Indiana Hospital Association

September 11, 2017

Ms. 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–1678–P, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule (Vol. 82, No. 138), July 20, 2017.

Dear Ms. Verma:

On behalf of our member hospitals and health systems, the Indiana Hospital Association (IHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital outpatient prospective payment system (OPPS) proposed rule for calendar year (CY) 2018.

340B Reductions

The IHA concurs with the comments and concerns submitted by the American Hospital Association (AHA) regarding the proposed changes to the 340B Drug Pricing Program. The proposed reduction in Medicare Part B payments for drugs acquired through the 340B program will greatly constrain safety-net providers in rural and urban areas parts of Indiana. These changes would also have implications for the vulnerable patients who receive care from these providers.

Many 340B hospitals are the lifelines of their community and guarantee care for all patients, regardless of their ability to pay. The 340B program savings are essential to allow these hospitals to stretch scarce resources and extend valuable services into the community. For example, St. Catherine Hospital in East Chicago, Indiana, treats a high percentage of Medicaid and uninsured patients, but has used 340B savings to expand population health efforts such as health screenings, home health and pharmacy services. This is just one example of the way in which the 340B program sustains much needed services to low income patients.

Medicare Beneficiary Copayments under 340B

Part of CMS's rationale for proposing a reduction in payment for Part B drugs acquired under the 340B program is that the agency believes the proposal will reduce Medicare beneficiaries' drug copayments when seeking care from 340B hospitals. However, this is not accurate. The majority of Medicare beneficiaries coming to 340B hospitals do not pay their own copayments. According to a Medicare Payment Advisory Commission analysis, 86 percent of all Medicare beneficiaries have supplemental coverage that covers their copayments, of which 30 percent have their

copayments paid for by a public program, such as Medicaid, or by their Medigap plan.[1] Thus, CMS's 340B payment reduction proposal would not directly benefit many Medicare beneficiaries, dually eligible Medicare beneficiaries included, as it so claims.

CMS's Proposed Modifier for Non-340B Drugs

In order to identify which drugs are 340B and which are non-340B, 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's proposed modifier would be administratively burdensome, costly to operationalize, and, for some hospitals, nearly impossible to implement. It also is at odds with the agency's commitment and active efforts to reduce regulatory burden for providers.

In addition, we have significant concerns about whether our providers can implement CMS's proposed modifier accurately. This would require putting the modifier onto the claim at the time service is rendered, or retroactively applying it, thus delaying the submission of the claim. In particular, this would be difficult in mixed-use areas, such as emergency departments, catheterization laboratories and pharmacies, where both 340B eligible patients and non-340B patients are served.

In conclusion, we believe that CMS's proposed reduction in Medicare Part B payments for 340B drugs will put significant financial pressure on our organizations, negatively impacting their ability to provide care to Medicare beneficiaries and communities at large. We urge CMS to abandon the 340B drug payment proposal and redirect its efforts toward direct action to halt the unsustainable increases in the cost of drugs.

Off-campus Provider-based Departments Reimbursement

The IHA concurs with the comments and concerns submitted by the AHA regarding the proposed changes to the payment rates for services provided in off-campus provider based departments (PBDs). Specifically, for CY 2018, the agency proposes significant reductions in payments for these services to 25 percent of the outpatient prospective payment system (OPPS) rate, instead of its current rate of 50 percent.

Regardless of setting, it is important for Medicare to make reasonable and adequate payment for the high-quality care that hospitals furnish to Medicare beneficiaries. Hospitals should not be penalized for providing services in locations like off-campus PBDs that may best meet the needs of patients and communities.

CMS calculated the 2018 proposed reduction using a different methodology than it used for 2017 – basing it exclusively on only one service, which reflects the most commonly billed service in the off-campus provider-based department setting under the OPPS. The agency should retain its current methodology, which bases the rates on a comparison of payment for the most frequently billed services in off-campus PBDs. However, we also urge CMS to improve the accuracy of this methodology to account for differences in packaging across the OPPS and the PFS and to ensure that it accounts for both direct and indirect expense.

[1] MedPAC, June 2016 Databook, Section 3, p 27.

SUPERVISION OF OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS HOSPITALS (CAHS) AND CERTAIN SMALL RURAL HOSPITALS

IHA supports CMS's proposal to reinstate a moratorium on enforcement of its direct supervision requirement for outpatient therapeutic services provided in CAHs and small and rural hospitals. However, we urge the agency to make the enforcement moratorium permanent and continuous. We also urge CMS to eliminate the gap in the moratorium for 2017.

We believe that CMS's direct supervision policy is unwarranted in CAHs and small rural hospitals for several reasons:

- Non-physician hospital staff are professionally competent, licensed health care professionals who provide services that fall within their scope of practice in accordance with state law. In addition, the provision of care, especially in rural areas, is governed by clinical protocols, policies and procedures approved by the hospital's medical staff. Non-physician staff can contact a physician by phone, radio or other means if needed for routine consultation. Should an unforeseen situation arise, medical staff physicians can be summoned promptly.
- CMS's requirements severely restrict the ability of hospitals and CAHs to use effectively their existing resources to make supervisory assignments and leave them with limited options to comply.
- The requirement that the supervisor must be "immediately available" to intervene means that the supervising professional cannot be engaged in any other activity that cannot be interrupted at a moment's notice. In effect, the supervising physician or NPP must be on-site at all times when outpatient services are being furnished by hospital professionals, waiting for the unlikely circumstance in which they will be called upon to assist.
- Ensuring compliance forces small rural hospitals and CAHs to consider seriously eliminating certain services or reducing their hours of operation.

For all these reasons, the IHA urges CMS to make its enforcement moratorium permanent and continuous for CAHs and small rural hospitals.

IHA appreciates your consideration of these issues. Please contact me at tcole@ihaconnect.org or Brian Tabor, President at btabor@ihaconnect.org if you have any questions.

Sincerely,

Terry L.Cole
VP Finance