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August 27, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1613-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS–1613–P, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; (Vol. 79, No.134), July 14, 2014.

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the calendar year (CY) 2015 hospital outpatient and ambulatory surgical center (ASC) prospective payment systems (PPS). The AHA's comments regarding CMS's proposal for partial hospitalization program policies and payments will be sent in a separate letter.

Our detailed comments (attached) address CMS's proposals related to: modification of the current process for accepting new and revised Common Procedural Terminology codes; changes to the inpatient-only list; changes to the proton beam radiation therapy policy; and changes to the outpatient quality reporting and ASC quality reporting programs. However, three areas of comment deserve particular emphasis:

- The AHA understands CMS's interest in learning more about the relatively recent trend in hospital acquisition of physician practices, but we are concerned that the proposed methodology of creating a Healthcare Common Procedure Coding System modifier to track services furnished in off-campus, provider-based hospital outpatient departments has not been considered thoroughly. We urge the agency to re-propose a data collection methodology that is less burdensome, test it among providers, make adjustments as needed and provide ample time for hospitals to implement the change.

- The AHA generally supports CMS's three new packaging proposals and the implementation of a new set of claims-level comprehensive ambulatory payment

classifications (C-APCs). However, we recommend that CMS make several changes to the C-APC policy to ensure that it does not negatively and disproportionately impact certain types of hospitals that have specialized case mixes. The AHA commends the agency for its responsiveness in addressing questions regarding this policy, providing the outpatient PPS data in a timely manner and the detailed documentation of its methodology.

- The AHA appreciates CMS's efforts to reduce administrative burden and supports the proposal to eliminate the physician certification requirement for hospital inpatient services. We continue to believe this change makes good policy sense. However, what the agency gives with one hand, it takes away with the other. We oppose the proposal to require a physician order for all inpatient admissions as a condition of payment under the agency's general rulemaking authority. CMS cannot use its general authority to require a physician order for every inpatient admission when the Medicare statute itself requires an order only for extended inpatient stays.

Thank you again for the opportunity to comment. Our detailed comments follow. If you have any questions, please contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development

Attachment

AMERICAN HOSPITAL ASSOCIATION
DETAILED COMMENTS ON THE PROPOSED RULE FOR CY 2015 HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER PPS AND QUALITY REPORTING PROGRAMS

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AMERICAN HOSPITAL ASSOCIATION DETAILED COMMENTS

TRACKING SERVICES IN OFF-CAMPUS PROVIDER-BASED DEPARTMENTS

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) cites recent reports of hospitals acquiring physician practices at an increasing rate and integrating those practices as hospital outpatient departments. The agency also notes concerns expressed by the Medicare Payment Advisory Commission (MedPAC) about increased Medicare program payments and higher cost-sharing experienced by beneficiaries as a result of hospital acquisition of physician practices. However, there is one aspect in this development that is not often acknowledged: as the health system transforms the delivery of care to meet the goals of the Triple Aim – improving the patient experience of care, improving the health of the population and lowering per capita health costs – hospitals are responding by integrating with physicians to achieve better care coordination and patient outcomes.

To understand how this activity affects the Medicare program, CMS proposes to collect data beginning in calendar year (CY) 2015 to allow it to analyze the frequency, type and payments for services furnished in off-campus, provider-based hospital outpatient departments. Specifically, CMS proposes to create a Healthcare Common Procedure Coding System (HCPCS) modifier to be reported with every code for physician services and hospital outpatient services furnished in an off-campus, provider-based department of a hospital.

The AHA understands CMS's interest in learning more about the relatively recent trend in hospitals' acquisition of physician practices, but we are concerned that the proposed information collection methodology has not been fully and thoroughly considered. Implementation details are missing and the methodology is untested. Operational issues must be settled and adequately tested before full-scale implementation, and adequate time must be allotted for hospitals to adjust and operationalize their systems to accommodate this proposed change. We also believe that the data collection would be very costly, time-consuming and burdensome at a time when hospitals and health systems are drowning in data requests while implementing meaningful use and ICD-10, and answering to a plethora of program auditors. **We urge the agency to re-propose a data collection methodology with a full description of how providers would apply the proposed HCPCS modifier; test it among a set of providers; make adjustments and provide additional guidance as necessary and then provide ample time for implementation across the hospital field.**

Operational and logistical details are lacking in this proposal. For example, it is unclear whether the modifier would apply to the location where a service is ordered or to the location where it is furnished and to which services it would apply. A typical situation might be when a physician sees a Medicare beneficiary in an off-campus provider-based clinic; she draws a specimen for a clinical diagnostic laboratory test, which she then sends to the laboratory on the hospital's main campus, and she orders an X-ray, which the patient obtains on the main campus of the hospital. It is unclear whether only the evaluation and management service receives the off-campus provider-based modifier or whether all services, including the laboratory test and the X-ray

would receive the modifier. A further complication could occur when services are furnished in several different off-campus provider-based departments of the hospital. Again, it is unclear whether there would be some way to identify at which off-campus location each service was furnished.

Adequate time must be allotted for hospitals to operationalize such a complex and costly proposal. A single Medicare claim can include hundreds of lines of services spanning a period of up to 30 days and often including services furnished in different locations on and off a hospital's main campus. Hospital billing systems currently do not have a way to distinguish efficiently where a particular service is furnished when services are provided in multiple locations on the same claim. Hospitals would be required to make significant modifications to their billing systems and devote substantial resources to training staff on how to use the new systems. To implement CMS's proposal, our members tell us that they would have to create a separate chargemaster for their off-campus locations, containing all applicable procedure codes with the new proposed modifier "hard-coded" into the system. Finally, such a modifier would be burdensome and complicated because it would apply only to the Medicare program, requiring the maintenance of two separate coding structures, one for Medicare patients and another for all other insurers.

INCREASING THE SIZE OF THE AMBULATORY PAYMENT CLASSIFICATION (APC) BUNDLE

For CY 2015, CMS makes three significant new packaging proposals, as well as a proposal to create a new set of claims-level comprehensive APCs. These approaches would shift the outpatient prospective payment system (OPPS) more definitively away from a per-service fee schedule to a prospective payment system (PPS) with larger payment bundles. These proposals include:

- Revising the add-on code packaging policy established in CY 2014 by packaging all add-on codes assigned to device-dependent APCs;

- Conditionally packaging certain ancillary services with a geometric mean cost less than or equal to $100;

- Designating prosthetic supplies, paid currently under the durable medical equipment, prosthetics, orthotic and supplies (DMEPOS) fee schedule, as covered outpatient department services payable under the OPPS and packaging their costs into the surgical procedure that implants the prosthetic device and with which they are billed; and

- Implementing 28 comprehensive APCs (C-APCs), a new classification for the provision of a primary service, referred to as the J1 service, and all adjunctive services provided to support the delivery of the primary service. CMS plans to calculate a single payment for the entire hospital stay, defined by a single claim, regardless of the dates of service on the claim.

The AHA generally supports CMS's three new packaging proposals and the proposal to create a new set of claims-level C-APCs. As noted in our comments on the CY 2014 OPPS proposed rule, the AHA generally has supported efforts to package more services and create larger payment bundles under the OPPS, as long as we can verify that CMS is calculating the payment rates correctly and that all costs are accounted for, including the costs of services brought into the outpatient payment system from other Medicare payment systems. We also are sensitive to ensuring that proposed packaging proposals do not negatively and disproportionately affect certain types of hospitals that have a special case mix, such as cancer hospitals and trauma centers.

When calculated rates can be verified and all costs are accounted for, we believe, like CMS, that appropriately sized bundles can provide incentives to improve efficiency and better manage resources. To that end, the AHA, the Association of American Medical Colleges and the Federation of American Hospitals contracted with The Moran Company and Watson Policy Analysis to replicate and validate CMS's methodology and the proposed weights and rates, as well as to better understand the impact of proposed policies across providers and provider types. **We are pleased to say that we have not identified any methodological problems.** We believe that CMS accurately computed the weights according to the established OPPS methodology and that areas where our results diverged from CMS were relatively minor and, given the extremely complex OPPS methodology, not unexpected.

Proposed Packaging Policies. **The AHA generally supports the new proposed packaging policies for add-on codes, ancillary services and prosthetic supplies.** As mentioned above, CMS appears to have followed its established methodology, and we do not believe that these proposals would disproportionately affect any particular type of hospital.

However, our support for the CY 2015 ancillary services packaging proposal does not extend beyond these CY 2015 proposals. Specifically, CMS has made it clear that it intends, in future years, to broaden this policy to incorporate additional ancillary services, stating that it may propose packaging ancillary services assigned to APCs with geometric mean costs higher than $100. Further, while the agency proposes in CY 2015 to exclude from this packaging policy certain low-cost drug administration services, the agency is currently examining various alternative payment policies for drug administration services, including the associated drug administration add-on codes. In the future, the AHA will assess its position on proposed expansions of the ancillary packaging policy on a case-by-case basis.

With respect to the proposed packaging policy on prosthetic supplies, the AHA recommends that CMS implement an exception to the policy, similar to an exception to the "unbundling" rule that currently exists in the inpatient PPS. Such an exception would allow DME suppliers to bill Medicare directly for prosthetic supplies furnished to patients during an outpatient visit when the supplies are intended primarily for home use. Specifically, under the inpatient PPS, there is an exception to the unbundling prohibition whereby a DME supplier can bill Medicare separately for prosthetic/orthotic supplies as long as they are delivered two days before discharge and needed primarily for home use. We urge CMS to implement a similar exception for the OPPS. Otherwise, since CMS proposes that all prosthetic supplies be packaged, it seems that hospitals would be required to bill Medicare

directly under the OPPS for all DME, even if a separate DME supplier furnishes these items during the patient's outpatient visit and these items are intended for home use (e.g., incontinence supplies).

C-APCs. **As noted above, we did not find any methodological problems with CMS's calculations of the C-APC weights and rates and generally support the agency's proposals.** However, as discussed below, we do have several concerns related to policy decisions CMS made in developing the C-APCs that we believe could have a disproportionately negative impact on certain categories of hospitals and services. We also seek clarification on several operational issues concerning the implementation of the C-APCs.

Including Whole Claims in C-APCs. For C-APCs, CMS calculates a single payment for the entire hospital outpatient stay, defined by a single claim, regardless of the dates of service on the claim. An outpatient claim can contain up to 30 days of services, some of which may be unrelated to the primary "J1" service. According to the AHA's analysis, for approximately 89 percent of the claims CMS used to develop the C-APCs, all services on the claim were either furnished on the same date of service or over two consecutive dates of service. For the remaining 11 percent of the claims, the dates of services for procedures on the claims spanned from three to 30 days.

The AHA is concerned that certain categories of hospitals, primarily hospitals with large volumes of patients with recurring services, such as chemotherapy and radiation therapy services, would be disproportionately negatively affected by this "whole claim" approach to the C-APCs because they would no longer receive separate payment for these presumably unrelated recurring services if they are furnished on the same claim with a J1 procedure. **In order to minimize this possibility, the AHA recommends that, in calculating the C-APC payments, CMS include only those services on the claim that were furnished on the date that the J1 primary service occurred and one day before and after the J1 service.**

If CMS decides against such a change to the C-APC policy, it is imperative that it update and educate hospitals about how recurring-services billing will affect their payments and rate-setting. In the CY 2014 final rule CMS stated, "We note that most commenters were concerned about unrelated services reported on claims spanning 30 days. We remind hospitals that we have previously issued manual guidance in the Internet-Only Manual at 100–4, Chapter 1, Section 50.2.2 that only recurring services should be billed monthly. Moreover, we have further specified that in the event that a recurring service occurs on the same day as an acute service that falls within the span of the recurring service claim, hospitals should bill separately for recurring services on a monthly claim (repetitive billing) and submit a separate claim for the acute service. We also do not expect that these claims for comprehensive services in the outpatient setting would extend beyond a few days."

We have learned that there is no consistent approach used by our members in billing for these recurring services. Our review of this section of the manual indicates that this CY 2014 final rule statement is correct only for the specific list of "repetitive services" spelled out in the manual (e.g., respiratory therapy and cardiac rehabilitation). By contrast, the revenue codes usually reported for chemotherapy and radiation therapy are not included on this list. For these services, hospitals have the option of billing all on the same claim or separately, by date of service. Our

members' billing practices range from billing single-day claims, to billing once per month, with everything in-between. Furthermore, the manual does not explicitly permit hospitals reporting such recurring non-repetitive services to bill separately for an acute service that falls within the span of the recurring service claim. **Therefore, hospitals furnishing these recurring non-repetitive services could experience a disproportionately negative impact under the whole claim C-APC approach. As such, we encourage CMS to review and update the manual to clarify that hospitals furnishing these recurring "non-repetitive" services may submit a separate claim for unrelated acute services (including a J1 service) that fall within the span of the recurring service claim. We also encourage CMS and its contractors to educate hospitals about these options.**

Costly Surgeries Furnished on the Same Claim as a J1 Service. In the CY 2014 final rule, CMS indicated that it was initially limiting the C-APCs to the most costly procedures, where the geometric mean cost of the comprehensive procedure was approximately five times the current beneficiary inpatient deductible. This emphasis on high-cost procedures was reflected in the illustrative CY 2014 comprehensive APCs geometric mean costs, which ranged from $4,230 to $32,948. However, with the proposed expansion, reconfiguration and restructuring of the CY 2015 C-APCs, several of the C-APCs would have much lower geometric mean costs compared to 2014. For instance, C-APC 0084, Level I Electrophysiologic procedures with a cost of $923, C-APC 0427; Level II Tube or Catheter Changes or Repositioning with a cost of $1,522; and C-APC 0622, Level II Vascular Access Procedures Catheters with a cost of $2,635 are examples substantially below the 2014 geometric mean costs.

The AHA recommends that CMS implement a policy that provides additional payment for high-cost surgical procedures not eligible for a complexity adjustment when they occur on a claim that would be paid under a low-cost C-APC. The complexity adjustments that CMS proposes for CY 2015 are intended to recognize variation in the complexity of services that will be paid through comprehensive APCs. The methodology assigns certain combinations of primary procedures that are reported together to higher paying comprehensive APCs. However, as there are only 52 such code combinations, we are concerned that hospitals would be placed at substantial financial risk if they bill a high-cost surgery or other procedure on the same claim as a low-cost J1 primary service for which there is no relevant complexity adjustment available to increase the payment rate. In this case, the hospital would receive payment only for the low-cost C-APC; the high-cost surgical procedure would be considered packaged. As an example, J1 CPT codes 36561 and 36558 describe procedures for the placement of a central line and both are assigned to C-APC 0622. These central lines are often placed when the patient will require some type of intravenous therapy following a surgical procedure. Neither of the two complexity adjustments proposed for C-APC 0622 capture the possible surgeries that would commonly occur with a placement of a central line, such as a partial or complete mastectomy. Therefore, hospitals billing this combination of codes on a claim would receive a payment of only $2,635 for the placement of the central line and no payment for the mastectomy.

Excluding Dialysis Services from the C-APCs. **The AHA recommends that dialysis and emergency dialysis services (CPT 90935 and G0257) be added to the list of services excluded from the calculation of the C-APC rates so that they would be paid separately in CY 2015 when they are present on the same claim as a J1 service**. The AHA's analysis of

Medicare data indicates that while dialysis services are not commonly furnished in conjunction with a J1 service, they are still provided occasionally, especially in certain C-APCs. For example, the Vascular Procedures C-APCs contain a dialysis service on the claim the following percentage of the time: C-APC 0083, Level I Endovascular Procedures (4.3 percent); C-APC 0229, Level II Endovascular Procedures (3.72 percent); C-APC 0319, Level III Endovascular Procedures (4.3 percent), and C-APC 0622, Level II Vascular Access Procedures (4.89 percent). Separate payment for dialysis services would improve payment fairness and accuracy because these services are costly to provide and are unrelated to the J1 service itself. Excluding these services from the C-APCs would reduce the risk of large losses for hospitals that perform a disproportionate amount of these services.

Inclusion of Therapy Services in the C-APCs. In the CY 2014 final rule discussion of which services would be packaged into the C-APCs, CMS noted that therapy HCPCS codes, when provided within the context of a comprehensive service, would be considered to be adjunctive outpatient department services in support of the primary service when those services occur within the perioperative period. CMS noted that these services do not constitute therapy services provided under a plan of care, are not subject to a therapy cap (if applicable) and are not paid separately as therapy services. CMS further stated in the CY 2014 final rule, "With respect to functional reporting, we note that these services reported with therapy codes are outpatient department services not therapy services and, therefore, the requirement for functional reporting does not apply. These changes will be implemented in the claims processing systems prior to the start of CY 2015." **Because implementation of these changes is imminent, we urge CMS to again clarify in the CY 2015 final OPPS rule that functional status G-codes do not need to be reported for therapy services furnished as part of a C-APC.**

Device Edits. CMS believes that the current device-to-procedure edits and procedure-to-device edits are overly burdensome and no longer necessary. However, in the proposed rule, the agency responds to the concerns raised by stakeholders, including the AHA, about the costs of devices being accurately reported and captured. Therefore, for CY 2015, CMS proposes to create a claims processing edit that would require hospitals to report *any* device code used in the previous device-to-procedure edits whenever any procedure code assigned to 26 proposed "device-dependent" C-APCs listed in the proposed rule is reported on the claim.

The AHA recommends that CMS continue to use the current device-to-procedure and procedure-to-device edits, including all existing exceptions, as described below. If CMS is unwilling to take this recommendation, we would recommend that it modify its proposed policy to incorporate edit logic that will allow exceptions in certain cases. While we appreciate CMS responsiveness to the concerns of commenters, we disagree with CMS's proposal and continue to assert that the use of these specific edits is not overly burdensome to hospitals. Instead, it promotes correct-coding discipline, and, ultimately, will ensure that that all relevant costs for 26 device-dependent C-APCs are appropriately included in the claims CMS uses for rate-setting.

Further, we are concerned that CMS's proposed policy to require any device code on all of these 26 device-dependent C-APCs is inconsistent with current policy, and, therefore will result in many claims being inappropriately returned to providers. This, of course, is undesirable from

both CMS's and hospitals' perspectives. Specifically, under the current CMS device edits, not all procedure codes linked to the device-dependent APCs (which will now be incorporated into the C-APCs) require that a device be coded on the same claim. In fact, more than half of the proposed device-dependent C-APCs do not require device codes to be reported with every assigned procedural code. This is because some of these codes describe revision procedures that do not involve the actual implantation of a device (e.g., 61888 and 64569); others are procedures where no suitable device code exists to describe the type of item used in the procedure (e.g., 57220, 0234T, 0236T, 0237T, 0238T). These exceptions to the device edits are allowed under CMS's current policy. As a result, CMS's proposed policy to require *any* device code on the 26 device-dependent C-APCs would cause many claims to be inappropriately returned to the hospital.

Interactions with the Ambulatory Surgery Center (ASC) PPS. **The AHA opposes CMS's proposal to base the ASC payment rates for device-dependent services on the CY 2015 OPPS relative weights that have been calculated using the standard "device-dependent" APC rate setting methodology, rather than the proposed C-APC methodology.** CMS's proposal is due to a Medicare computer system issue and is not based on a well-considered policy rationale. **Therefore, the AHA recommends that CMS reprogram the ASC pricer software as soon as possible to allow it to perform the complex logic needed to implement the C-APCs in the ASC system.**

According to current CMS payment policy, most ASC PPS payments are based on the OPPS payment weights, with the exception of some services that are based on the physician fee schedule weights. For CY 2015, CMS's proposes not to use its C-APC policy for ASCs. CMS states that, unlike the OPPS claims processing system, the ASC claims processing system cannot be configured to make a single payment for the comprehensive service whenever a J1 code assigned to a C-APC appears on the claim.

In addition to creating differences in how individual procedures are paid, CMS's proposed policy would lead to differences between the two systems in what is packaged versus what is paid separately. Specifically, in the OPPS, under the C-APCs, hospitals would receive one payment based on the geometric mean cost for everything on the claim. In contrast, ASCs would get separate payment for individual services and procedures on the claim, resulting in multiple payments for each claim.

The AHA's analysis found that this proposed policy would result in a dramatic relative payment differential between the OPPS and the ASC PPS. Such differentials should not be based on CMS's operational difficulties with ASC software. This proposal distorts the payment relationship between ASCs and hospital outpatient departments (HOPDs). We believe that fair and accurate payment that recognizes justifiable differences in costs is a desirable goal of Medicare payment policy. However, this proposal could result in incentives to direct patients to one setting or another. We are concerned that this could, in turn, lead to volume and aggregate payment shifts both into and out of HOPDs and ASCs, which we fear may cause instability in the payment weights from year to year.

Specifically, under the current OPPS and ASC payment methodologies, ASC payments are approximately 60 percent of OPPS payments for similar services. However, in our analysis, we found that some services described by the C-APCs and provided in ASCs would be paid an amount that is greater than 60 percent of the OPPS amount. In fact, several C-APCs would be paid more in the ASC setting than in the OPPS setting, including intraocular procedures (C-APCs 0351 and 0293) and neurostimulator and related procedures (C-APCs 0039 and 0318). On the other hand, for some services described by the C-APCs, ASCs would be paid an amount that is much less than 60 percent of the OPPS amount. For instance, the mean payment for C-APC 0067 Single Session Cranial Stereotactic radiosurgery when furnished in an ASC would be 28 percent of the OPPS payment.

Reprogramming the ASC pricer software to allow it to perform the complex logic needed to implement the C-APCs in the ASC system, as we have recommended, would remove the potential issues caused by changes in the payment relativities between the ASC PPS and the OPPS. In addition, it would streamline and simplify CMS's rate-setting process by eliminating the need to continue to calculate payments for the same services in two ways.

EMERGENCY DEPARTMENT (ED) VISITS

CMS proposes to continue its current methodology to recognize the existing five Common Procedural Terminology (CPT) codes for Type A ED visits, as well as the five HCPCS codes for Type B ED visits, and to establish the associated CY 2015 OPPS payment rates using its standard process. However, the agency believes that additional study is needed to assess the most suitable payment structure for ED visits, including the number of visit levels necessary to ensure that the resources required to treat the most complex patients, such as trauma patients, are not underrepresented. Therefore, CMS intends to further explore the issues related to ED visits and may propose changes to the coding and APC assignments for ED visits in future rulemaking.

The AHA commends CMS for proceeding with caution in this area. In response to CMS's CY 2014 proposal to collapse the ED codes into a single code for Types A and B ED visits, the AHA found that collapsing the ED codes would introduce bias into the rate-setting and inappropriately depress ED payment rates. In particular, we expressed concern that the payment bias created by CMS's ED visit coding proposal would unfairly penalize certain providers, such as trauma centers and major teaching hospitals, which provide care for more severely ill Medicare beneficiaries. We look forward to working with CMS on a future policy proposal to create an appropriate payment structure for ED visits.

PHYSICIAN CERTIFICATION OF HOSPITAL INPATIENT SERVICES

Section 1814(a)(3) of the Social Security Act provides that Medicare Part A payment will be made only for such inpatient hospital services "which are furnished over a period of time, if a physician certifies that such services are required to be given on an inpatient basis." Starting in federal fiscal year (FY) 2014, CMS interpreted this statute to require a physician certification as a condition of Part A payment for *all* inpatient admissions. Specifically, CMS required a written physician order as a "required component of [the] physician certification of the medical necessity of hospital inpatient services" (42 C.F.R. § 412.3(c)). CMS adopted that requirement even though the AHA had explained that it was contrary to the plain language of the Medicare statute and that the legislative history of the provision showed that Congress made an explicit choice not

to require a physician certification for each inpatient admission, but instead for only long-term stays. As a result, the AHA filed suit challenging the new regulation requiring physician certification for all inpatient hospital admissions.

CMS has now changed course, stating that in an effort to reduce administrative burden on hospitals, it would require a physician certification for cases only 20 inpatient days or longer or ones that are considered outliers.

The AHA appreciates CMS's efforts to reduce administrative burden and supports the proposal to eliminate the certification requirement. We continue to believe this change is dictated by the plain language of the Medicare statute and makes good policy sense**.** But, what the agency gives with one hand, it takes away with the other. Additionally, the proposal lacks operational clarity.

We remain troubled, because at the same time the agency proposes to eliminate the physician certification requirement, CMS proposes to require a physician order for all inpatient admissions as a condition of payment under its general rulemaking authority in Section 1871 of the Social Security Act. **The AHA opposes this proposal. CMS cannot use its general rulemaking authority under Section 1871 to require a physician order for each inpatient admission and, if finalized, this change would conflict with the Social Security Act.**

As noted above, the plain language of Section 1814(a)(3) of the Social Security Act and its legislative history are clear: CMS may not require a physician certification as a condition of payment for inpatient hospital services, except for when those services are "furnished over a period of time." And, in practice, requiring a physician order for inpatient admission is no different from requiring a physician certification. An order serves the same purpose as the certification that CMS proposes to eliminate: it is the tool by which a physician requests that medically necessary services be furnished to a given patient. Under CMS's proposal, in the order for inpatient admission, the physician would be required to document that inpatient services are reasonable and necessary and based on the physician's expectation that the beneficiary would need to remain in the hospital for two midnights. This is precisely the same information CMS requires in the physician certification – and CMS specifically acknowledged as much when it made the physician order an explicit "component" of the physician certification.[3] The Medicare regulations make clear that there is no specific form required for a "certification," 42 C.F.R. § 424.11, and it is well-established elsewhere in the Medicare program that where a certification of medical necessity is required, an order is a component of/or evidence to support that certification. For example, where "certification" is required for diagnostic procedures, the CMS Medicare Benefit Policy Manual instructs that there should be an "order" for those services.

Given that these two requirements are essentially the same, Section 1814(a)(3) forecloses CMS from requiring a physician order as a condition of payment for all inpatient admissions, whether CMS calls it a "certification" or an "order." The agency cannot use its general rulemaking authority under Section 1871 to circumvent that limitation. Although Section 1871 provides CMS authority to implement regulations to administer the Medicare program, the agency cannot

[3] *42 CFR 412.3(c).*

impose requirements that are contrary to Congress' unambiguously expressed intent. And Congress made its intent clear in Medicare law.

Moreover, according to canons of statutory construction, specific provisions govern over more general provisions, especially where those provisions are part of a complex statutory system like the Medicare program. Therefore, CMS cannot rely on its general authority to impose the same requirement that the more specific provision of the Medicare statute forbids. **The proposal to require a physician order for all inpatient admissions violates Section 1814(a)(3).**

Finally, even if CMS could require a physician order as a condition of Medicare Part A payment, the agency has not fully explained how this proposal would impact hospital documentation for inpatient services. For example, as part of the "two-midnight" policy, CMS requires hospitals to document that inpatient services are being provided in accordance with the two-midnight benchmark; the agency's regulations and guidance specifically require this documentation to be included as part of the physician certification.[1] If a physician certification will no longer be required for each inpatient admission, it is unclear where this documentation should be included. In addition, critical access hospitals (CAHs) must have a physician certify that the beneficiary may reasonably be expected to be discharged or transferred within 96 hours of admission to the CAH in order to receive payment for inpatient services. CMS's guidance indicates that this certification requirement also should be captured in the physician certification.[2] Again, if a physician certification will no longer be required for each inpatient admission, it is unclear where this certification requirement should be included. **We urge the agency to expeditiously issue clear and consistent guidance to hospitals regarding these issues.**

In addition, CMS has proposed an effective date of Jan. 1, 2015 for this new policy. Accordingly, the regulation requiring physician certification for all inpatient admissions would be effective from Oct. 1, 2013 (the effective date of the two-midnight policy) through Dec. 31, 2014. However, because the agency is now reversing its previous interpretation, enforcing it during this 15-month period is fundamentally unfair. We understand that some enforcement of the two-midnight policy and its associated physician certification requirements has been delayed, because Recovery Audit Contractors are prohibited from reviewing short-stay inpatient claims through March 31, 2015. But all other contractors, including Medicare Administrative Contractors (MACs), are enforcing the physician certification requirement. **Therefore, we urge CMS to require its MACs, and any of its other contractors, to review and reverse all claims denials for services provided from Oct. 1, 2013 through Dec. 31, 2014 that are based on a failure to comply with the physician certification requirement.** Failure to do so will require hospitals to enter the lengthy and already extremely back-logged appeals process in order to achieve restitution for an issue that CMS now recognizes is bad policy.

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[1] *Hospital Inpatient Admission Order and Certification issued by CMS on January 30, 2014.*
[2] *Hospital Inpatient Admission Order and Certification issued by CMS on January 30, 2014.*

MODIFICATION OF CURRENT PROCESS FOR ACCEPTING NEW AND REVISED CPT CODES

CPT and Level II HCPCS codes are used to report procedures, services, items and supplies under the OPPS. CPT codes are established by the American Medical Association (AMA), and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update change requests (CRs). CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective for reporting on Medicare claims outside of the formal rulemaking process via OPPS quarterly update CRs.

CMS proposes to make changes to the process used to establish APC assignments and status indicators for new and revised CPT codes. The OPPS proposed rule is published prior to the publication of new and revised CPT codes that are generally made public in the fall of each year, with a Jan. 1 effective date. As a result, CMS is unable to include these codes in the OPPS proposed rule, which is published in early July. Instead, CMS currently assigns the new CPT and Level II HCPCS codes to interim status indicator and APC assignments. These interim assignments are finalized in the OPPS final rule published in November. This quarterly process offers hospitals more timely access to new codes than if CMS waited for the annual rulemaking process. CMS annually solicits public comments on these new codes and finalizes proposals related to these codes through its annual rulemaking process.

In the CY 2015 proposed rule, CMS proposes to delay the adoption of new and revised codes received from the AMA CPT Editorial Panel too late for inclusion in the proposed rule for a year. Instead, CMS would adopt coding policies and payment rates that conform, to the extent possible, to the policies and payment rates in place for the previous year. CMS proposes to create HCPCS G-codes to describe the predecessor codes for any codes that were revised or deleted as part of the annual CPT coding changes. If CMS does not receive the code for a wholly new service in time to include proposed APC and status indicator assignments in the proposed rule for a year, CMS would establish interim APC and status indicator assignments for the initial year. However, if certain CPT codes are revised in a way that would not affect the cost of inputs (for example, a grammatical change to CPT code descriptors), CMS would use these revised codes and continue to assign those codes to their current APC.

The AHA objects to the proposed modification of the process for accepting new and revised CPT codes. The proposal is neither an improvement over the current policy, nor does it fix the timing issue between CMS's rulemaking cycle and AMA's code updating cycle. The use of interim HCPCS G-codes for services that have corresponding CPT codes is administratively burdensome and confusing for hospital coders because they have to understand and apply a new layer of codes that exists for only a few months each year, as well as understand and apply two separate sets of codes for the same service.

As we have seen from prior experience, it is extremely burdensome to have different coding requirements for different payers. This was demonstrated when CMS implemented a subset of the CY 2006 new CPT codes for drug administration along with six HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same service, while all other payers required

the entire set of drug administration CPT codes. In 2007, CMS rescinded this ill-advised policy and the six HCPCS C-codes and implemented the full set of CPT codes for drug administration.

Rather than implement its proposed policy, we urge CMS to work with the AMA and other interested stakeholders to develop a more feasible process and timeline to create and implement new CPT codes before any proposals to change the current process for accepting new and revised CPT codes are offered.

PROPOSED CHANGES TO THE INPATIENT LIST

The AHA supports CMS's proposal to return CPT 22222 (*Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic*) to the inpatient-only list. This service was removed from the inpatient-only list on Dec. 31, 2004, and has been separately payable under the OPPS since that time. However, our members tell us that the risks of this procedure warrant it being deemed an inpatient procedure exclusively. Common complications of this procedure, including pneumothorax and hemorrhage, may be difficult to identify in the immediate post-operative period and can rapidly progress to a life-threatening complication if patients are not in an environment where they are closely monitored by qualified personnel with immediate access to diagnostic tests and equipment. In addition, similar CPT codes in the range of this service (including CPT codes 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22224, and 22226) are on the inpatient-only list.

While CMS does not propose to remove any services from the inpatient-only list for CY 2015, the AHA recommends that CPT 63044 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace) **be removed from the inpatient-only list**. CPT 63044 is an add-on code to CPT 63042, which is payable under OPPS. Other similar services in the range of CPT 63044 also are payable under the OPPS, including CPT codes 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63040, 63045, 63046 and 63047. Both InterQual and Milliman guidelines list CPT 63044 as appropriate for outpatient/ambulatory care and a recent research study suggests that outpatient lumbar discectomy patients have lower overall complication rates than inpatients.

PROTON BEAM RADIATION THERAPY

CMS proposes to reassign proton therapy CPT code 77522 from APC 664 Level I Proton Beam Radiation Therapy to APC 667 Level IV Radiation Therapy. **The AHA does not support this proposal given the significant differences in the clinical nature and resource intensity of the codes in these two APCs.** While we agree with CMS that there is currently a "two-times rule" violation for APC 0664, to which CPT codes 77520 and 77522 are assigned, we urge the agency to ignore this violation in order to maintain the clinical homogeneity of this group, as it has done for other APCs. **Therefore, we recommend that CMS keep CPT codes 77520 and 77522 together in APC 0664 to preserve this APC's clinical homogeneity.** Doing so also would maintain the clinical homogeneity of APC 0667, which contains CPT codes 77523 and 77525 for intermediate and complex proton beam therapy. Clinically, complex and intermediate proton therapy services are fundamentally different from simple treatments and should not be assigned to the same APC as simple treatments.

OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

The Tax Relief and Health Care Act of 2006 requires CMS to establish a program under which hospitals must report data on the quality of outpatient care in order to receive the full annual update to the OPPS payment rate. Hospitals failing to report the data incur a reduction in their annual payment update factor of 2 percentage points.

New Measure for CY 2017. **The AHA does not support CMS's proposal to adopt, for the CY 2017 OQR program, OP-32, seven-day risk-standardized hospital visit rate after outpatient colonoscopy. We are concerned that the measure fails to portray hospital performance accurately, and does not focus on an issue of sufficiently high priority for a national reporting program.** OP-32 assesses the rate of all-cause, unplanned hospital admissions, ED visits and observation stays within seven days of a colonoscopy procedure. Similar to the hospital readmission measures used in the inpatient quality reporting (IQR) program, each hospital's performance would be scored as a risk-adjusted ratio of predicted hospital visits to expected hospital visits. The AHA agrees with CMS that colonoscopies are high-volume procedures, and that the public and hospitals may be interested in understanding the quality of such procedures; **however, publicly reporting a quality measure equips the public and hospitals with useful information only if the measure provides accurate and actionable results. Based on the information available to us, OP-32 falls well short of this standard**.

We also are disappointed that the agency proposes OP-32 before it has completed endorsement review by the National Quality Forum (NQF). Indeed, when the Measure Applications Partnership (MAP) reviewed OP-32 in January, it supported the measure on the condition that it receive NQF endorsement prior to being added to the OQR program. The AHA has repeatedly and consistently urged CMS to use only NQF-endorsed, MAP-supported measures in federal quality reporting programs. NQF endorsement, taken together with MAP review, ensure that measures focus on high-priority issues, are backed by solid evidence, provide accurate data and are feasible to collect and report.

The recent NQF endorsement review of OP-32 highlighted several shortcomings of the measure. If CMS is intent on adopting OP-32, then we strongly urge the agency to improve the measure's reliability. A reliable measure reflects a hospital's true underlying performance, and not simply random variations in a hospital's patient population. The measure submission for OP-32 indicates that the developer assessed reliability using the "test-retest" method. Such a method assesses the degree to which repeated measurements of the same entity – in this case, hospitals – agree with each other. If a measure is reliable, then we would expect a high level of agreement of the results of each test. Reliability can be summarized in an intra-class correlation coefficient (ICC), with values ranging from 0 to 1; higher values indicate stronger reliability. However, when using two years of data, OP-32's ICC was only 0.335, which the developer states is "fair" reliability.

Fair reliability is not sufficient for a publicly reported quality measure, and the use of such an unreliable measure could provide misinformation to providers and the public. Additionally, we are concerned that CMS's implementation of OP-32 would lead to even lower reliability results. Indeed, CMS suggests in the proposed rule that it will report OP-32 using one year of data, the same amount as its other claims based measures. In general, using less

data degrades measure reliability even further. **If CMS is intent on adopting OP-32 for the OQR program, then at the very least, we urge it to conduct further analysis to understand how much data must be reported to achieve "good" reliability,** which would be an ICC of at least 0.60. It may be appropriate, for example, for the agency to use data reported over a three-year time frame, as it does for claims-based readmission and mortality measures in the hospital IQR program.

Moreover, we are concerned that this measure fails to exclude hospital visits that are unrelated to the colonoscopy procedure. We appreciate that the measure includes a mechanism for excluding hospital visits for certain "planned" procedures, such as varicose vein removal. Yet, the measure does not exclude hospital visits for a wide range of issues that appear to have little relevance to a colonoscopy procedure. For instance, hospital visits for various bone fractures, as well as behavioral health disorders, are always included in the measure rate. Failing to exclude hospital visits unrelated to colonoscopy impinges upon the usability of the measure result. In short, including unrelated hospital visits adds unnecessary "noise" to the quality signal the measure is intended to assess.

While we appreciate that colonoscopies are a common procedure, the decision to add a measure to a national reporting program should not be solely driven by the volume of the procedure. Rather, it should be based on evidence that there is a sufficiently extensive and reliably measured quality issue where the added attention of public reporting is needed to drive improvement. Based on the data available to us, we do not believe that colonoscopy complications rise to such a level of importance. In support of adopting the measure, the proposed rule cites evidence suggesting that hospital visit rates after outpatient colonoscopy range from 0.8 to 1.0 percent in the seven to 14 days after the procedure. While we agree that one preventable complication is one too many, it appears such complications for colonoscopies are rare.

Finally, to be clear, the AHA certainly agrees hospitals should focus on eliminating preventable complications from colonoscopies and other procedures performed in hospital outpatient departments. However, hospitals take steps each day to make such procedures safe and effective. For example, hospitals institute careful infection control practices to minimize the risk of post-procedure infection. They carefully review patient medication lists to minimize the possibly of adverse reactions. They improve the clarity of discharge instructions so that patients know what to expect after the procedure. These efforts will continue regardless of whether the agency adds OP-32 to the program.

<u>'Topped Out' Measure Criteria</u>. CMS states that, in previous years, it has used several general criteria to determine whether measures should be removed from the OQR program, including a consideration of whether "measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made." In the rule, CMS proposes to adopt additional quantitative criteria for identifying topped out measures that are very similar to those used in the hospital value-based purchasing (VBP) program and recently have been finalized for the hospital IQR program. Specifically, the agency proposes to remove measures from the OQR if national measure data meet two specific criteria:

- The difference in performance between the 75th and 90th percentile is statistically insignificant; and
- The coefficient of variation (CV) is less or equal to 0.10.

The AHA supports CMS's proposed new criteria. In applying these criteria, however, we urge CMS to assess the broader context and uses of topped out measures carefully before removing them from programs. In limited cases, retaining measures that meet the quantitative criteria for being topped out may still provide value to patients and hospitals. We appreciate the intent behind CMS's proposal – that is, to provide more specific, and therefore, potentially more objective, criteria for determining topped out performance in the OQR. In some limited circumstances, however, retaining a topped out measure can help maintain focus on issues where hospitals have achieved high performance. For instance, it is likely that vaccinating health care personnel for the flu will remain important for hospitals in the foreseeable future, even after the measure is topped out.

Proposed Measure Removal. **The AHA supports CMS's proposal to remove three topped out measures using its newly proposed criteria.** Specifically, the agency proposes to remove three measures from the CY 2017 OQR program:

- OP-4: Aspirin at arrival;
- OP-6: Timing of antibiotic prophylaxis; and
- OP-7: Prophylactic antibiotic selection for surgical patients.

However, we continue to urge CMS to remove several other measures from the OQR program, based on recommendations from the MAP. In early 2012, the MAP conducted a review of measures from CMS, including measures in the current OQR program. The MAP suggested that the seven previously finalized OQR measures listed below were directionally correct, but not appropriate for use in the OQR program as currently constructed.

OQR Measures Not Recommended by the MAP
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-14: Simultaneous Use of Brain CT and Sinus CT
OP-15: Use of Brain CT in the Emergency Department for Atraumatic Headache
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
OP-22: ED Patient Left Without Being Seen
OP-25: Safe Surgery Checklist Use

The AHA has commented to CMS on several occasions that the imaging efficiency measures (OP-9, OP-10, OP-14 and OP-15) should not be included in the OQR program because several of them have failed the NQF-endorsement process. Further, we continue to hear from members that the implementation of OP-20, OP-22 and OP-25 has been difficult and produced results that are not accurate or suitable for public reporting. Finally, the 2013 MAP assessment recommended the removal of OP-22 because the measure has lost NQF endorsement. **Given this assessment and the MAP recommendations, the AHA urges CMS to remove these seven measures (see chart above) immediately from the OQR program.**

Voluntary Reporting of OP-31. In the CY 2014 OPPS final rule, despite the AHA's objections, CMS added OP-31 (Improvement in Patient's Visual Function within 90 Days following Cataract Surgery) to the CY 2016 OQR program. The measure assesses the percentage of cataract surgery patients whose visual function has improved within 90 days of surgery. Improvement in visual function is assessed by comparing a patient's results on a visual function instrument before and after surgery. In response to the significant operational issues with implementing OP-31, CMS suspended the reporting of the measure in April for the CY 2016 OQR program. CMS now proposes that the collection and reporting of OP-31 will not be required for CY 2017 and subsequent years. However, hospitals would have the option of reporting OP-31 measure data on a voluntary basis.

The AHA commends CMS for its responsiveness to stakeholder concerns about OP-31. However, we recommend CMS completely remove the measure from the OQR program. We appreciate that CMS is interested in a measure of cataract surgery in the OQR, and it is possible that some hospitals may be able to report OP-31. However, the purpose of the OQR and other reporting programs is to provide the public and other providers with a consistent set of quality information. We are concerned about the potential signal being sent by publicly reporting measure data for some hospitals but not others. It would be inappropriate to conclude that some hospitals are somehow less committed to improving cataract surgery care simply because they do not report the measure. This is especially true in light of the significant operational barriers to implementing OP-31.

Future OQR Measures: Electronic Clinical Quality Measures (eCQMs). The current hospital OQR measure set includes measures that assess process of care, imaging efficiency patterns, care transitions, ED throughput efficiency, use of health information technology (IT), care coordination, patient safety, and volume. For future payment determinations, CMS is considering expanding the current Hospital OQR measure set to include eCQMs, partial hospitalization, behavioral health and other measures that align with the National Quality Strategy and the CMS Quality Strategy domains.

The AHA strongly supports the long-term goal of using electronic health records (EHRs) to streamline and reduce the burden of quality reporting while increasing access to real-time information to improve care and support continuous quality improvement. **However, we remain concerned about the readiness of eCQMs to be used in lieu of the chart- and claims-based quality measures of the same title for quality reporting programs with public accountability.** A rushed inclusion of additional eCQMs in the OQR program would provide little insight into whether EHRs can be used to effectively report comparable data for purposes of public reporting in the future.

Before the addition of eCQMs in the OQR, the AHA recommends additional work by CMS, in partnership with the Office of the National Coordinator for Health Information Technology, to ensure the maturity of e-specifications of eCQMs, and the ability of certified EHRs to support valid, feasible and reliable eCQMs. Additional time for the eCQM development also would allow time for hospitals to optimize their certified EHRs for clinical care and time for the development of information sharing networks that support National Quality

Strategy goals. We agree with CMS that a collaborative effort by measure stewards, electronic measure developers and health IT developers and implementers is needed to develop, test, validate and implement eCQMs prior to an expansion in the OQR.

Future OQR Measures: PHP and other Behavioral Health Measures. **The AHA agrees that measures of behavioral health topics and PHP programs could be appropriate additions to future years of the OQR program. However, we do not support the use of the three PHP measures that CMS is proposing.**

CMS is considering the use of three PHP measures currently reported in the Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) developed under the Comprehensive Error Rate Testing (CERT) program.

- *30-day readmission.* The measure assesses the proportion of initial (or "index") PHP episodes of care for which a resumption of care occurred within 30 days to either the same or different PHP. The PEPPER user guide suggests that higher rates of PHP readmission could indicate that patients are being prematurely discharged from PHPs, or that the discharge planning process could be strengthened.

- *Group therapy.* The measure assesses the proportion of PHP episodes of care where only group therapy (revenue code 0915) is billed. The PEPPER user guide states that using only group therapy may indicate PHPs are not providing individualized plans of care.

- *No individual psychotherapy.* The measure assesses the proportion of PHP episodes of care that do not have units of individual psychotherapy (revenue code 0914) or psychiatric testing (revenue codes 0900 or 0918). The PEPPER user guide suggests that not using individual psychotherapy may indicate that PHPs are not providing a sufficient intensity of services to meet patient needs.

None of the three above measures is NQF-endorsed. Moreover, in its January review, the MAP did not support any of them, citing the same concern about the lack of NQF endorsement. The MAP also indicated that the therapy measures are backed by limited evidence of the relative value of individual versus group therapy, and that the readmission measure is poorly defined.

Review and Corrections Process. CMS requires hospitals to collect chart-abstracted OQR measures on a quarterly basis. Hospitals must then submit measure data four months after the end of each quarter. CMS states that it "generally" provides the rates for chart-abstracted measures 24 to 48 hours after hospitals submit the data. CMS indicates that hospitals are permitted to review this information, determine whether any corrections are necessary and submit corrections, as long as those changes are submitted before the data submission deadline.

CMS proposes to make the formal OQR data review and corrections process for chart-abstracted data concurrent with the OQR data submission period. That is, hospitals would be expected to review and submit any corrections to chart-abstracted measures during the measure submission period and before the measure submission deadline. After the measure data submission deadline,

hospitals would not be permitted to change their submitted data. CMS would continue to urge hospitals to submit data as early as possible in the submission period in order to accommodate review and correction activities.

The AHA does not support this proposal. We do not believe a data submission period should somehow substitute for a review and corrections period. With nearly all of its other quality reporting programs, CMS provides a separate time period during which hospitals can review their submitted data and submit corrections if necessary. This policy appropriately recognizes that the process of collecting and reporting quality measure data is time and resource intensive. By combining the data submission and review/corrections periods, CMS would effectively abridge the allotted time that hospitals have to collect and submit their data. **We recommend that CMS instead provide a period of at least 30 days immediately after the measure submission deadline to review and submit corrections to data.** We believe this approach would give CMS the chance to process data as soon as possible, while allotting hospitals the full amount of allowed time to submit measure data.

Validation. CMS proposes only minor modifications to its previously finalized OQR data validation processes. First, CMS proposes that for CY 2017, a hospital could be eligible for validation if it submits at least one case to the Hospital OQR Program Clinical Data Warehouse during the quarter with its most recently available data. For example, if a validation sample is drawn in December 2014, then the most recent available data would be from the second quarter of 2014. This is because the data submission deadline for second quarter data is Nov. 1, 2014. **The AHA supports this proposal.**

Second, CMS proposes to give hospitals the option to either submit paper copies of patient charts for validation or to transmit securely electronic versions of medical information using either electronic media (e.g., CD, DVD, flash drive) or PDFs submitted using a Secure File Transfer Protocol on QualityNet. Finally, CMS proposes that hospitals identify the medical record staff person responsible for submitting validation records for the hospital OQR program. **The AHA supports this proposal.**

AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM

The Affordable Care Act required CMS to establish a program under which ASCs must report data on the quality of care delivered in order to receive the full annual update to the ASC payment rate. ASCs failing to report the data will incur a reduction in their annual payment update factor of 2 percentage points beginning with the CY 2014 update.

New Measure for CY 2017. For CY 2017, CMS proposes to add the same measure of seven-day risk-standardized hospital visit rates after outpatient colonoscopy as it proposed for the hospital OQR. **The AHA does not support the addition of this measure to the ASCQR. We are concerned that it fails to accurately portray ASC performance, and does not focus on an issue of sufficiently high priority for a national reporting program.** We refer the agency to our discussion of this measure in the OQR section of this letter.

Voluntary Reporting of ASC-11. Against the AHA's recommendation, CMS added ASC-11 (Improvement in Patient's Visual Function within 90 Days following Cataract Surgery) to the

CY 2016 ASCQR program in the CY 2014 OPPS final rule. The same measure also was added to the hospital OQR as OP-31. As with OP-31, CMS has already suspended ASC-11 from the CY 2016 ASCQR program, and proposes to make reporting of ASC-11 voluntary beginning with the CY 2017 program. **The AHA commends CMS for its responsiveness to stakeholder concerns by suspending ASC-11 from the ASCQR. However, we recommend that CMS permanently remove this measure from the ASCQR.** We refer the agency to our discussion of this measure in the OQR section of this letter.

Measure Removal Policy. While CMS does not propose to remove any measures from the ASCQR at this time, it does propose to adopt the same policy for measure removal used for the hospital IQR program. Specifically, CMS proposes to remove immediately any measure whose continued reporting may lead to patient harm. This removal could occur without the use of formal rulemaking. The agency would notify ASCs and the public of the measure removal using existing communications channels, and then use subsequent rulemaking to confirm the measure's removal from the program. **The AHA greatly appreciates CMS's attentiveness to this issue, and strongly supports this proposal.**

For measures whose continued use does not pose a patient safety concern, CMS proposes to use the regular rulemaking process to remove a measure from the ASCQR. It would use the same criteria that it uses in the hospital IQR program. **The AHA commends CMS for fostering an aligned approach to removing measures across its programs, and we support this proposal.**

Health Care Personnel Influenza Vaccination Reporting. In the CY 2014 OPPS final rule, the agency added ASC-8 (Influenza vaccination coverage among health care personnel) to the ASCQR program for CY 2016 payment determination. The agency also finalized a data reporting timeframe of Oct. 1, 2014 through March 31, 2015, but did not specify a data submission deadline. In this year's rule, the agency proposes a submission deadline of May 15, 2015, which is aligned with the submission deadline for the hospital IQR and OQR programs. **The AHA supports this proposal.**