WISCONSIN HOSPITAL ASSOCIATION, INC.

September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1676-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Ms. Verma:

On behalf of our more than 135 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to payment policies under the Physician Fee Schedule (PFS).

WHA was established in 1920 and is a voluntary membership association. We are proud to say that we represent all of Wisconsin's hospitals and integrated health systems. Our members include small, mid and large-sized hospitals, including many Critical Access Hospitals and several large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans hospitals among our members. In addition, many of these entities employ or are closely affiliated with physicians and other providers. Our comments will focus on proposed payment changes for off-campus provider-based hospital outpatient departments, the Physician Quality Reporting System (PQRS) and the 2018 Value Modifier.

Provider-Based Department (Section 603) Payment Reduction

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) required that, with the exception of emergency department services, services furnished in off-campus provider based departments (PBDs) that began billing under the Outpatient Prospective Payment System (OPPS) on or after Nov. 2, 2015 (referred to as "nonexcepted services") were no longer to be paid for under the OPPS. Instead, these services were covered and paid for under "another applicable Part B payment system." For CY 2017, CMS finalized the PFS as the applicable Part B payment system for most nonexcepted services and set payment for most nonexcepted services at 50 percent of their prior OPPS rate.

In the CY 2018 PFS proposed rule, CMS proposes further reductions to these nonexcepted services, setting those rates at 25 percent, rather than the previous 50 percent, of the OPPS rate.

CMS indicates it is basing this reduction solely on a comparison of one payment code (hospital outpatient clinic visit) to the payment for a similar outpatient visit under the PFS. CMS then uses this differential to establish a "PFS Relativity Adjuster" of 25 percent. WHA objects to this approach. We do not believe basing an entire group of nonexcepted service payments on one code is sound policy. In fact, CMS admits the proposed methodology fails to take into consideration the many other services provided in off-campus PBDs which are not akin to the one payment code it reviewed. Basing all payment rates on one code disregards multiple other factors, including the mix of services furnished by nonexcepted PBDs, differences between the packaging policies under OPPS versus the PFS, and other payment adjustments that differ between the payment systems.

Unfortunately even though CMS recognizes the deficiency in its approach and states that it cannot review claims data to develop a better cost comparison, it still views the 25 percent PFS relatively adjuster as its "proxy." Since the agency requests comments about moving to the 25 percent relatively adjuster or another relatively adjuster, WHA suggests that, in the absence of data and payment fairness, the agency maintain its current payment approach instead.

WHA expressed strong concerns in our 2017 OPPS comment letter on the approach CMS was taking at that time to operationalize the Section 603 change. That letter read: **"CMS must revamp its proposed policy entirely and establish one that provides for appropriate reimbursement to hospitals for services delivered and to ensure that Medicare patients have continued access to high quality care in their local communities." We strongly object to further payment reductions as are proposed in the FY 2018 PFS. Hospitals must be paid adequately in order to continue serving as essential access points to care. We urge you <u>not</u> to move forward on the proposed PFS reductions for nonexcepted services.**

Further, WHA urges CMS to provide flexibility under this policy for the following issues:

- ***Relocations.*** WHA continues to urge CMS create a reasonable and fair policy for relocating off-campus PBDs. Freezing these locations in time as they existed on November 2, 2015 works counter to providing the most efficient, patient-centered care because it will lock into place a delivery system structure based on a snapshot in history. We believe CMS's approach may result in *less* coordinated care and *less* access to care for Medicare beneficiaries for various services. Relocation or even rebuilding may be necessary due to any number of reasons, including updating outdated facilities or providing a new, needed access point to care in a rural community, as examples. There is precedence with CMS allowing relocation or rebuilding of grandfathered facilities, so this would not break new regulatory ground. **WHA urges CMS to support local access to care by developing a more flexible policy for relocating excepted PBDs under appropriate circumstances.**

- ***Partial Hospitalization Programs.*** WHA continues to believe Section 603 creates an additional barrier for providing access to care for individuals with mental health care needs. We know of multiple instances in Wisconsin where partial hospitalization programs (PHPs) were to be placed into communities where comprehensive outpatient psychiatric services were needed. At issue with these critical mental health care services

under Section 603 is that they are not reimbursable in a like way under any other Medicare reimbursement schedule. **When there is a growing chorus of support and recognition that treating individuals with mental health care is vital, WHA urges CMS to help provide access to care for those with mental health care needs by exempting the small number of PHP codes from Section 603 entirely.**

- ***Change of Ownership.*** WHA urges CMS to provide for an excepted off-campus PBD to retain its excepted status if it is individually acquired by or merged with another hospital, particularly in an intra-system PBD transfer or merger. In an intra-system transfer or merger there may be situations where one of the provider agreements would need to be terminated, but since there is no sale or purchase of these PBDs and the originating hospital and PBD would still be within the same health care system, we do not see how or why excepted status should be at risk. **We urge CMS to allow for individual PBDs to be transferred or merged from one hospital to another within a health care system and be able to maintain their excepted status.**

Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System (PQRS) is being replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures in 2016 are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS services. 2016 was the last reporting period for PQRS. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. The first MIPS performance period is January through December 2017.

WHA supports the proposed change to the current PQRS program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS. Clinicians in our member health systems who must report under MIPS appreciate CMS's goal to provide continuity between the phased-out PQRS reporting requirements and the MIPs quality measures. As our member health systems adjust to the Quality Payment Program's requirements, providing this continuity will assist them in making the transition from the PQRS to MIPS.

2018 Value Modifier

CMS is proposing the following changes to previously-finalized policies for the 2018 Value Modifier:

- Reducing the automatic downward payment adjustment for not meeting minimum quality reporting requirements from negative four percent to negative two percent (-2.0 percent) for groups of ten or more clinicians; and from negative two percent to negative one percent (-1.0 percent) for physician and non-physician solo practitioners and groups of two to nine clinicians.

- Holding harmless all physician groups and solo practitioners who met minimum quality reporting requirements from downward payment adjustments for performance under quality-tiering for the last year of the program.
- Aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.

WHA supports these proposed changes that will reduce penalties on providers during the last year of the value based modifier payment adjustment. These proposed changes will allow providers time to manage the transition to the QPP.

Should you have additional questions or if we can assist in other ways, please contact Jenny Boese, VP-Federal Affairs & Advocacy at 608-268-1816 or jboese@wha.org or me.

Sincerely,

Eric Borgerding
President & CEO