQR program and the STAR rating.**
MEDICARE ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

Hospitals strongly support the use of electronic health records (EHR) and other technology to support our shared goals of better-coordinated, value-based care, and they have been working diligently to implement new health information technology (IT) to improve the coordination, quality and safety of care for patients. However, the complexity of the EHR Incentive Program has required excessive spending and focus on meeting meaningful use (MU) criteria; diverting resources that could be better spent on patient care.

HAP appreciates, and supports, the CMS-proposed changes to the Medicare and Medicaid EHR Incentive Programs:

- Changes to the EHR Incentive Program objectives and measures for eligible hospitals (EH) and critical access hospitals (CAH) for Modified Stage 2 and Stage 3, starting with the EHR reporting periods in CY 2017
- Changes to the EHR reporting period in CY 2016 for EHs, CAHs, and eligible providers (EP)
- To revise the reporting period for EHs, CAHs, and EPs that are new program participants in CY 2017
- To clarify the policy on measure calculations for actions outside the EHR reporting period, and
- A one-time significant hardship exception from the 2018 payment adjustment for new EPs in the EHR Incentive Program in CY 2017 that are transitioning to the Merit-Based Incentive Payment System (MIPS) in CY 2017

Hospitals do require further clarification regarding the applicability of the proposals to remove objectives and measures or change measure thresholds on dual-eligible EHs and CAHs attesting under the Medicaid EHR Incentive Program. **Please confirm that dual-eligible hospitals will be able to attest to the modified MU requirements with CMS and that state Medicaid programs will be able to rely on the Medicare attestation to determine Medicaid EHR Incentive Program payment eligibility.**

These proposed changes to the MU requirements begin to reflect the EHR Incentive Program experience to date. **However, there needs to be additional flexibility in the program measures so that providers can use certified EHRs to support high-quality clinical care and patient engagement, and delay new program requirements until the standards and infrastructure supporting the exchange of health information are mature.**
HAP recommends the following:

- **Ninety-Day Reporting Period**: Allow a reporting period of any 90 consecutive days in the first year of a new stage of meaningful use.

- **Postpone Stage 3**: Postpone the required start of Stage 3 until a date no sooner than 2019.

- **Eliminate All-or-Nothing Approach**: Eliminate the all-or-nothing approach in meaningful use. HAP recommends that EHs and CAHs that attest to meeting 70 percent of the MU requirements be designated as having met meaningful use.

- **Mature Functionality**: Focus on the availability of mature functionality in certified EHRs rather than thresholds that count the use of functionality. Mature standards must exist before providers are required by regulation to use them.

Pennsylvania’s hospitals are working toward a health care system where all providers are meaningfully using certified EHRs to improve patient care and safety as well as achieve national goals for improvement in the care of patients and populations. HAP believes the recommendations presented in this letter will fulfill the goals of the HITECH Act to create a constructive and positive pathway for nationwide adoption of EHRs. The focus on increased EHR adoption and on interoperability will ensure that EHRs and other health IT tools can enable the efficient sharing of health information in support of care delivery, patient engagement, and new models of care.