Texas Hospital Association

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Via electronic submission

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1717-P,
P.O Box 8013
Baltimore, MD 21244-1850

RE: CMS-1717-P, CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

Dear Ms. Verma:

On behalf of our more than 470 member hospitals and health systems, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the Hospital Outpatient Prospective Payment System. This is the second of our two comment letters concerning this proposed regulation. These comments address CMS' proposals regarding the following issues:

- Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals
- Area Wage Index
- Site-Neutral Payments
- Prior Authorization Process and Requirements for Certain HOPD Services
- Changes to the Inpatient-Only List/ASC Covered Surgical Procedures
- Preparation and Use of the Medicare Cost Report

Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals

CMS proposes to change the minimum required level of supervision from direct supervision to general supervision for hospital outpatient therapeutic services provided by all hospitals and CAHs. The direct supervision requirement for hospitals outpatient therapeutic services places an additional burden on providers-especially small rural hospitals and CAHs. This reduces their flexibility to provide medical care in a manner best suited to the needs of their patients.

- As this is a critical issue for our 150 rural hospitals, including 80 CAHs, THA strongly supports this proposal.

Area Wage Index

CMS proposes to adopt the final fiscal year IPPS wage index as the calendar year wage index for OPPS. While we commend CMS for increasing the wage index for those hospitals below the 25th percentile, CMS chose to modify the standardized amount to make this policy budget neutral. The implementation of this policy resulted in decreased payments for those hospitals below the 25th percentile.

- Rather than implementing this policy by adjusting the standardized rate in a budget-neutral manner, we strongly recommend that CMS use its existing authority to do so in a non-budget neutral manner.

Site-Neutral Payments

In it's CY 2019 OPPS final rule, CMS adopted the proposal to cut payments to excepted provider- based departments and to make the cuts in a non-budget neutral manner. CMS elected to phase in the payment reduction over two years-50% in 2019 and the remaining 50% in 2020.

Congress has established a clear structure for CMS to make annual changes to payments for covered hospital outpatient services under Medicare. Changes to payments that target only specific items or services must be budget neutral. Blaming increases in OPPS expenditures on the unnecessary shifting of services from physician offices to PBDs in response to payment differentials ignores the many factors outside of hospitals' control that also result in increases in OPPS volume and expenditures.

Making changes to hospital reimbursements of the magnitude proposed in the clinic visit policy would be excessive and harmful. CMS proposes to complete the phase-in of the cut in payment for clinic visits furnished in excepted- off-campus PBDs, resulting in payment at the physician fee schedule equivalent rate of 40 percent of the OPPS rate. Making additional cuts to outpatient payments of the magnitude proposed in the clinic visit policy would be excessive, harmful, and would endanger the critical role that HOPDs playing their communities.

- We recommend CMS immediately restore the higher payment rates for clinic visits furnished by excepted off-campus PBDs that existed before CMS adopted the payment cuts;
- CMS promptly repay hospitals the difference between the amounts they would have received under those higher rates and the reduced amounts they were paid; and
- CMS abandon its proposed second phase of the payment cut in 2020.

Prior Authorization Process and Requirements for Certain HOPD Services

CMS proposes to implement a prior authorization requirement for five categories of services. CMS claims that the volume of these services has unnecessarily increased and that a prior authorization would hep to ensure these services are billed only when medically necessary. While CMS presents data on increases in the volume of these services, CMS has not demonstrated that these volume increases are unnecessary.

- THA opposes CMS' proposal to implement a prior authorization requirement for these services;
- There are several existing processes CMS could use to verify medical necessity instead of imposing a new and costly prior authorization process that runs completely contrary to the agency's goal of reducing regulatory burden; and
- It is unclear why the regulatory burden is being imposed on hospitals when it is physicians who order and furnish the services that CMS claims have experienced an unnecessary increase in volume.

Changes to the Inpatient-Only List/ASC Covered Surgical Procedures

Each year CMS reviews the current list of procedures on the Inpatient-Only list to identify any procedures that may be safely removed from the IPO list. Over the last five years, CMS has removed 28 procedures from this list including total knee arthroplasty. This trend would accelerate if CMS finalizes its proposal to remove total hip arthroplasty (THA) from the IPO list in 2020. For CY 2020 CMS proposes to remove Total Hip Arthroplasty from the inpatient-only list.

CMS proposes to add eight procedures to the ASC list of covered surgical procedures including a TKA procedure as well as three coronary intervention procedures and three related add-on procedures.

CMS acknowledges in the proposed rule that TKA procedures were still predominately performed in the inpatient hospital setting in CY 2018 and that most beneficiaries may **not** be suitable candidates to receive TKA in an ASC setting. In a prior proposed rule, CMS proposed to eliminate the requirement that ASCs have a written transfer agreement with a nearby hospital or ensure that its physicians have admitting privileges at a hospital. Taking away these reasonable safeguards would put beneficiaries at even more risk.

- We oppose CMS' proposal to remove Total Hip Arthroplasty from the inpatient-only list as we do not believe it would be clinically appropriate;
- Removing THA from the inpatient-only list would pose serious risks and would have negative quality of care implications for vulnerable Medicare patients-many with numerous chronic conditions. We are concerned that it is neither safe nor clinically appropriate for Medicare beneficiaries to receive such major surgical procedures in an ASC;

- We are concerned removing THA could put the CJR and BPCI programs at risk. If CMS were to finalize this policy, we recommend that CMS modify the CJR and BPCI programs to account for the removal of THA from the inpatient-only list; and
- We oppose adding these coronary intervention procedures to the ASC list. Doing so would be unsafe for Medicare beneficiaries and not clinically appropriate in an ASC setting. We are concerned that these procedures, which involve major blood vessels, could lead to serious complications in ASCs. These procedures should only be performed on Medicare beneficiaries in settings in which immediate rescue is available, including rapid access to on-site cardiac surgery as well as an intensive care unit in a hospital.

Preparation and Use of the Medicare Cost Report

The Medicare cost report plays an essential role in determining many types of Medicare reimbursements. Since the advent of IPPS in the 1980s, the cost report has received less attention from the various Medicare Administrative Contractors. Even so, the cost report remains a viable tool for the industry as well as CMS. Additionally, the cost report is also a good tool for providers to estimate the cost of services.

The report itself requires a massive amount of data to be gathered, analyzed and summarized in a short five months. At times, accurate information is not available until after the filing date. With the enormity of information required, errors will occur and may surface at a later date. Many errors are found during the preparation of a subsequent cost report or an audit by another entity. Providers who find errors can only change the report through a formal amendment or at the time of audit; both avenues are only available at the MAC's discretion. Amending the cost report causes significant resources for both the provider and the MAC, with acceptance contingent on the MAC, who can arbitrarily reject the amendment.

Implementing the following changes to the current system would retain the value of the cost report while promoting a greater level of accuracy.

- We believe that the greatest force to improve cost reporting would be to allow providers to easily correct errors in filed cost reports. We suggest that CMS create an online system, much like the claims system, so that providers can make corrections to their cost report up until the date the MAC reviews it for audit. A system that requires uploading documentation attributable to the change should be included;
- The cost report should have worksheets dedicated to a review and comparison of prior year to current year variances. Any variances over a certain threshold should require explanation;
- Cost centers should be updated to reflect modern hospital operations and provide flexibility for large, complex system. For example, hospitals now have many administrative cost centers for different service lines, but the only line set up is for Nursing Administration. Without flexible cost center lines for these types of

departments, preparers must develop another way of allocating the cost. Some put the cost in A&G, others reclassify the direct costs, and some simply put it in the largest cost center served. The result is a less than ideal and inconsistent between providers;

- Employee benefits cost center should become two cost centers: one for direct employee benefit expense with instructions to include costs for those listed on S-3 and another cost center for the human resources departments that deal with employee issues. The ability to match costs on S-3 to A would allow providers to verify the accuracy of S-3;
- Pension costs should be handled consistently between worksheets S-3 and A;
- A&G cost center should be broken into several cost centers. It is now one of the largest cost centers on the cost report and the allocation basis is not sophisticated enough to allow for proper allocations of some costs;
- Costs disallowed by Medicare should be reviewed and updated for modern hospital operations and for the burden on providers. As an example, we suggest that CMS consider the television adjustment. The monitor on the wall is often the nurse call system, television, meal ordering system, and source for information about the hospital. There is no accurate method of allocating the costs;
- Worksheets should be revised to remove inputs no longer needed by CMS. For example, Worksheet A-7 is no longer needed and its preparation is burdensome to providers;
- Explanations in the Provider Reimbursement Manual should be enhanced, and regulations consistently applied across the country;
- Cost report worksheets should be revised to allow for efficient reporting of physician costs.
- RCE limits should be expanded for more specialties and updated on a frequent, systematic basis to show CMS acknowledgement that they consider the cost report treatment of physician costs to be important;
- CMS should provide more training for providers by producing periodic webinars on cost report principles to ensure that cost reports between hospitals across the nation are prepared in a consistent manner; and
- The listing of protested items should become inputs within the cost report, allowing specific issues and amounts to be easily identified within the report.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions or comments, please email me at rschirmer@tha.org.

Sincerely,

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