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December 21, 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-FC and CMS-1656-IFC, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital; Final Rule with Comment Period and Interim Final Rule with Comment Period, (Vol. 81, No. 219), November 14, 2016.

Dear Mr. Slavitt:

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) calendar year (CY) 2017 hospital outpatient prospective payment system (OPPS) final rule with comment period and interim final rule with comment period (IFC). We address several of the areas for which the agency has requested comments, including implementation of the hospital off-campus provider-based department (PBD) provisions of Section 603 of the Bipartisan Budget Act (BiBA) and CMS's plans to monitor and implement a claims edit for partial hospitalization program (PHP) services. Finally, we recommend steps the agency should immediately take to implement the mid-build provisions in the 21st Century Cures Act.

Among our key recommendations, the AHA urges CMS to increase the nonexcepted payment rate in 2017 to 64 percent of the OPPS rate, inclusive of packaging. In addition, we support CMS's policy to allow hospitals to expand the scope and volume of services provided at their excepted PBDs so that they may continue to address changes in clinical practice and meet the growing needs of their communities without losing their ability to be reimbursed under the OPPS. Our detailed comments follow.



IMPLEMENTATION OF SECTION 603 PAYMENT REDUCTIONS IN CERTAIN OFF-CAMPUS PBDs

The AHA is pleased that CMS's final rule and IFC appropriately recognize that providing no payment to new off-campus hospital PBDs for the services they provide to patients, as the agency proposed, was an untenable policy. However, we are concerned that in its analysis, CMS does not consider differences between packaging amounts within the OPSS as compared to the physician fee schedule (PFS) payment system. When these differences, as well as other technical details, are accounted for, it is clear that CMS should raise its nonexcepted rate from 50 percent to 64 percent of the OPSS rate. In addition, while the AHA appreciates the modifications CMS made to its proposal to allow existing off-campus PBDs to expand their services, without penalty, to meet the changing needs of their patients and communities, we are alarmed that by penalizing hospitals that need to relocate their PBDs and by indicating that the agency may impose limits on the expansion of excepted HOPDs in the future, CMS continues to ignore the need for hospitals to modernize existing facilities so that they can provide the most up-to-date, high-quality services to patients in locations that best meet patients' needs. Our comments that follow address these specific concerns.

CY 2017 Nonexcepted Payment Rates. In the IFC, CMS establishes the Medicare PFS as the "applicable payment system" for most nonexcepted items and services furnished in an off-campus PBD. In response to concerns voiced by the AHA and others, the agency will pay hospitals directly for their nonexcepted services and sets the new interim final rates at 50 percent of the OPSS payment rate, inclusive of packaging. CMS arrived at the 50 percent rate by comparing: (1) the weighted average payment differential for overall payment under OPSS and the agency's determination of the "equivalent" practice expense amount under the PFS for the 22 most frequently billed services reported with the PO modifier (indicating items and services furnished in off-campus PBDs), arriving at 45 percent; and (2) the payment differential between the OPSS and the ambulatory surgical center (ASC) payment rates, noting that covered surgical procedures in ASCs are paid at 55 percent of the rate under the OPSS.

CMS emphasizes that it views this 50 percent payment reduction as a transitional policy while it gathers more precise data on the services furnished in off-campus PBDs. The agency requests comment on the new payment mechanism and rates for nonexcepted items and services and notes that, based on these comments, the agency will make adjustments as necessary through rulemaking that could be effective in CY 2017.

As noted, the AHA is pleased that CMS appropriately recognizes that providing no payment to new off-campus PBDs for the services they provide to patients was an untenable policy. Hospitals deserve to be paid a reasonable rate for the safe and high-quality care they furnish to beneficiaries. We also appreciate that CMS has clarified that items and services that are already paid under other Medicare Part B payment systems, such as separately payable drugs and laboratory services, will continue to be paid under their current payment system and rates. **However, while we support CMS's intent to continue to gather more precise data in order to fine-tune its payment rate, we strongly recommend against increasing the percentage payment reduction above 50 percent. In fact, we believe that a**

smaller percentage reduction is appropriate considering that the agency has instituted the IFC payment policy for nonexcepted items and services, *inclusive of packaging*.

That is, while CMS's analysis compared the OPPS rate to a rate that CMS determined physicians would have been paid for their practice expense under the PFS for each of the 22 Healthcare Common Procedure Coding System (HCPCS) codes evaluated, the agency's analysis did not explicitly account for the fact that the OPPS incorporates far more packaging into its payments for services than does the PFS. CMS acknowledged this limitation in the IFC, stating, "As noted with the clinic visits, we recognize that there are limitations to our data analysis including that OPPS payment rates include the costs of packaged items or services billed with the separately payable code, and therefore the comparison to rates under the MPFS will not be a one-to-one comparison." To make the analysis truly equivalent and accurate, the agency would need to remove from its analysis the packaged costs that are incorporated in the OPPS rates, but not in the PFS practice expense rates.

The AHA undertook such an analysis to estimate the amount of packaging included in the 22 codes. We estimate that, on average, the amount of packaging in these codes is approximately 20 percent of their total cost. Table 1, attached, shows our calculations of the packaging percentages for single claims used in rate setting for the CY 2017 final OPPS rule. This packaging should be removed from the OPPS rates when comparing OPPS and PFS rates. Accordingly, we urge CMS to adjust the OPPS denominator to be 80 percent of the value it had calculated, which increases the calculated percentage of the OPPS amount that CMS reported from 45 percent to 56 percent.

In addition, CMS's comparison was often based on only a portion of the nonfacility PFS rate and not the full payment rate that Medicare makes under the PFS for practice expenses in a physician's office (the "nonfacility" rate). For services where Medicare's PFS payment is not differentiated by facility and nonfacility locations, the full PFS payment for practice expenses was used in this comparison. However, where the PFS payment is differentiated by facility and nonfacility locations, CMS used the difference between the facility and nonfacility practice expense payment to make the comparison. Thus, in many cases, CMS did not use the full amount Medicare pays under the PFS for practice expenses for the comparison to the OPPS rate, but rather an amount that represents only the direct practice expense costs of the service. For these services, the agency includes no compensation for the indirect practice expense costs that a hospital continues to incur when a service is provided in the hospital outpatient department. **The AHA believes that this comparison should always use the full PFS payment for practice expenses in a nonfacility setting because a hospital continues to incur indirect costs when a service is provided in the off-campus PBD. When this is done in addition to the packaging correction above, our analysis shows that the resulting ratio of PFS payment to OPPS payment is 63.7 percent.**

While CMS may posit that the purpose of Section 603 is to make what it calls a "site-neutral" payment, nowhere does Section 603 use this terminology or indicate that Medicare's payment under Section 603 is required, or even intended, to be site-neutral to the amount Medicare would pay if the same service were done in a physician office. Section 603 merely directs the Secretary not to pay for services provided in a new off-campus PBD under the OPPS, but rather to pay

under a different “applicable payment system.” If CMS had both accounted for packaging and used the full amount that Medicare makes for practice expenses, the PFS payment as a percent of the OPPS payment would be substantially higher than the 45 percent the agency calculated in its analysis.

In the IFC, CMS states, “Generally speaking, we arrived at 50 percent by examining the 45-percent rate noted above, the ASC payment rate – which is roughly 55 percent of the OPPS payment rate on average – and the payment rate for the large number of OPPS and MPFS and evaluation and management services, as noted above.” **We find that if CMS substituted 63.7 percent for the 45 percent in their comparison, a more appropriate and justifiable percentage upon which to base payments for nonexcepted services would be 64 percent, consistent with accounting for differences in packaged costs and compensating hospitals for their continued indirect costs, as opposed to the 50 percent that the agency stated it will use in 2017. We urge the agency to adopt this more accurate payment rate.**

Packaging Policy for Claims with both Excepted and Nonexcepted Services. As noted, CMS will apply the standard OPPS packaging logic when calculating payment rates for nonexcepted items and services. **The AHA seeks clarification about how the OPPS packaging logic will be applied when the items and services included on a single claim are furnished in both excepted and nonexcepted PBDs; that is, when a claim includes line items both with and without the PN modifier (reported with a nonexcepted service).** For instance, under the current comprehensive Ambulatory Payment Classification (C-APC) policy, if a primary service (i.e., a service with a status indicator of J1 or J2) appears on a claim with other services, the primary service is paid at the applicable C-APC rate, and all other services on the claim are packaged into that payment rate.

However, CMS has not clearly stated how this C-APC logic would apply if the J1 or J2 service and other services on the claim are furnished in both excepted and nonexcepted locations. The same question arises pertaining to other OPPS packaging policies, such as the packaging policy for laboratory services, ancillary services and composite APCs. **Section 603 of BiBA does not give the agency the authority to apply payment reductions to services furnished in excepted PBDs. Therefore, the AHA presumes that CMS will process services on a claim *with* the PN modifier separately from those services *without* the PN modifier.** In other words, we expect that the agency will separately apply its packaging logic to the services on a claim that have the PN modifier attached, and pay for these service at the special rate of 50 percent of the OPPS rate. For the other services on the claim that were furnished in excepted locations, we expect that the agency will pay these according to the usual OPPS packaging payment policies at the final OPPS rates for 2017.

Payment Rate for the Mental Health Composite Services Furnished in Nonexcepted PBDs. In the final rule, CMS establishes a policy under which nonexcepted hospital-based PHP services will be paid at the same rate as community mental health centers (CMHCs), which is \$121.48 in CY 2017.

In addition, for CY 2017, CMS also continues its longstanding policy that when the aggregate payment for non-PHP mental health services provided exceeds the maximum payment rate for PHP services, those mental health services are paid through composite APC 8010 (Mental Health Services Composite), which CMS policy holds must be set at the highest payment for hospital-based PHP services. Thus, the payment rate for APC 8010 is set at \$207.27, the same payment rate as for APC 5863 (Partial Hospitalization, three or more services per day, for hospital-based PHPs). Therefore, for nonexcepted PBDs, the payment rate for APC 8010 would be set at 50 percent of the OPSS rate, or \$103.63, consistent with the percentage reduction applied to other nonexcepted services. However, this is actually less than the maximum payment rate for nonexcepted hospital-based PHP services, which is set at the CMHC rate of \$121.48.

Setting the nonexcepted payment rate for the mental health composite at an amount that is less than the nonexcepted payment rate for hospital-based PHP is inconsistent with CMS's longstanding policy. **Therefore, the AHA recommends that CMS adjust the nonexcepted payment rate for the mental health services composite APC 8010 to match the rate for the nonexcepted hospital-based PHP APC, which is \$121.48 in CY 2017.**

Expansion of Services. While CMS did not finalize its proposed policy to limit service line expansions in excepted off-campus PBDs for 2017, the agency states its concern that allowing unlimited expansion of services could lead to a continuation of practices that CMS believes Congress intended to prevent. Therefore, CMS will monitor expansion of clinical service lines by off-campus PBDs and consider limiting expansion in the future. To that end, the agency requests public comments on what data are currently available or could be collected that would allow CMS to implement a limitation on service expansion. The agency also is interested in public comments about such a policy, including feedback on how a limitation on volume of services or on lines of service would work in practice, including suggestions for changes to the clinical families of services that CMS proposed.

The AHA supports CMS's decision in the CY 2017 final rule not to penalize hospitals that expand services in their excepted PBDs. While we are not opposed to CMS monitoring the type or volume of services being furnished at excepted off-campus PBDs, as long as doing so does not impose an undue burden or cost on patients, hospitals and health systems, the AHA continues to strongly believe that hospitals should be able to expand the items and services offered in excepted PBDs. Doing so allows hospitals to address changes in clinical practice and meet the evolving needs of their communities without losing their ability to be reimbursed under the OPSS. Given the rapid pace of technological advances in medicine, the treatments and services offered by PBDs today will inevitably evolve into newer, innovative and more effective care in the future. CMS's policy must not hamper access to innovative technologies and services. In addition, many hospitals have plans to consolidate complimentary services that are currently scattered across several PBDs within their health system into an excepted off-campus PBD for the purpose of improved patient convenience and quality of care. Such expansions of services at excepted PBDs represents a beneficial reshuffling of existing excepted services within health systems and should be allowed to continue without penalty.

Further, as we discussed in our proposed rule comment letter, the AHA continues to question CMS’s authority to limit the expansion of services at an excepted off-campus PBD. That is, there is a reasonable argument to be made that BiBA’s reference to “a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of the date of the enactment of this paragraph)” indicates that Congress intended to allow expansion of services at excepted PBDs. In defining which off-campus HOPDs are excepted from payment reductions, BiBA specifically references the provider-based regulation’s definition of a “department of a provider” as it existed at enactment. This means that CMS must consider the *entire regulatory definition* in developing its policies. However, in the proposed rule, and as reiterated in the final rule, CMS considers only *select phrases*, focusing on only one part of this regulatory definition in justifying its authority to remove excepted status when an excepted PBD expands. That is, the agency cites only the part of the definition that states: “A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility.”

However, the first part of the regulatory definition, which also must be considered under the law, states that the “Department of a provider means a facility or organization that is either created by, or acquired by, a main provider *for the purpose of furnishing health care services of the same type as those furnished by the main provider* under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section.” We believe that this means that expansions in services at an excepted off-campus PBD may occur because they are furnishing services “of the same type as those furnished by the main provider.” **Therefore, we believe that Congress intended to except off-campus PBDs that were furnishing services under the hospital’s provider number prior to Nov. 2, 2015, including all current and future services provided at that PBD’s location because, by definition, they are “of the same type as those furnished by the main provider.”** In other words, unlike free-standing physician practices, PBDs are, by definition, fully integrated with their main hospital. This includes complying with the same Medicare conditions of participation and conditions of payment and full integration of their clinical, financial and administrative functions. This is consistent with how many PBDs operate and, indeed, with the other parts of the provider-based regulations at 42 CFR 413.65, which are designed to ensure integration with the main hospital. Services change over time at the main provider and similarly at the on-campus and off-campus PBDs as the practice of medicine evolves and the needs of patients change.

With regard to CMS’s request for comments on how a limitation on families of service or volume of services would work in practice, including how the clinical families of service it proposed could be changed so as to impose a limitation on expansion of services at excepted PBDs in the future, **we reiterate our concerns about the “clinical families of service” approach CMS had proposed in July. Any approach assessing expansion that categorizes services by clinical families would be overly complex to apply and maintain and would raise daunting operational issues.** As we discussed in our proposed rule comment letter, it would be exceedingly difficult to track families of service given the dynamic nature of the APCs

such as the annual changes in APC definitions and composition, as well as frequent changes to the Current Procedural Terminology (CPT)/HCPCS codes contained in those APCs.

Further, alternative approaches, such as that proposed by the Medicare Payment Advisory Commission (MedPAC) to limit expansions in the volume of services furnished in an excepted PBD, also would pose significant implementation challenges. First, although it is possible to identify which items and services are furnished in an off-campus PBD through the use of the PO modifier, hospitals and health systems often have more than one off-campus PBD and there is no way to distinguish which off-campus PBD furnished which services. Also, the use of the PO modifier was first implemented in 2015, on a voluntary basis. It would be misleading to use PO modifier data from CY 2015 as a pre-BiBA baseline for this reason. Post-CY 2015 data are problematic as well. Specifically, the intention of this approach would be to compare the volume of *excepted* services furnished at a particular *excepted* PBD for a period of time before and after the implementation of BiBA, but the PO modifier does not distinguish between services furnished in excepted versus nonexcepted off-campus PBDs. Only the PN modifier, to be implemented Jan. 1, 2017, does that. Therefore, there is no way to determine whether services with a PO modifier with dates of service between Nov. 2, 2015 and Jan. 1, 2017 represent services furnished in excepted or nonexcepted off-campus PBDs. Thus, there is no way to use Medicare data to determine whether the volume of excepted services has expanded at a particular excepted off-campus PBD since Nov. 2, 2015.

Section 603: CY 2019 and Beyond. In the IFC, CMS states that it intends for CY 2019 and beyond to adopt an approach under which the agency would pay nonexcepted PBDs for their nonexcepted services at a PFS-based rate that would reflect the relative resources involved in furnishing the services. Specifically, under what it states as its “preferred” approach, payment amounts would approximate the amount Medicare would pay under the PFS to cover facility overhead costs if the same services were furnished in a physician’s office. CMS notes that for most services, this rate would equal the nonfacility payment rate minus the facility payment rate under the PFS for the service in question. For other services, the payment rate would vary, with some services paid at the full PFS nonfacility rate, others paid at the PFS technical component rate, and yet others at another rate similar to the rate that is paid to ASCs. However, substantial systems changes would need to be made before CMS could implement such a change. Therefore, the agency is seeking public comment on this intended payment approach.

Alternatively, CMS also is seeking public comment on the possibility of continuing to make payment using a methodology similar to that described under this IFC, under which the agency would pay nonexcepted off-campus PBDs under the PFS at a percentage of standard OPFS rates that reflects the relative resources involved in furnishing the services. However, CMS notes that this percentage could be lower or higher than the percentage adopted in this IFC, and the agency would utilize billing data to the extent they are available, initially from CY 2017 and CY 2018, to determine the appropriate percentage adjustment.

The AHA cannot substantively comment on a payment approach for 2019 and beyond in the absence of at least a year of data on CMS’s current Section 603 payment policy, its operational impact on hospitals, and its impact on access to hospital-level care in

communities across the nation. As such, the AHA recommends that CMS continue to uphold its IFC payment policy to base payment on a percentage of the OPPS amount, inclusive of packaging, subject to our comments above.

That said, we wish to note our serious conceptual concerns about CMS's "preferred" payment approach for CY 2019. That is, CMS indicates that under its preferred approach, it would pay for most services at a rate that is calculated as the difference between the PFS nonfacility and facility rate, which is similar to the site-neutral payment policy that MedPAC has recommended in recent reports. **The AHA continues to oppose this policy.**

We strongly believe that payment to hospitals for outpatient care should reflect PBD costs, not physician payments. PBD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule, in particular the practice expense component, which is relevant for the Section 603 payment methodology, is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment "fixes." CMS seems to agree, stating in the IFC that "We believe that, for nonexcepted items and services furnished by an off-campus PBD, the quality of the data currently used to develop payment rates under the OPPS, including hospital claims data and cost reporting, far exceeds the quality of data currently used for MPFS payments."¹ The agency even notes it would like to use the OPPS data in the PFS rate-setting in future years. Thus, the PFS data are not only inappropriate to use for calculating hospital PBD payment rates, it may not even be the best dataset to use for calculating physician payment rates.

In addition, the significantly higher level of packaging in the OPPS than in the PFS would not be accounted for if the payment amount for most services in nonexcepted PBDs were based on only the residual difference between the PFS nonfacility and facility rates, as CMS discussed in the IFC. Even MedPAC recognized this discrepancy and amended its proposed site-neutral recommendations to add-back the cost of the additional packaging in the OPPS. Further, this discrepancy in the relative amount of packaging between the two payment systems has grown tremendously with the rapid advent and growth of the C-APCs, composite APCs, claims-level packaging and packaging of most ancillary and laboratory services. If CMS were to move forward in CY 2019 and beyond with this approach, the agency must account for this difference in the level of packaging.

Lastly, we note that, as described, CMS's preferred approach for 2019 and subsequent years seems overly complex, as it would use different approaches to establish payment rates for individual services and potentially use different payment systems' methodologies for other services. This would be very complex for CMS and its contractors to implement, as the agency has noted. It also would be very difficult for hospitals, including by creating many uncertainties about their budgeted revenues. In addition, CMS has provided very little detail regarding to which services these various payment approaches will apply.

¹ Federal Register, Vol. 81, No. 219, Nov. 14, 2016, Page 79722.

Continued Use of the Institutional Bill. The AHA strongly supports CMS’s decision in the IFC to allow hospitals to continue to bill for items and services furnished in nonexcepted PBDs using the institutional bill (UB04/837I). As CMS has noted, this also would be a significant advantage of continuing to use CMS’s 2017 IFC payment approach for future years. Continued use of the institutional bill will allow for these PBDs to continue to properly use cost reporting procedures and to accurately reconcile the cost report to hospital ledgers for all services and departments and to correctly allow revenue for nonexcepted PBDs to flow through the Provider Statistical and Reimbursement (PS&R) report. Thus, hospitals will be able to continue to track their costs and charges for cost-reporting purposes and for certain important programs, such as the 340B Drug Pricing Program.

IMPLEMENTING THE MID-BUILD PROVISIONS IN THE 21ST CENTURY CURES LAW

On Dec. 13, President Obama signed the 21st Century Cures Act into law. Contained within the law is a section on “Continuing Medicare Payment Under the OPSS for Services Furnished by Mid-build Off-campus Outpatient Departments of Providers.” This revises Section 603 of the BiBA to move the date by which a new off-campus PBD must begin furnishing covered outpatient department services in order to be excepted from Nov. 2, 2015 to 60 days after the law is enacted (which we calculate as Feb. 11, 2017), as long as the PBD was under development prior to Nov. 2, 2015. This provision allows those PBDs that narrowly missed the original Nov. 2, 2015 deadline for furnishing covered outpatient department services, but already have opened or will soon open, to qualify for the higher OPSS rate.

The law provides that, for purposes of items and services furnished in 2017, if CMS received an attestation from a hospital prior to Dec. 2, 2015 indicating that their off-campus department was a PBD of the hospital, the department would be fully grandfathered, even if they were not providing covered outpatient department services and billing Medicare under the OPSS before Nov. 2, 2015. **The AHA recommends that CMS issue as soon as possible instructions, via subregulatory guidance, informing hospitals that qualify for this exception that that they should not to use the PN modifier for items and services furnished in the qualifying off-campus PBDs.**

In addition, the law describes an alternative exception that would impact payments for items and services furnished in 2018 and beyond. Under this alternative exception, an off-campus PBD would be grandfathered if: CMS received an attestation from the hospital prior to Feb. 11, 2017 indicating that its department was a PBD of the hospital; the provider properly updated its Medicare enrollment form to include the PBD; and prior to Nov. 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of the department (referred to in the bill as the “mid-build requirement”) and the Secretary of the Department of Health and Human Services receives from the hospital’s chief executive officer (CEO) or chief operating officer (COO) a written certification that the PBD met the mid-build requirement no later than Feb. 11, 2017. The law also requires CMS to audit each of the PBDs that were grandfathered under the alternative exception for compliance with these

provisions by Dec. 31, 2018. **The AHA recommends that CMS clearly explain as soon as possible, via subregulatory guidance, how, in what form, to whom and by what exact date the hospitals that qualify for this mid-build exception should submit their attestation and their certification statement. Furthermore, the agency should:**

- **Clarify whether qualifying hospital PBDs that are part of a larger health system must have the certification statement signed by the individual hospital's CEO/COO or the larger health system's CEO/COO;**
- **Include in the instructions "or the equivalent" if the titles of CEO or COO are not used by the organization and indicate that the signature on the certification be the official within the hospital or health system who is authorized to enter into a "binding written agreement with an outside unrelated party for the actual construction of such department";**
- **Clarify whether the deadline for submitting the attestation and the certification is the receipt date by agency or the postmark or other date the attestation is sent;**
- **Establish a process by which the timely receipt of the required documents from hospitals is verified; and**
- **Advise hospitals about what information they should maintain, in what form and for how long in order to enable the agency to carry out the required audit.**

PARTIAL HOSPITALIZATION PROGRAM 20-HOURS PER WEEK CRITERION

In the final rule, CMS expresses concern that some providers may be providing too few services to beneficiaries enrolled in PHPs. The agency notes its longstanding eligibility requirement that PHP beneficiaries require a minimum of 20 hours per week in services per the plan of care and reiterates its view that a typical PHP beneficiary should receive five to six hours of services per day. CMS plans to monitor PHP claims beginning in January 2017 to determine whether PHP participants are receiving at least 20 hours per week in PHP services as well as to determine whether there is an increase in furnishing only three services a day, known as "three-service days." CMS states that payments for claims will not be affected now, but it is working expeditiously to implement claims edits in the future to ensure that eligible Medicare beneficiaries are receiving the intense level of services that the statute and regulations require PHPs to provide. The agency requests comments on the advantages, disadvantages and potential challenges of strengthening the tie between payment and furnishing at least 20 hours of services per week to eligible beneficiaries.

The AHA understands that the PHP benefit is designed as an intensive benefit requiring physician certification that the patient requires a minimum of 20 hours per week of therapeutic services. We agree with CMS that it is critical to ensure that patients eligible for PHP services

receive the appropriate intensity of services. We also share the agency's concerns about the possibility that replacing the current two-tiered PHP APCs with a new single hospital-based PHP (APC 5863) and CMHC PHP (APC 5853) that would pay these providers for providing three or more services per PHP service day could provide an incentive for some providers to inappropriately reduce patient intensity of services. **Therefore, we believe that it is appropriate for CMS to monitor PHP claims to track the intensity of services furnished in 2017.**

However, we also believe that it would be premature for CMS to implement a claims edit requiring 20 hours per week of services in order to qualify for PHP payment prior to conducting a thorough analysis of the monitoring data that the agency will collect for 2017, as well as seeking engagement from the PHP provider community. Such a step should not be taken in the absence of data indicating that the new single PHP APC for each site-of-service has inappropriately reduced the intensity of services furnished to patients eligible for the PHP benefit.

In addition, we are concerned that a claims edit could result in inappropriate changes and perhaps reduced access to the PHP benefit. While CMS's eligibility criteria state that PHPs "are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care," *CMS has previously clarified that there should be reasonable exceptions for this criterion.* For instance, in the preamble to the 2009 OPPS/ACS final rule, in which the agency added the 20 hours per week eligibility criterion to its regulations, it states, "[W]e are clarifying that the patient eligibility requirement that patients require 20 hours of therapeutic services *is evidenced in a patient's plan of care rather than in the actual hours of therapeutic services a patient receives.* The intent of this eligibility requirement is that for most weeks we expect attendance conforming to the patient's plan of care. We recognize that there may be times at the beginning (or end) of a patient's transition into (or out of) a PHP where the patient may not receive 20 hours of therapeutic services." (Emphasis added) Further, a strict claims edit policy would be inconsistent with local coverage determinations for PHP, which allow for exceptions to the 20-hour programming week for situations involving patient physical illness, bad weather, holidays, transportation issues or medically necessary absences.

If the claims edit the agency is considering is similar to the edit the agency proposed, but did not implement, in 2016, it would impose a new requirement for weekly billing. This new requirement would be inconsistent with existing Medicare policy (MM8048, "Enforcing Interim Billing for Partial Hospitalization Services") which allows daily, weekly or monthly billing as long as bills are submitted sequentially.

As such, if upon evaluation of the monitoring data, CMS finds a systemic and significant decline in the intensity of PHP services among providers, and so ultimately decides to implement a claims edit, we strongly recommend that the policy include reasonable exceptions, as described above, not mandate weekly billing for PHP and not implement the edit in an administratively burdensome manner.

Andrew M. Slavitt
December 21, 2016
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Thank you again for the opportunity to comment. If your team has any questions or would like to discuss further, Roslyne Schulman, director of policy, is the point of contact at the AHA. You can reach her at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachment

American Hospital Association Table 1 – Packaging Percentages

Codes limited to those that CMS used in Table X.B.1. Calculations based on CY 2017 OPPS final rule methodology and the same data used in the rate-setting for that rule.

HCPCS	Short Descriptor	Mean Costs based on singles used in rate-setting			Percentage packaging
		Procedure	Packaging	Procedure plus packaging	
	Total: Top 22	\$ 162.88	\$ 39.55	\$ 202.43	20%
96372	Ther/proph/diag inj sc/im	\$ 47.02	\$ 33.61	\$ 80.63	42%
71020	Chest x-ray 2vw frontal&latl	\$ 63.67	\$ 5.68	\$ 69.35	8%
93005	Electrocardiogram tracing	\$ 33.08	\$ 49.42	\$ 82.50	60%
96413	Chemo iv infusion 1 hr	\$ 171.54	\$ 189.03	\$ 360.56	52%
93798	Cardiac rehab/monitor	\$ 198.04	\$ 0.05	\$ 198.09	0%
96375	Tx/pro/dx inj new drug addon	\$ 50.84	\$ 0.03	\$ 50.87	0%
93306	Tte w/doppler complete	\$ 485.20	\$ 11.57	\$ 496.77	2%
77080	Dxa bone density axial	\$ 98.73	\$ 12.18	\$ 110.91	11%
77412	Radiation treatment delivery	\$ 205.71	\$ 33.34	\$ 239.05	14%
90853	Group psychotherapy	\$ 107.39	\$ 0.08	\$ 107.47	0%
96365	Ther/proph/diag iv inf init	\$ 140.92	\$ 121.14	\$ 262.06	46%
20610	Drain/inj joint/bursa w/o us	\$ 262.99	\$ 95.31	\$ 358.31	27%
11042	Deb subq tissue 20 sq cm/<	\$ 410.21	\$ 91.54	\$ 501.75	18%
96367	Tx/proph/dg addl seq iv inf	\$ 69.52	\$ 0.09	\$ 69.61	0%
93017	Cardiovascular stress test	\$ 215.77	\$ 58.90	\$ 274.66	21%
77386	Ntsty modul rad tx dlvr cplx	\$ 567.49	\$ 15.06	\$ 582.55	3%
78452	Ht muscle image spect mult	\$ 743.17	\$ 536.90	\$ 1,280.06	42%
74177	Ct abd & pelv w/contrast	\$ 291.26	\$ 111.55	\$ 402.81	28%
71260	Ct thorax w/dye	\$ 175.31	\$ 92.51	\$ 267.81	35%
71250	Ct thorax w/o dye	\$ 134.51	\$ 11.07	\$ 145.58	8%
73030	X-ray exam of shoulder	\$ 71.42	\$ 21.16	\$ 92.58	23%
90834	Psytx pt&/family 45 minutes	\$ 148.40	\$ 0.44	\$ 148.85	0%

Notes:

- Calculations based on CY 2015 data used in CY 2017 rate-setting.
- Final Rule data and policies followed.
- Based on costs with singles.
- Costs have been standardized to account for wage index.
- Means are arithmetic.