DIGESTIVE HEALTH
PHYSICIANS ASSOCIATION®

December 27, 2016

BY ELECTRONIC SUBMISSION

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments to CMS-1656-FC and IFC

Dear Acting Administrator Slavitt:

On behalf of the more than 1,500 gastroenterologists and other physician specialists whose independent medical practices are members of the Digestive Health Physicians Association ("DHPA"), we want to thank you for the opportunity to comment on the Outpatient Prospective Payment System ("OPPS") Final Rule for Calendar Year 2017.[1] Earlier this year, we submitted comments on CMS's proposed implementation of section 603 of the Bipartisan Budget Act of 2015 ("BBA"),[2] which prohibits new, hospital off-campus provider-based departments ("PBDs") from billing under the OPPS. We appreciate the efforts CMS made in the Final Rule to stem the tide of hospitals acquiring physician practices and converting them to PBDs.

At the same time, CMS has retreated from certain important elements of the site neutrality payment provisions that had been presented in the Proposed Rule. We are concerned that modifications made in the Final Rule will encourage hospitals to continue acquiring independent physician practices for the purpose of obtaining higher reimbursement for the same services—a practice that Congress sought to eliminate through passage of Section 603 of the BBA. Overall, we have the following comments:

- We agree with CMS's decision to finalize the requirement that an "excepted" PBD cannot relocate if it seeks to maintain its "excepted" status and continue billing under the OPPS.
- We disagree with CMS's decision to eliminate restrictions on the types of services a PBD can furnish and still maintain its "excepted" status; and

[1] 81 Fed. Reg. 79562 (Nov. 14, 2016).

[2] Public Law 114-74 (2015).

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- We are concerned that CMS's interim final policy of allowing "nonexcepted" PBDs to collect a hospital-specific "facility fee" will simply incorporate existing payment disparities into the MPFS, thereby undermining the very purpose of the site neutrality payment policy that Congress enacted.

I. Digestive Health Physicians Association

DHPA formed in 2014 to promote and protect the high quality, cost-effective and coordinated care furnished in independent gastroenterology practices. DHPA is the only national medical association that exclusively represents the voices of those gastroenterologists who have chosen to care for patients in the independent practice setting. In less than three years, DHPA has grown to include 65 member gastroenterology practices from 31 states in every region of the country. Our more than 1,500 physicians provide care to approximately 2.5 million patients annually in more than 3.5 million distinct patient encounters. Our physician members are on the front lines of providing innovative treatments for serious diseases and chronic conditions such as colon cancer, Crohn's disease, and ulcerative colitis.

II. CMS Should Implement Section 603 of the BBA Consistent With Congress's Intent to Limit Hospitals' Unfair Reimbursement Advantages.

In the Proposed Rule, CMS discussed at length Congress's intent in passing section 603 of the BBA. As CMS explained, Congress sought "to curb the practice of hospital acquisition of physician practices that then result in receiving additional Medicare payment for similar services."[3] To that end, the Agency stated that Section 603 is designed: 1) to maintain services delivered in excepted off-campus PBDs "as they were being furnished on the date of enactment," and 2) to require any nonexcepted PBD to bill under an "applicable payment system" other than the OPPS.[4]

We believe that CMS accurately captured Congress's purpose in enacting Section 603 of the BBA. As we stated in our comments to the Proposed Rule, provider-based status is a major driver of consolidation in the healthcare system. It allows a hospital to purchase a physician practice and then bill a significantly more expensive "facility fee" under the OPPS for services provided by that practice—even when the practice continues to treat identical patients in identical ways. These acquisitions provide hospitals with an unfair competitive advantage in the healthcare marketplace, particularly when combined with other hospital-centric policies such as the 340B drug discounting program.[5] The "vertical consolidation" resulting from these hospital-centric policies increases costs for patients and for the healthcare system.[6]

[3] 81 Fed. Reg. at 45684.

[4] Id. at 45684-5.

[5] MedPAC estimates that about 50% of hospitals are eligible to purchase outpatient drugs at steep discounts under the 340B program, with an average discount of 22.5% on such drugs. See MedPAC, June 2015 Report to the Congress, p. 70.

[6] Government Accountability Office, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform*, GAO-16-189 (Dec. 2015) ("GAO Report"), p. 1.

Various government entities have expressed great concern about the serious implications associated with the growth of provider-based departments. HHS-OIG plainly stated that CMS "has not provided OIG with evidence that services in provider-based facilities deliver benefits that justify the additional costs to Medicare and its beneficiaries."[7] MedPAC advised that provider-based status was inconsistent with Medicare's mission to be a "prudent purchaser."[8] And, the GAO determined that provider-based status drives increased vertical consolidation that "exacerbates a financial vulnerability in Medicare's payment policy" and called for Congressional action to "equalize payment rates between settings."[9]

The clear and consistent message from HHS-OIG, MedPAC and GAO confirms the need for CMS to implement a truly site neutral payment structure. We believe that CMS shares this goal and has implemented policies designed to limit vertical consolidation through hospital acquisition of independent physician practices. We are concerned, however, that in certain, significant ways the changes CMS made from the Proposed Rule to the Final Rule will enable hospitals to circumvent this objective.

III. CMS Should Implement Policies That Eliminate the Reimbursement Disparity Between Off-Campus PBDs and Physician Offices to the Fullest Extent Authorized by Congress.

A. The Final Rule Restricts Excepted PBDs From Physical Expansion, But Inappropriately Allows PBDs Latitude to Expand the Services They Provide.

Under Section 603 of the BBA, an off-campus PBD may continue to bill under the OPPS if it was in place prior to November 2, 2015. Such PBDs are deemed "excepted PBDs."[10] The Proposed Rule included careful limits on a PBD's ability to maintain "excepted" status. First, a PBD would only be excepted as along as it did not change its physical location (even if it were just a move to a different suite within the same office building).[11] Second, the PBD could only bill under the OPPS for services in the same "clinical family" as services it actually provided prior to November 2, 2015.[12] The Final Rule adopts only one of these proposals: the limitation on physical expansion or relocation.[13] However, the Final Rule removes *any* limitation on the types of services for which an excepted PBD may receive reimbursement under the OPPS.[14]

[7] HHS Office of Inspector General, *CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain*, OEI-04-12-00380 (June 2016) ("OIG Report"), p. 3.

[8] MedPAC, *March 2014 Report to Congress* ("MedPAC Report"), p. 75-76.

[9] GAO Report, p. 17.

[10] 42 U.S.C. § 1395L(t)(21)(B).

[11] 81 Fed. Reg. at 45864.

[12] Id. at 45865.

[13] Id. at 79705.

[14] Id. at 79706.

We commend CMS for placing limits on the use of "excepted" status. According to the OIG, half of the nation's hospitals have already integrated at least one off-campus PBD.[15] A significant portion of the nation's physicians now work for hospitals and bill under the OPPS fee schedule.[16] Unless the Agency places strong limits on excepted PBD status, hospitals associated with these pre-existing PBDs would be able to bill under the OPPS even as they acquire additional physician practices. This would frustrate Congress's clear intent in enacting Section 603. The limitations on relocation and physical expansion are reasonable protections against this outcome, because they link "excepted" status to objective indicators of a PBD's growth.

At the same time, we are concerned that CMS has not finalized an equally important provision of the Proposed Rule: a limitation on the *services* that an excepted PBD can bill under the OPPS.[17] Without such a limitation, an excepted PBD may completely alter or expand the services it provides—including by purchasing new physician practices—and continue to receive elevated reimbursement under the OPPS. Without restricting the types of services that an "excepted PBD" can furnish to those services that were actually furnished prior to November 2, 2015, hospitals will be incentivized to alter and/or expand the clinical services they provide in their excepted PBD locations in order to maximize reimbursement under the OPPS.

We acknowledge that CMS faced operational difficulties in implementing its proposed "clinical families" model.[18] Indeed, we had outlined in our comments to the Proposed Rule alternative models to prevent abuse of excepted PBD status.[19] And, yet, in the Final Rule, CMS removed all limits on the expansion of services within an excepted PBD.[20] As a result, as long as the physical characteristics of a PBD do not change, the Final Rule will allow the "excepted PBD" to expand, without limitation, the scope of services it provides. We ask the Agency to monitor the services provided under these excepted PBDs, and work to operationalize a method that would preclude an "excepted PBD" from expanding its reimbursement advantage into wholly new clinical areas.

B. The Final Rule Incorporates into the MPFS Substantive Payment Disparities Between Off-Campus PBDs and Physician Offices.

By contrast to excepted PBDs, nonexcepted PBDs are not entitled to bill for an expensive "facility fee" under the OPPS.[21] Instead, Section 603 requires nonexcepted PBDs to be paid under an "applicable payment system. . . if the requirements for such payment are otherwise met."[22] We agree with CMS's decision to adopt its proposal to establish the Medicare Physician

[15] OIG Report at p. 10.

[16] Cutler DM, Morton FS, *Hospitals, Market Share, and Consolidation*, JAMA, 2013;310(18):1964-1970, finding that just 41% of physician practices were owned by physicians in 2013.

[17] 81 Fed. Reg. at 79706.

[18] Id. at 79707.

[19] DHPA Comments to 2017 OPPS Proposed Rule. Specifically, we recommended that an excepted, off-campus PBD should only be able to bill under the OPPS for those items and services for which it submitted claims at some point from November 1, 2014 through November 1, 2015.

[20] 81 Fed. Reg. at 70707-8.

[21] 42 U.S.C. § 1395L(t)(21)(C). See also 81 Fed. Reg. at 45688.

[22] 42 U.S.C. § 1395L(t)(21)(C).

Fee Schedule ("MPFS") as the "applicable payment system" for most services furnished in a nonexcepted PBD. However, we are concerned that CMS has created an opportunity for nonexcepted PBDs to *continue* billing for a facility fee, albeit under the MPFS.

Under the Final Rule, CMS allows PBDs to receive payments of facility fees because: 1) the Agency believes hospitals provide a wider range of services than physician offices and 2) different packaging and bundling rules apply to hospital services.[23] As a result, a nonexcepted PBD will be entitled to bill a facility fee under the MPFS that will be valued at 50% of the OPPS rate.[24] Nonexcepted PBDs will be able to bill a facility fee for most services, even when no similar facility fee is available for physician offices.[25] We strongly disagree with this approach, which contradicts Congress's goal of equalizing payments between off-campus PBDs and physician offices.

As a practical matter, off-campus PBDs commonly were the offices of independent physician practices before being acquired by hospitals. Accordingly, the cost of providing services in a physician office versus an off-campus PBD should not differ materially. Of concern, the OIG found that CMS has limited information regarding the costs associated with PBDs (as distinct from other forms of hospital outpatient departments), because the Agency's data systems could not isolate and analyze PBD-specific data prior to changes in claim processing rules in 2016.[26] It is troubling that CMS would effectively allow off-campus PBDs to enjoy substantially higher reimbursement, particularly for common codes, even under the MPFS. For example, under CMS's interim final policy, nonexcepted PBDs would be paid much more for common evaluation and management codes (which typically would not require significant hospital overhead costs to provide):

CPT	Descriptor	MPFS Non-Facility Reimbursement	Total Excepted PBD	Total Nonexcepted PBD
99214	Follow-Up, Moderate	$108.75	$186.24	$132.96
99213	Follow-Up, Intermediate	$73.93	$158.24	$104.96
99204	New Patient, Moderate	$166.17	$238.28	$185.00
99203	New Patient, Intermediate	$109.46	$184.44	$131.16
99215	Follow-up, Complex	$146.43	$219.25	$165.97

As the Table shows, a nonexcepted PBD will receive a payment that is anywhere from 11% to 42% more than an independent physician practice receives for an identical E&M code (e.g., $132.96 compared to $108.75 for CPT Code 99214) just by virtue of the site of service being deemed a "PBD" versus a physician office.

[23] 81 Fed. Reg. at 79716, 79721.

[24] Id. at 79725.

[25] Id. at 79722.

[26] OIG Report at 7.

This is not what Congress intended when it enacted Section 603 of the BBA. Rather, Congress made clear—and CMS seemed to have acknowledged in the Proposed Rule—that the purpose of Section 603 was to establish a site neutral payment structure that would eliminate hospitals' incentive to acquire physician practices. Unfortunately, the interim final policy perpetuates the payment disparity between off-campus PBDs and independent physician practices by embedding this disparity into the MPFS. We strongly disagree with the interim final policy and do not believe that CMS can properly characterize a payment made under the MPFS using these special, PBD-specific rules as adhering to the dictates of Section 603.[27]

CMS explains that its policy decision is partly due to operational concerns. To that end, the Agency proposes two options for future years (starting in 2019). First, CMS states that it could continue a similar model in which nonexcepted PBDs may recover a facility fee based on a percentage of OPPS billing, in a manner designed to achieve *aggregate* site neutrality across all items and services (but that would leave certain procedures or specialties disadvantaged in the office setting).[28] Second, CMS states that it could adopt operational changes to modify the valuation of codes within the MPFS to equalize reimbursement in the physician office and PBD settings on a code-by-code basis.[29] We believe that CMS should adopt the second of these two approaches, given that it is the only one that is consistent with Section 603 of the BBA.

IV. Request for Action

CMS has taken important steps to implement a site neutral payment structure. The Agency has not gone far enough, however, and has revised certain of its proposals in ways that will perpetuate the payment disparity between off-campus PBDs and independent physician practices that furnish identical services. This is the exact opposite of what Congress intended in Section 603 of the BBA. Accordingly, we urge CMS to take the following steps to eliminate payment disparities between sites-of-service, thereby reducing hospitals' incentives to continue acquiring physician practices:

- CMS should limit the items and services that an excepted PBD may bill under the OPPS to those items and services for which the PBD actually billed between November 2, 2014 and November 2, 2015.
- CMS should reverse its interim final policy of allowing nonexcepted PBDs to receive a unique facility fee under the MPFS.
- CMS should prioritize making the operational changes needed in order to adopt a truly site neutral payment policy for future years that establishes equivalent levels of reimbursement for identical services between nonexcepted PBDs and physician offices.

[27] 42 U.S.C. § 1395L(t)(21)(C).

[28] 81 Fed. Reg. 79728.

[29] Id.

DHPA—with its more than 1,500 gastroenterologists who prevent, detect and treat serious gastrointestinal disease and chronic conditions on a daily basis—looks forward to serving as a resource to CMS as it continues its efforts to implement Section 603 of the BBA. Please reach out with any questions to DHPA's Chair of Health Policy, Dr. Lawrence Kim (lkim@gutfeelings.com, 303-788-8888), or to DHPA's legal counsel, Howard Rubin (Howard.Rubin@kattenlaw.com, 202-625-3534).

Sincerely,

Fred Rosenberg, M.D.
President

Lawrence Kim, M.D.
Chair, Health Policy

cc: Howard Rubin, Esq., Katten Muchin Rosenman LLP
Kevin Harlen, DHPA Executive Director