Business Group on Health

September 17, 2021

Submitted electronically via: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges

Dear Sir or Madam:

Business Group on Health (The Business Group) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS's) notice of proposed rulemaking revising the Medicare hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) payment systems and other issues.

The Business Group represents a network of today's largest and most progressive employers, including 70 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries

As the largest single payer for health care in the U.S., Medicare has significant influence to transform the delivery system away from a costly fee-for-service (FFS) structure that leads to misaligned incentives. Medicare should join with private sector efforts to transform the delivery system to one that will reduce overall costs and improve health outcomes by adopting alternative payment models, managing the total cost of care, achieving health equity, managing population health and keeping people well. The solvency and stability of the Medicare trust fund would be enhanced by undertaking these efforts.

20 F Street, NW
Suite 200
Washington, DC 20001

202-558-3000
info@businessgrouphealth.org

Visit us at:
www. businessgrouphealth.org

Specific to the proposed rule, the Business Group is commenting on proposed changes to site-of-service and closing the health equity gap in CMS quality programs.

Site-of-Service

Business Group members are actively engaged with providers in improving health care delivery, either via direct contracting or partnering with health plan administrators. One critical element is assuring that payment policy and plan design encourage the use of lower cost, high quality sites of care for services where appropriate, commonly referred to as site-of-service. Previously, CMS also recognized the importance of site-of-service and has made appropriate payment changes. The Business Group supported CMS' efforts.

The Business Group strongly recommends that CMS reconsider its policy to reverse phasing out the Inpatient Only (IPO) List, an effort to further address site-of-service. The IPO list includes procedures that Medicare will not pay for under the OPPS system. In calendar year (CY) 2021 final rules, CMS initiated a phase out the IPO list in favor of deferring to a provider's clinical judgement of site-of-service, including performing procedures in a hospital inpatient setting if it is the appropriate care site based upon the clinical needs of the patient.

As an alternative to reinstating the IPO, the Business Group recommends that CMS phase out the IPO list over a longer time than 3 years (e.g., 5-7 years). Additionally, to address CMS quality and safety concerns identified in CY 2022 rules, we recommend CMS perform a comprehensive review of IPO procedures to identify an initial set to test whether robust patient quality and safety safeguards, identified in CY 2021 rules, for outpatient or ASC care are working as intended. A gradual phase in will give CMS time to further review and reverse course if justified.

If CMS reinstates the IPO list, it will favor the most expensive care setting, exacerbate capacity problems in hospitals experiencing COVID-19 surges and remove a catalyst for the health care system to increase efficiency by adhering to advances in the practice of medicine.

Most expensive care setting

The relative price differentials between performing a procedure in different care settings (e.g., inpatient, outpatient or ambulatory surgical center (ASC)) is well studied (e.g., unicompartmental knee arthroplasty (UKA study), reference pricing study, health

affairs comparative study on ASCs). These studies generally indicate that inpatient is the most expensive care setting. What is less clear is the price that CMS pays for services performed in an inpatient vs. outpatient vs. ASC setting. CMS maintains a tool where beneficiaries can compare costs of procedures provided in a hospital outpatient department (HOPD) vs. an ASC. Utilizing 2019 data, the American Academy of Orthopedic Surgeons released a report that indicated price differentials between these two sites of care can be substantial "knee arthroscopy are $1,005 to ASCs versus $2,098 to HOPDs, with similar differentials in procedures such as knee arthroplasty ($5,914 versus $9,349, respectively) and open reduction internal fixation (ORIF) of a lateral malleolus fracture ($2,854 versus $4,559, respectively)." We recommend that CMS expand this tool to include inpatient prices to get a true cost comparison.

Once expanded, the Business Group expects that the data will reflect an even more substantial price difference. It is critical that in addition to ensuring patient safety and quality that CMS weighs the relative prices of procedures to be a responsible steward of Medicare's finances. There could be significant savings for Medicare and beneficiaries from transitioning care sites when determined clinically appropriate by a physician.

Exacerbating hospital capacity during the COVID-19 pandemic

The IPO list may have the unintended consequence of exacerbating hospital capacity during the COVID-19 pandemic. By reinstating the IPO list, CMS is effectively eliminating these procedures from being performed in other appropriate care settings, such as a HOPD or ASC. This is particularly problematic if there is a surge of COVID-19 hospitalizations, currently driven by unvaccinated people and delta variant, that could lead to hospitals rationing or deferring care in order to care for COVID-19 patients. For example, a leading health care system in Utah recently announced that they were pausing all urgent surgeries to preserve hospital capacity to treat COVID-19 patients.

Studies during the COVID-19 pandemic indicate potentially dire clinical outcomes for deferred care. In addition to worse clinical outcomes, a McKinsey study indicates a potential increase of spending of $30-$65 billion due to deferred care.

Advances in the Practice of Medicine

By reinstating the IPO, CMS is removing a catalyst to encourage the delivery system to optimize, while ensuring that patients with the most acute care needs continue to be

treated in an appropriate care setting as determined by a physician's medical expertise. As mentioned above, a gradual phase out over a longer time is prudent and should give the delivery system the necessary time to adjust and provide CMS time to further review and reverse course if justified.

CMS indicated in CY 2021 rules an understanding of advances in the practice of medicine and has previously removed procedures (total knee arthroplasty (TKA) and total hip arthroplasty (THA)) from the IPO. While a step in the right direction, two procedures being eliminated in 3 years (2018 – 2020) will not be sufficient to address Medicare's finances.

Ambulatory Surgical Center Changes

The Business Group also has similar concerns with CMS decision to remove the 267 medical procedures that were added to the ASC Covered Procedures List in previous rulemaking. CMS previously indicated that it reviewed these procedures and decided that "ASCs are increasingly able to safely provide services that meet some of the general exclusion criteria." Echoing our CY 2021 comments, we recommended that CMS proceed with the first set of procedures and closely monitor and evaluate the experience to determine safety and efficacy and, if appropriate, take steps towards expanding the list of eleven procedures to the potential 267 surgery or surgery-like codes meeting CMS criteria.

However, like the IPO list, in CY2022 CMS changed its policy direction in favor of more expensive care settings. We recommend that CMS reconsider its policy direction and implement a longer phase-in period to cover these procedures, perform a comprehensive review, and return to site-neutral policies as justified with less stakeholder disruption.

Closing The Health Equity Gap in CMS Quality Programs

The Business Group wholeheartedly supports CMS efforts to close the health equity gap to reduce and eventually eliminate health disparities. The Business Group recognizes that the health care system cannot improve what it cannot measure. To reduce health disparities and achieve health equity, CMS efforts must be built upon robust data collection to accurately track health outcomes stratified by race, ethnicity, socio-economic factors and more.

We strongly recommend that CMS adopt a consistent data collection system across all sites of care and refer CMS to our comments on 2022 Medicare Hospital Inpatient Payments for more detail on data elements to collect.

Thank you for considering our comments and recommendations. Please feel free to contact me (kelsay@businessgrouphealth.org or Matthew Sonduck (sonduck@businessgrouphealth.org) Policy Associate to discuss.

Sincerely,

Ellen Kelsay
President and CEO