WISCONSIN HOSPITAL ASSOCIATION, INC.

September 2, 2016

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

RE: CMS-1656-P, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Certain Off-campus Outpatient Departments of a Provider; Proposed Rule (Vol. 81, No. 135), July 14, 2016.

Dear Mr. Slavitt:

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 rule for calendar year (CY) 2017 hospital outpatient prospective payment system (OPPS).

WHA was established in 1920 and is a voluntary membership association. We are proud to say that we represent all of Wisconsin's hospitals. 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.

Regarding the 2017 OPPS rule, the majority of our letter will focus on CMS's proposed implementation of the Bipartisan Budget Act 2015's (BBA 2015) Section 603 related to hospital outpatient departments and their use of the OPPS, but we will offer several comments on CMS's proposals for meaningful use as well.

Section 603 Implementation Concerns

While the hospital field and more than half of the U.S. House and Senate this spring urged CMS to provide reasonable flexibility when implementing BBA 2015 Section 603, unfortunately, CMS has proposed a policy that is unworkable and, further, unfair with respect to reimbursing hospitals for services rendered to Medicare beneficiaries.

WHA believes 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.

Payment Policy for Nonexcepted HOPDs

CMS states that complexities in its own systems would require it to make *no payment* in 2017 to "nonexcepted" hospital outpatient departments (HOPDs) for the services they provide to Medicare beneficiaries. In other words, the agency would not provide any reimbursement to HOPDs for a host of services, including nursing, laboratory, imaging, chemotherapy, surgical and many other reasonable and necessary services they provide to Medicare beneficiaries. **WHA strongly believes this is inappropriate with respect to implementing Section 603.**

While there may be complexity to the implementation of this policy by CMS, this complexity does not allow CMS to disregard its responsibility in providing hospitals adequate and fair reimbursement. We believe that the agency's basis for its "non-payment" policy is faulty and that it has found ways in the past to pay hospitals directly under a non-OPPS Medicare Part B payment system. While it may not be the easiest way for CMS to pay hospitals, CMS certainly does have a means to do so for those nonexcepted services. **A zero reimbursement policy for hospitals in 2017 is unreasonable.**

The agency has a responsibility to develop or use mechanisms it has used in the past to provide reasonable payment to hospitals. It should not implement these policies until it addresses this unfairness.

Partial Hospitalization Programs

One specific concern we continue to have is the negative impact of Section 603 on 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. Providing services in the outpatient setting delivers care to those in need at a substantially lower cost to the Medicare program.

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. Further, **CMS's proposed policy would make no payment whatsoever to hospitals for establishing new, much-needed access points for these mental health care services.** WHA believes failure to address the PHPs will mean new outpatient treatment services will likely *not* materialize in communities where need is greatest.

When there is a growing chorus of support and recognition that treating individuals with mental health care needs is absolutely necessary, WHA urges CMS to help provide access to care for those with mental health care needs by exempting current or future partial hospitalization programs from Section 603. These services must be appropriately reimbursable under the OPPS.

Relocation and Rebuilding

As CMS considers how to create a reasonable and fair payment policy for hospitals, WHA has additional concerns with other elements of the CMS proposed rule. When we look at the CMS proposed policy, we see one that seeks to implement a "point in time" exception to Section 603. In other words, CMS attempts to freeze HOPDs in time as they existed on November 2, 2015, the date of the BBA 2015's enactment. **WHA disagrees with using this approach and believes CMS's policy will work 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.** We cannot believe this is an outcome Medicare or its beneficiaries would desire.

WHA is concerned that unless adequately addressed in the final OPPS rule, current provider-based HOPDs could potentially lose their excepted status should they need to relocate or rebuild a facility. Relocation or 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.

The issue of relocations is both an urban and a rural issue, and CMS's proposed policy would penalize hospitals as they work daily to meet the health care needs of their unique communities. Further, rural Prospective Payment System hospitals face different demographics and delivery system designs in order to meet the needs of their rural communities. HOPDs may be used to help push the doors of the hospital out into surrounding rural communities and to locate care – especially primary care – where Medicare beneficiaries live.

Therefore, WHA would urge CMS to support local access to care by ensuring that current excepted HOPDs are able to relocate or rebuild under appropriate circumstances. At a bare minimum, we urge CMS to provide a realistic exceptions process for HOPDs that need to relocate or rebuild. Limiting that process to a natural disaster or extraordinary circumstance fails to provide a real remedy. Rather, we suggest CMS look at any number of other variables, such as maintaining access to care for Medicare beneficiaries, as it develops a suitable exceptions process.

Expansion of Services

CMS proposes that, if an excepted HOPD expands the types of services it provides after November 2, 2015, those services would be consider "nonexcepted" and, therefore, would also receive no payment in 2017. This is problematic. Off-campus HOPDs must be able to alter or expand the items and services that they offer in order to meet changes in clinical practice and the changing patient care needs of their local communities. CMS policy, instead, creates a barrier to ensuring Medicare beneficiaries would have access in the future new, emerging technologies or new, needed services. Further, we do not find any statutory language in the BBA 2015 that requires CMS to treat these varying services in an excepted HOPD in this way. A plain language reading of that statutory text makes no specific reference to changes in services.

Therefore, WHA believes CMS must provide more flexibility in expansions of services so that patients continue to have access to the services they need at their local health care facility.

Change of Ownership

WHA is concerned that CMS's proposal would not permit an excepted off-campus HOPD to retain its excepted status if it is individually acquired by or merged with another hospital. Hospitals in financial difficulty that plan to close their inpatient hospital beds may offer to transfer their HOPDs to other hospitals in order to ensure that critical hospital-based outpatient services are still accessible to patients in the community. Such acquisitions would not be financially feasible if the HOPD were to lose its payment.

Additionally, we are unsure how CMS's proposed language would impact intra-system HOPD transfers or mergers. CMS proposes transferring the excepted HOPD status to the "new" owner only if ownership is transferred and the Medicare provider agreement is accepted/assumed. With an intra-system transfer or merger, we would suggest there is no "new" owner per se, so an HOPD's excepted status would not be in jeopardy. However, CMS then indicates that if the provider agreement is terminated then so, too, is its excepted status. 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 HOPDs and the originating hospital and HOPD would still be within the same health care system, we do not see how or why excepted status should be at risk. We would urge CMS to state that in its final rule.

At minimum, we urge CMS to allow for individual HOPDs to be transferred or merged from one hospital to another within a health care system and be able to maintain their excepted status.

Section 603 Implementation: Conclusion

Overall, WHA believes CMS's proposed policy is unworkable and unfair in its current form. Ultimately, the proposed rule works contrary to creating patient-centered, streamlined care delivery systems as desired by the Medicare program. It creates inefficiencies in the delivery and operations of health care providers, and is a step backwards from where healthcare should be going. CMS's proposed implementation of Section 603 only complicates the underlying law and creates further unfair and untenable requirements.

<u>Medicare and Medicaid EHR Incentive Programs</u>

While WHA is opposed to CMS's proposed implementation of Section 603, we are pleased to see that the agency has heeded the recommendations that WHA and others have made to CMS in previous comment letters regarding the need for flexibility under the Medicare and Medicaid EHR Incentive Programs for hospitals (PPS hospitals and CAHs) and physicians seeking to attest to meaningful use. WHA urges CMS not only to finalize these proposals but also to expand the proposals to cover additional EHR reporting periods, as explained below.

2016 EHR Reporting Period

WHA is pleased that CMS has proposed shortening the Medicare and Medicaid EHR Incentive Program 2016 reporting period for physicians and hospitals to any continuous 90-day period within CY 2016, and we urge CMS to finalize this proposal.

CMS notes that it received feedback from hospitals and hospital associations and "now understand[s] from those stakeholders that more time is needed to accommodate some of the updates from the 2015 EHR Incentive Programs Final Rule." WHA, which was among those hospital associations that provided CMS with such feedback, is concerned that when hospitals begin reporting on the Stage 3 objectives and measures, similar accommodations likewise will be needed. **For that reason, we reiterate our recommendation from previous comment letters that CMS should establish a 90-day EHR reporting period for the first year of any new meaningful use "stage."**

Elimination of the CDS and CPOE Reporting Objectives and Measures Starting in 2017

WHA supports CMS's proposal to eliminate the clinical decision support (CDS) reporting objective (and two associated measures) and the computerized provider order entry (CPOE) reporting objective (and three associated measures) for hospitals attesting to meaningful use under the Medicare EHR Incentive Program in 2017 and future years. Reducing unnecessary reporting requirements creates flexibilities and promotes successful provider performance.

In addition to finalizing this proposal, CMS should apply the proposal to the 2016 EHR reporting period for both hospitals and physicians. CMS says that based on 2015 attestation data, it believes that the CDS and CPOE objectives and measures have widespread adoption among hospitals and are no longer useful in gauging performance. If these objectives and measures are not useful for gauging hospital performance according to 2015 data, CMS should not wait until 2017 to eliminate the requirement to report on them.

In addition, CMS's proposal should extend to physicians in 2016, in order to align the reporting requirements for hospitals and physicians across the Medicare EHR Incentive Program. CMS is not proposing to eliminate these reporting objectives and measures for the Medicaid EHR Incentive Program because "states would have to implement major process changes within a short period of time if the changes were to apply to Medicaid." **WHA is disappointed that the late timing of this rulemaking will cause the reporting requirements of the Medicare and Medicaid EHR Incentive Programs to be misaligned.**

Reduction of Measure Thresholds in 2017 and 2018

WHA supports CMS's proposal to reduce the thresholds for a variety of measures in modified Stage 2 and Stage 3 for hospitals attesting to meaningful use under the Medicare EHR Incentive Program in 2017 and 2018. We urge CMS to adopt the proposed lower measure thresholds, which relate to patient engagement with the EHR, health information exchange, and public health reporting. CMS explains that these proposals originated from the

concerns raised by hospitals, hospital associations, and other stakeholders. Last year, WHA submitted comment letters to CMS that described how many of the modified Stage 2 and Stage 3 meaningful use measures were not experienced-based, not supported by mature certification standards, used arbitrarily high performance thresholds, and unfairly made success contingent on patient action and outside of the control of the hospital. CMS's proposals are consistent with our prior comment letters and will promote hospital success in meaningful use attestation.

CMS is not proposing a similar reduction to measure thresholds for the *Medicaid* EHR Incentive Program because "states would have to implement major process changes within a short period of time if the changes were to apply to Medicaid." As stated in the previous section, WHA is disappointed that the late timing of this rulemaking will cause the reporting requirements of the Medicare and Medicaid EHR Incentive Programs to be misaligned

Conclusion

WHA appreciates the opportunity to provide comments to CMS as you develop your forthcoming final regulation. While we are appreciative of the agency's adjustments to the Meaningful Use program, we have serious concerns with the proposed implementation of Section 603. With respect to the latter, WHA strongly believe CMS should revamp this proposal entirely before moving forward with any type of implementation. CMS policy must provide for fair reimbursement to hospitals for services delivered and must ensure that Medicare patients have continued access to high quality care in their local communities.

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