Illinois Health and Hospital Association

September 11, 2017

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: CMS-1656-P, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule (*Federal Register,* Vol. 82, No. 138, July 20, 2017)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for hospital outpatient and ambulatory surgical services for calendar year (CY) 2018. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule. However, IHA has strong concerns with certain provisions, and presents the following comments for your consideration:

REDUCTION IN PAYMENT FOR DRUGS PURCHASED UNDER THE 340B DRUG PRICING PROGRAM:

IHA strongly opposes CMS' proposal to reduce Medicare Part B payments for drugs acquired through the 340B Drug Pricing Program; consequently, we urge the agency to withdraw its proposal for the following reasons:

- CMS states that one goal of its proposal is to "make Medicare payment for separately payable drugs more aligned with the resources expended by hospitals to acquire such drugs while recognizing the intent of the 340B program to allow covered entities, including eligible hospitals, to stretch scarce resources while continuing to provide access to care." However, in reality, the proposal would do great harm to these hospitals that serve our most vulnerable citizens, undermining the purpose of the 340B program established by Congress. Specifically, it would undercut the 340B program's value as a tool for lowering drug prices and disrupt access to care for those in greatest need, including low-income Medicare beneficiaries.

  Congress created the 340B program for hospitals that care for a high percentage of low-income and uninsured patients. Many 340B hospitals are

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the economic engines of their community, and the discounts they receive through the 340B program play an important role in allowing these organizations to care for patients. However, these facilities are financially vulnerable. According to the latest estimates available for Illinois hospitals, the average Medicare margin for outpatient services in 2016 was -13.12 percent.

In order to identify which drugs are covered under the 340B and which are not, CMS would require hospitals to report a modifier on the Medicare claim that would be reported with separately payable drugs that were not acquired under the 340B program. Implementing CMS' proposed modifier would be administratively burdensome, costly to operationalize and would appear to contradict the agency's commitment and active efforts to reduce regulatory burden for providers. In addition, we have significant concerns about whether our hospitals can implement CMS' proposed modifier accurately. The modifier would have to be added to the claim at the time service is rendered, or it would have to be retroactively added, thus delaying the submission of the claim. In particular, this would be difficult in multi-use areas, such as emergency departments, catheterization laboratories and pharmacies, where both 340B eligible patients and non-340B patients are served.

In conclusion, IHA believes that CMS' proposed reduction in Medicare Part B payments for 340B drugs will put significant financial pressure on our hospitals, negatively impacting their ability to provide high-quality care to their Medicare beneficiaries and their communities at large. **IHA urges CMS to withdraw the 340B drug payment proposal and redirect its efforts toward halting the unsustainable increases in the cost of drugs.**

DIRECT SUPERVISION OF HOSPITAL OUTPATIENT THERAPEUTIC SERVICES: IHA has long advocated for the repeal of the application of Medicare's direct physician supervision requirement of outpatient therapeutic services provided in small rural and critical access hospitals. In the proposed rule, CMS is reinstating the moratorium on the application of this requirement for CYs 2018 and 2019. **While IHA supports the proposal, ultimately, our recommendation to CMS is to repeal the policy in its entirety. We also strongly recommend that CMS apply the moratorium retro-actively to CY 2017 as well, as it is our understanding that the direct supervision requirement is currently being implemented.** Lifting the moratorium for a single year only is an inconsistent and illogical approach.

REMOVAL OF TOTAL KNEE ARTHROPLASTY FROM THE INPATIENT ONLY, COVERED LISTING: CMS proposes to remove total knee arthroplasty (TKA) from the inpatient-only list, which would allow for Medicare coverage of the TKA in either an inpatient or an outpatient setting. CMS has identified two procedures to remove from the inpatient-only list for CY 2018. These services are:

• CPT 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (TKA)) and
• CPT 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed).

IHA supports the versatility of coverage in both an inpatient and outpatient setting. **However, we advise CMS to respect the physician's decision on which of those settings is most appropriate based on the individual patient's medical condition, and does not base its coverage decision on which of the two settings results in a lower Medicare payment to the provider.**

PARTIAL HOSPITALIZATION PROGRAM (PHP) PAYMENTS: In CY 2017, CMS consolidated the two previous current ambulatory payment classification (APC) categories for hospital-based, partial hospitalization services into one. Previously, there were two APC per diem payments based on the number of daily services—one for three services and the other for four or more services. CMS is proposing to continue the one APC per-diem payment for three or more daily services, with little recognition of the additional costs.

Maintaining beneficiary access to partial hospitalization services is one of several important objectives of IHA's focus on the provision of behavioral health services in Illinois. It is very important that fair reimbursement for those services be made to those providers to allow for the access to those services to be maintained in Illinois communities. **Therefore, IHA recommends that CMS rescind its current policy and revert back to the use of two current ambulatory payment classification (APC) categories, along with two separate per diem payments.**

PROPOSED INCREASE IN THE FIXED LOSS OUTLIER THRESHOLD: CMS proposes to increase the fixed loss threshold for Medicare outlier payments from $3,825 in CY 2017 to $4,325 in CY 2018, a 13.1 percent increase. CMS defends this increase as necessary in order to ensure that outlier payments remain at the statutorily mandated 1 percent of total OPPS payments. **IHA is concerned that such a drastic reduction in outlier payments will have an adverse effect on access to services by Medicare beneficiaries and recommends that CMS implement this comparatively large increase over a three-year transition period.**

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at (630) 276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO