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Via Electronic Submission (www.regulations.gov)

September 2, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS–1613-P
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Ms. Tavenner:

Re: CY 2015 Outpatient Prospective Payment System Proposed Rule, File Code CMS–1613–P.

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: Appeals Process for Overpayments Associated With Submitted Data; Proposed Rule," 79 *Fed. Reg.* 40916 (July14, 2014). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

Our comments focus on the following areas:

- Packaging of Ancillary Services
- Collecting Data on Off-Campus Provider-Based Facilities
- No Collapsing of Visit Codes for Emergency Department Visits
- Comprehensive Ambulatory Payment Classifications (C-APCs)
- New and Revised CPT Codes; Interim HCPCS G-Codes
- Revised Physician Certification Requirements

- Inpatient-only List
- Separately Payable Drugs and Biologicals
- Payments to Certain Cancer Hospitals
- Proton Beam Radiation Therapy
- Payment for Partial Hospitalization (PHP) Services
- Hospital Outpatient Quality Reporting Program

PACKAGING OF ANCILLARY SERVICES

AAMC Urges CMS Not to Implement the Proposal to Package Ancillary Services until Further Analysis is Conducted Regarding the Proposal's Impact on Teaching Hospitals; Encourages CMS to Clarify to Which Ancillary Procedures the Proposed New Policy Applies

In the CY 2014 proposed rule, CMS proposed to package "ancillary procedures", which are identified with status indicator "X". The Agency did not finalize this proposal, believing additional evaluation was necessary. In this year's proposed rule, CMS proposes to conditionally package ancillary service APCs that have a proposed geometric mean cost of less than or equal to $100 (prior to application of the conditional packaging status indicator).

The AAMC is generally supportive of CMS' attempt to improve payment accuracy through increased bundling of services. The Association appreciates that CMS reconsidered the Agency's proposal from CY 2014 and refined it to address concerns that certain low volume but relatively costly ancillary services would have been packaged into high volume but relatively inexpensive primary services (for example, visits) by setting the $100 threshold.

The AAMC is extremely concerned, however, that this policy disproportionately affects teaching hospitals because of the types of patients these hospitals serve. The AAMC's data analysts, the Moran Company and Watson Policy Analysis, estimate that major teaching hospitals will lose approximately -0.4 percent on average as a result of CMS' packaging proposal, compared to non-teaching hospitals, who will gain approximately 0.2 percent. The AAMC is concerned that the negative impact is a direct result of academic medical centers' caring for unique and complex patient populations, for example, trauma patients who are seen in teaching hospital emergency departments. Our analysis indicated that a large proportion of several of the APCs listed on Table 11 (APCs 0012, 0099, 0260, 0261, 0340, and 0420) are packaged into emergency department visits and related services. For example, when APC 0012, Level I Debridement and Destruction, is packaged as an ancillary service, it is packaged more than half of the time into an emergency department visit. This makes sense from a clinical perspective, as trauma patients suffering from wounds would regularly require debridement and destruction services. AAMC's analysis shows that hospitals with a Level I trauma center will, on average, lose nearly -0.6 percent of their OPPS payment as a result of this proposed packaging policy.

Given that hospitals with trauma centers tend to treat a higher proportion of emergency department patients with higher acuity, whose care requires more packaged services, CMS' proposed policy change would harm teaching hospitals for providing exactly the type of care they are best equipped to provide. The AAMC strongly urges CMS not to finalize this ancillary packaging policy, at least until such time as CMS completes a thorough analysis of the distribution of these ancillary services and can determine a way to account properly for the special and complex patient populations treated at teaching hospitals.

Additionally, as CMS moves to a payment system that bundles more and more services together and accounts less and less for individual patient complexity, the AAMC urges the Agency to take a fresh look at the overall adequacy of OPPS payments to teaching hospitals. When the inpatient setting moved to a DRG system, there was a broad recognition that DRG payments would not be able to account fully for factors such as severity of illness of patients requiring the specialized services and treatments provided by teaching institutions. Congress implemented the indirect medical education (IME) payment to account for the higher costs of hospitals' complex missions, not captured by DRG payments. No similar adjustment has been introduced on the outpatient side, however, despite CMS' intentional movement of the APC system to mirror DRGs.

As the Agency makes policy decisions – such as packaging of ancillary services – that bundle payments together and move the OPPS system in the direction of a DRG system, the AAMC urges CMS to determine both whether individual policy proposals disproportionately affect teaching hospitals and also whether major teaching hospitals' payment to cost ratios (PCRs) are consistently lower than those of other hospitals, and if they are, the reasons for any systematic differences. If there is a disproportionate impact and if differences are found to exist because of the unique missions of teaching hospitals, the AAMC encourages CMS to propose a teaching adjustment to the OPPS, to ensure equitable payments for all classes of hospitals.

Finally, Table 11 of the proposed rule should be clarified and explained in greater detail in the final rule. Table 11 lists the APCs that CMS is proposing will be affected by the Agency's ancillary packaging proposal. At first glance, it appears CMS is proposing to include some APCs with a geometric mean cost greater than $100, in apparent contradiction to the proposed rule. However, it appears that the geometric mean figures reported in Table 11 may indicate the geometric means of the remaining "singles" in the APC *after* the new policy has been applied. The AAMC encourages CMS to explain and clarify this table in the final rule.

COLLECTING DATA ON OFF-CAMPUS PROVIDER-BASED FACILITIES

AAMC Urges Caution, More Clarity and Postponed Effective Date in Collection of Information on Off-Campus Provider-Based Facilities

CMS states that the Agency is interested in better understanding hospital acquisition of physician practices and the integration of those practices as departments of the hospital, particularly given the co-

payment implications for Medicare beneficiaries and the cost to the Medicare program of paying hospital facility fees. In the CY 2014 OPPS proposed rule, CMS asked whether a claims-based approach or a cost reporting approach to collecting information about off-campus departments (*i.e.*, those departments located beyond 250 yards of the provider's main buildings) would be preferable, but comments the Agency received reached no consensus on a preferred approach. In this year's rule, to collect data on the frequency, type, and payment for services furnished in off-campus provider-based departments, CMS proposes to require hospitals to report a new HCPCS modifier with every code for physician services and outpatient hospital services furnished in off-campus provider-based departments on forms CMS-1500 (for physician services) and UB-04 (CMS Form 1450, for hospital outpatient services), effective January 1, 2015.

The AAMC is concerned about the administrative burden associated with such a proposal and the extremely short timeline for implementation. The Association recognizes the importance of beginning to collect this type of data, given how little is currently known in the aggregate about provider-based facilities and how important having accurate information is to the broader conversation around the site in which healthcare services are delivered. The AAMC urges CMS to consider, however, that requiring this new modifier will necessitate significant changes to internal billing processes at hospitals and practices, which will require substantial time, effort, and resources. AAMC member hospitals report that many charge codes would need to be adapted for the new modifiers, charge masters would need to be rebuilt, systems would need to be built for Medicare-specific claims edits, coordinating with professional billing will be a challenge, and communicating the changes to large numbers of employees will take time. If CMS implements this proposal, the AAMC urges the Agency to postpone the effective date by at least one year.

Given the complexities surrounding this data collection, the AAMC encourages CMS to convene a group of CMS staff and hospital and physician stakeholders to identify the most accurate and least burdensome way of collecting meaningful data. In discussing this proposal, AAMC members raised granular issues with implementation that are best identified by providers themselves and must be resolved by CMS before implementing this proposed policy. For example, CMS should determine how to address cases in which a patient is treated on the same day in both on-campus and off-campus provider-based settings and a single claim is submitted for services provided in both locations. The Agency should consider the appropriateness of the current definition of a "campus," given the varying definitions of this term from state to state and that some departments just beyond 250 yards of the main buildings may be treated as real and functional parts of the provider's campus. Additionally, given the inaccuracies that often persist in codes on claims that are not tied to payment, CMS should work with a stakeholder group to determine the best way of collecting the most accurate data.

The AAMC also urges CMS to work with stakeholders to review results of the survey the Department of Health and Human Services Office of Inspector General (OIG) conducted on some of these issues. CMS and the provider community should have the advantage of understanding what the OIG has learned from this effort and should target future data collection at questions that remain unanswered.

The AAMC notes with appreciation CMS's assessment in the CY 2014 proposed rule that the Agency "expect[s] hospitals to have overall higher resource requirements than physician offices because hospitals are required to meet the conditions of participation, to maintain standby capacity for emergency situations, and to be available to address a wide variety of complex medical needs in a community." 78 *Fed. Reg*. 403534, 43627 (July 29, 2013). These costs for hospital outpatient departments (HOPDs) are real and are documented annually through an audited cost report. HOPD costs also stem from the unique role the hospital has in the health system. An AAMC analysis of office visits confirmed that HOPDs see more complex patients, and a higher proportion of dual-eligible, disabled, and non-white patients, compared to physician offices. HOPDs provide comprehensive and coordinated care settings for patients with chronic or complex conditions, such as pain centers or cancer clinics. Many centers of excellence provide services in the HOPDs; provide outstanding team-based, patient-centered care (the gold standard of care); and include wrap around services, such as translators.

Finally, the AAMC strongly encourages CMS to engage the hospital and physician stakeholder community in putting any data the Agency collects on off-campus provider-based departments into context. CMS says the Agency wants to better understand trends around hospital acquisition of physician offices, but the type of data CMS proposes to collect will not answer the questions the Agency is asking. This data will provide only a snapshot in time and will not immediately identify shifts in hospital ownership of physician practices or the types of patients who are treated in these off-campus provider-based locations. Beginning to collect data on these locations may be an important first step, but it should only be an introduction to a much broader dialog with providers about what services are being provided and the characteristics of patients who are treated in provider-based facilities.

NO COLLAPSING OF VISIT CODES FOR EMERGENCY DEPARTMENT VISITS

CMS Exercised Appropriate Caution in Not Proposing Changes to Emergency Department Visit Codes

In the CY 2014 proposed rule, CMS proposed to collapse all five levels of Type A Emergency Department (ED) visit codes into a single code and all five levels of Type B ED visit codes into a single code. The AAMC and others raised serious concerns with a broad policy of collapsing ED visit codes and urged CMS to study carefully the effects of such a proposed policy on hospitals that have trauma facilities and/or are academic tertiary referral centers, as these facilities tend to treat higher acuity ED patients. Based on the data the Moran Company was able to analyze for the AAMC last year by isolating this proposal as best they could from other proposed policy changes in the CY 2014 proposed rule, collapsing ED E/M visit codes into a single code would have had a disproportionately negative effect on major teaching hospitals.

The AAMC appreciates that CMS did not finalize this proposal in the CY 2014 final rule or offer a new proposal to collapse these codes in the CY 2015 proposed rule. The Association concurs with CMS that

"additional study is needed" on this issue and commends the Agency for moving forward with appropriate caution. The AAMC is more than willing to engage in a dialog with CMS as the Agency continues to explore this issue.

COMPREHENSIVE AMBULATORY PAYMENT CLASSIFICATIONS

CMS Should Account for Unrelated Services within the Comprehensive APC Policy

In the CY 2014 final rule, CMS created but deferred implementation of a new policy to create comprehensive APCs (C-APCs) to replace existing device-dependent APCs. CMS defined a C-APC as "a classification for the provision of a primary service and all adjunctive services provided to support the delivery of a primary service." 78 *Fed. Reg.* 43558. Under the new policy, CMS will make a single prospective payment based on the cost of all individually reported codes representing a primary service and all adjunctive services; all other services would be conditionally packaged. In the CY 2015 proposed rule, CMS provided additional information on the complexity adjustment and expanded the services that will trigger a C-APC to include all device-dependent procedures as well as single-session cranial stereotactic radiosurgery and intraocular telescope implantation.

As noted above, the AAMC is generally supportive of CMS' attempt to improve payment accuracy through increased bundling of services and appreciates the refinements CMS proposes to the complexity adjustment requirements. The AAMC is concerned, however, that CMS' proposal may not properly account for diagnoses that are unrelated to the primary condition. Because C-APCs are based on an entire claim, which can include up to 30 calendar days of other activities, hospitals would be paid differently if they included all services on one claim or if they split the claim into separate claims. More specifically, the AAMC is concerned that hospitals providing large volumes of recurring services such as chemotherapy, radiation therapy, and dialysis would be disproportionately negatively impacted by CMS' proposed "whole claim" approach, because they would no longer receive separate payment for unrelated services listed on the same claim with a primary "J1" procedure. Before finalizing this proposal, the AAMC encourages CMS to explore options for making payment adjustments for unrelated procedures that are performed simultaneously or nearly simultaneously with the primary service and to present a proposed solution to this problem in an interim final rule.

One particular category of unrelated service the AAMC urges CMS to address is that of costly surgeries that are 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 CY 2014 comprehensive APCs geometric mean costs, which ranged from $4,230 to $32,948. However, with the expansion, reconfiguration, and restructuring of the proposed CY 2015 C-APCs, several of the proposed C-APCs have much lower geometric mean costs. 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.

The AAMC is concerned that hospitals may 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. In this case, the hospital would receive payment only for the low-cost C-APC, and 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 which often is placed when the patient will require some type of intravenous therapy following a surgical procedure. Both of these J1 codes are assigned to C-APC 0622. Neither of the two complexity adjustments proposed for this C-APC involve the possible surgeries that would commonly occur with a placement of a central line, such as a partial or complete mastectomy. Hospitals billing this combination of codes on a claim would only receive the $2,635 for the placement of the central line and no payment for the mastectomy.

To address these situations, the AAMC recommends that CMS implement a policy that would allow 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. CMS might consider a "multiple-procedure reduction" approach in which the higher-paying non J1 surgical procedure would be paid at 100 percent while the lower-paying C-APC would be paid at 50 percent.

In addition to concerns about unrelated services, the AAMC urges CMS to proceed cautiously with the C-APC policy in the future. If CMS decides to expand the category of C-APCs, the AAMC expresses concern that adding and removing complexity adjustments with frequency or maintaining complexity adjustments that are no longer relevant, could lead to significant complexity, confusion, and shifts for particular rates. The AAMC encourages CMS to adopt goals of clarity and simplification in making changes to C-APC policies and to avoid packaging too many services into a single C-APC.

NEW AND REVISED CPT CODES; INTERIM HCPCS G-CODES

CMS Should Not Adopt Interim G-Codes for New and Revised CPT Codes

In this year's proposed rule, CMS notes that several stakeholders have expressed concern with the process CMS uses to recognize new and revised CPT codes, particularly with the lack of opportunity for public comment prior to the January 1 implementation date for these codes. In both the OPPS and Medicare Physician Fee Schedule proposed rules, CMS proposes to implement a revised process for 2016 that would create and use temporary HCPCS G-Codes that mirror predecessor CPT codes and would retain the current APC and status indicator assignments for one year until CMS could include proposed assignments in the following year's proposed rule.

While AAMC appreciates CMS' willingness to attempt to provide stakeholders with a proper opportunity to comment on new and revised codes, the Association strongly urges CMS not to finalize this proposal.

The administrative burden of this proposal far outweighs any potential benefits of an increased comment period, given that hospitals will be required to implement new, temporary codes that are only effective for several months and will only be able to be used for Medicare billing purposes. Instead, the AAMC encourages CMS to adopt the proposed revised process submitted to CMS by the American Medical Association (AMA) and supported by other associations, including the AAMC.[1]

REVISED PHYSICIAN CERTIFICATION REQUIREMENTS

CMS Should Finalize the Proposal to Limit the Physician Certification Requirement to Stays of 20 Days or Longer, but the Two Midnight Rule and the Subregulatory Guidance Implementing the Rule Still Need to be Substantially Revised or Replaced

The FY 2014 IPPS final rule included new physician order and certification requirements in conjunction with the Two Midnight rule. For one of these requirements, CMS interpreted the certification requirement for inpatient stays under Section 1814 (a)(3) of the Social Security Act (SSA) to apply to *all* inpatient admissions. CMS maintains that this interpretation is correct, despite the statute's specifying the need for certification for Part A payment only for services "which are furnished over a period of time."[2] Although, the AAMC disagrees with this interpretation, the Association agrees with CMS that the administrative burden of formal physician certification outweighs the benefits for the majority of cases. The requirement that certification occur before discharge for all inpatient stays has certainly presented logistical and EHR-related challenges for large academic medical centers. Accordingly, the AAMC supports CMS' proposal to limit the physician certification requirement to stays of 20 days or longer.

Specifically, CMS proposes to require physician certification only for cases that are 20 inpatient days or more, and for outlier cases. This certification must include: "1) the reasons for either --- (i) Continued hospitalization of the patient for medical treatment or medically required diagnostic study; or (ii) Special or unusual services for cost outlier cases…2) the estimated time the patient will need to remain in the hospital. (3) The plans for posthospital care, if appropriate." 79 *Fed. Reg*. 40916, 41057 (July 14, 2014).

CMS has proposed a January 1, 2015, effective date for this proposal, and the regulation requiring physician certification for all inpatient admissions took effect October 1, 2013. Therefore, the AAMC also urges CMS to require that Medicare Administrative Contractors (MACs) and any of the Agency's other contractors review and reverse claims denials for services provided in the period between when the certification requirement for all inpatient stays took effect (October 1, 2013) and December 31, 2014, the effective date for the proposal to limit the certification requirement to longer stays and outliers. The

[1] https://www.aamc.org/download/401884/data/aamcrucandcpttimelinesignonletter.pdf
[2] Section 1814(a)(3) of the Social Security Act provides Medicare Part A payment will be made only for such 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."

Association acknowledges that a partial enforcement delay is in place preventing reviews over this time period by Recovery Audit Contractors, but MACs and other contractors have been enforcing the physician certification requirement even though CMS currently acknowledges it is unduly burdensome.

The AAMC strongly believes that the Two Midnight rule and the subregulatory guidance implementing the rule need to be substantially revised or replaced with a policy that appropriately defers to the critical role of medical judgment and adequately reimburses hospitals for medically necessary short hospitalizations. Given that CMS is including new proposals in the OPPS rule related to the physician order and certification requirements, the Association again urges CMS to update guidance implementing the Two-Midnight Rule entitled "Hospital Inpatient Admission Order and Certification,"[3] because this guidance excludes most residents from the list of medical professionals who can furnish orders for admission. Specifically, the guidance requires the "ordering or admitting practitioner" to be "licensed by the state to admit inpatients to hospitals" and "granted privileges by the hospital to admit inpatients to that specific facility."

There are several reasons this subregulatory guidance is confusing and onerous. First, states generally grant licenses to practice medicine, rather than licenses to admit inpatients to hospitals. Second, residents at most teaching hospitals rarely have been granted their own admitting privileges as they are not considered to be part of the medical staff. Instead, hospitals' by-laws allow these residents to write orders on behalf of the attending physicians who supervise them. Therefore, against longstanding hospital practice, CMS' subregulatory guidance excludes the majority of residents from writing inpatient orders unless they complete the added step of tracking down the attending physician for a countersignature. The AAMC urges CMS to replace the existing guidance with the following language:

> **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner ("ordering practitioner") who is: (a) **licensed by the state to practice medicine,** (b) granted privileges by the hospital **to write inpatient admission orders**, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission.[4] (*Emphasis added.*)

The AAMC also encourages CMS to use the following language to replace paragraph B.2.a of CMS' guidance:

> Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located **to practice medicine**, and are allowed by hospital by-laws or

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[3] *Hospital Inpatient Oder and Certification*, CMS, 1 (Jan. 30, 2014). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf.
[4] *Id.*

> policies to **furnish orders**. The admitting practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the admitting practitioner approves and accepts responsibility for the admission decision **as demonstrated by documentation in the medical record, such as progress notes**, prior to discharge. **In this case a countersignature of the order is not needed.** (*Emphasis added*.)[5]

The AAMC maintains that the clear priority is for CMS to revise and replace the Two Midnight Rule with a new policy that defers to clinical judgment, adequately reimburses hospitals for short stays, and that is understandable to beneficiaries. Yet given that in this rule, CMS is proposing to modify the associated physician order and certification requirements, the AAMC urges CMS to modify these requirements in a manner that effectively relieves unnecessary burden for teaching hospitals.

PROPOSED CHANGES TO THE INPATIENT LIST

CMS Should Add CPT 22222 to the Inpatient List

The AAMC supports CMS' proposal to include CPT 22222 (*Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic*) on the inpatient-only list. The potential complications associated with this procedure require close monitoring by health care professionals and access to the technology and diagnostic tests that can only be provided in the inpatient setting. Without this level of monitoring and care, these complications, which include pneumothorax and hemorrhage, can quickly escalate into life threatening conditions. The fact that CPT 22222 was previously on the inpatient-only list and similar CPT codes in the range of this service (including CPT codes 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22224, and 22226) are currently on the inpatient-only list provides further support for including this service on the list.

PROPOSED PAYMENT FOR SEPARATELY PAYABLE DRUGS AND BIOLOGICALS

CMS Should Finalize the Proposal to Pay Separately Payable Drugs and Biologicals at ASP Plus Six Percent

The AAMC commends CMS for once again proposing to pay separately payable drugs at ASP (average sales price) plus six percent. Since CY 2013 when CMS first finalized a proposal to pay for separately payable drugs and biologicals at the ASP plus six percent, the AAMC has supported this rate. The Association agrees with CMS that this rate is appropriate. Paying separately payable drugs at ASP plus

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[5] *Id*.

six percent increases predictability in payments for separately payable drugs and biologics under the OPPS. Accordingly, the AAMC urges the Agency to finalize this proposal.

PROPOSED ADJUSTMENT FOR CANCER HOSPITALS

CMS Should Finalize the Proposal to Continue the Cancer Hospital Payment Adjustment

The AAMC strongly supports CMS' proposal to continue the policy of providing additional payments to each of the eleven cancer hospitals so that each hospital's final payment-to-cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (or "target PCR") for other hospitals paid under the OPPS. For CY 2015, CMS estimates a weighted average or target PCR of 0.89, which is unchanged from CY 2014. Therefore, the cancer hospital payment adjustment would be the additional payment needed to result in a proposed 0.89 target PCR for each cancer hospital. The actual amount of the CY 2015 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY 2015 payments and costs.

The AAMC continues to believe that CMS' policy to provide additional payments to cancer hospitals to reflect their higher costs addresses many provider and beneficiary concerns. The Association therefore supports CMS' proposal to continue the same policies for payment adjustments to cancer hospitals in CY 2015.

PROTON BEAM RADIATION THERAPY

CMS Should Not Assign CPT Code 77522 for Proton Beam Radiation Therapy to APC 667

In the proposed rule, CMS proposes to reassign proton therapy CPT code 77522 from APC 664, for Level I Proton Beam Radiation Therapy to APC 667, for Level IV Radiation Therapy. Given the significant differences in the clinical nature and resource intensity of the codes in these two APCs, the AAMC does not support CMS' proposed change.

The AAMC is concerned that the current CMS proposal would result in inappropriate groupings of clinical services, inappropriately low payments for certain services, and inappropriate economic incentives to treat simple cases. As the rates established by CMS often serve as the foundation for rates established by Medicaid and commercial payors, the proposed rule also would adversely affect access to treatment for vulnerable populations such as pediatric cancer patients who are treated with complex proton therapy. The AAMC urges CMS to maintain the current APC configuration, which is more reflective of the significant differences in clinical nature and resource intensity between the CPT codes in APC 0664 and APC 0667.

PROPOSED PAYMENT FOR PARTIAL HOSPITALIZATION (PHP) SERVICES

CMS Should Not Finalize Significantly Reduced Payment Rates for Hospital-Based PHPs

The AAMC does not support CMS' proposal to continue the policy from CY 2014 that would calculate payment rates for the four PHP APCs (Level I and II partial hospitalization services computed separately for Community Mental Health Center (CMHC)-based PHPs and hospital-based PHPs) based on geometric mean per diem costs using the most recent claims data for each provider type. The Association is concerned that the proposed per diem costs for hospital-based PHPs are significantly lower (by approximately $14 or 8% for Level I and $24 or 13% for Level II PHP services) for hospital based PHPs than the final 2014 rates. The AAMC does not have data that would support such a significant decline in hospital-based PHP rates and urges CMS to reexamine the Agency's data to determine what factors may have caused these fluctuations year to year. The Association is concerned that such large payment reductions could result in hospital-based PHP closures, creating access problems for Medicare beneficiaries and resulting in the unintended effect of increasing the use of more costly inpatient psychiatric care. Given these factors, the AAMC strongly urges CMS not to finalize the significantly reduced payment rates for hospital-based PHPs.

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

In the CY 2015 rule, CMS outlines changes to the Hospital Outpatient Quality Reporting (OQR) program and the Ambulatory Surgical Center Quality Reporting Program (ASCQRP) which would take effect starting CY 2017. The Agency proposes one new measure, the addition of a voluntary measure, and the removal of three "topped out" measures, and clarifies the reporting periods for two delayed measures for the OQR program in the rule. CMS proposes similar changes for the ASCQRP. The AAMC's comments on the proposed changes and measures to the OQR program are provided below.

MEASURES PROPOSED FOR OQR PROGRAM CY 2017

CMS Should Not Finalize the Hospital Visit Rate Following Outpatient Colonoscopy Measure

CMS has proposed one new measure for the OQR program starting CY 2017:

Identifier	Measure name
OP-32	Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

OP-32 assesses all-cause, unplanned hospital visits (including admissions, observation stays, and emergency department visits) up to seven days following a patient's outpatient colonoscopy procedure.

This measure has not been tested or fully reviewed by the National Quality Forum (NQF) and was conditionally approved by the Measures Applications Partnership (MAP) in 2014.

The AAMC supports efforts to reduce unplanned and adverse patient hospital visits following all outpatient procedures. However, the Association has concerns regarding the feasibility and usefulness of this measure when it has not yet been fully evaluated by the NQF to determine whether it meets the standards of reliability, scientific acceptability, and validity. This measure was submitted to the NQF for review in February 2014 and is still undergoing the consensus development process. Once reviewed by the NQF, the AAMC believes that CMS should consider submitting this measure as part of the socioeconomic status (SES) trial period, which was recently created by the NQF Board of Directors as a way to assess certain measures influenced by SES factors.

As an additional concern of the AAMC, hospital return visits following outpatient colonoscopies within a seven day window are relatively rare, affecting approximately one percent of such patients after the measure is risk-adjusted. While some return visits may be problematic, it is unclear whether there is much room to improve on these measures; therefore, these measures may not be effective as part of a national quality reporting program. NQF review is necessary to help make this determination and to better inform MAP discussion of this measure.

Last, the AAMC has concerns that providers lack actionable information on this measure, particularly if a patient returns to an inpatient or outpatient unit at an institution unrelated to the location where the initial colonoscopy occurred. If this measure is adopted, we ask that this data be available for providers.

AAMC Opposes Inclusion of the Improvement in Patient's Visual Function Following Cataract Surgery as a Voluntary Measure

CMS previously adopted OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery in the OPPS CY 2014 final rule. The measure assesses whether patients experienced improvements in vision following cataract surgery. The AAMC previously expressed concerns that the measure had not been tested for the outpatient setting, and that there was unclear guidance on how facilities could respond to the survey in a way that leads to improved care. CMS has twice delayed the start of data collection for this measure, in December 2013 and then again in April 2014. CMS now proposes both to exclude the measure from CY 2016 payment determination and to make this measure voluntary for CY 2017. Under the proposal, hospitals that do not report data for this measure would not be penalized.

The AAMC supports CMS' decision not to use this flawed measure for payment purposes. However, to avoid further confusion for providers and consumers, we urge the Agency to remove this measure from the OQR program immediately. It remains unclear how OP-31, if it is voluntarily reported, will be useful as a measure of care coordination if the data collection issues and other concerns with this measure are not addressed systematically.

MEASURES PREVIOUSLY DELAYED

AAMC Requests that CMS Justify Data Collection for Two Previously Delayed Measures

In December 2013, CMS issued guidance through Qualitynet delaying the implementation of three measures that had been finalized in the CY 2016 OPPS rule:

Identifier/NQF #	**Measure Name**
OP-29/ NQF # 0558	Endoscopy/polyp Surveillance: Appropriate Follow-up Interval for Patients with a History of Adenomatous Polyps
OP-30/NQF # 0659	Endoscopy/polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
OP-31/ NQF # 1536	Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery in the OPPS CY 2014 final rule

For CY 2016 payment determinations, data collection for these three measures had been delayed three months, so that the encounter period would now be April 1, 2014, through December 31, 2014, (instead of January 1, 2014, through December 31, 2014, as previously specified). CMS proposes in this rule to suspend data collection for OP-31 for CY 2016 payment purposes and to make this measure voluntary in CY 2017 (discussed earlier in our comments). For the other two measures, OP-29 and OP-30, CMS clarifies that these measures would move forward without further delay.

CMS did not state the reasons for the delay in data collection in the December 2013 Qualitynet guidance or in this rule. The AAMC requests that CMS include the rationale for this decision and an explanation for what has changed to make data collection feasible starting April 2014. While the AAMC supports efforts to limit the overuse of colonoscopies, the Association continues to remain concerned that these measures have not been specified or tested at the facility level, and that data collection for providers is exceedingly difficult due to the nature of the data abstraction process.

MEASURES PROPOSED FOR REMOVAL FROM OQR PROGRAM CY 2017

AAMC Supports Proposal to Remove Three Measures and Asks that CMS Consider Removal of Additional Measures

Starting CY 2017, CMS proposes to remove three "topped out" measures from the OQR Program, listed below:

Identifier/NQF #	Measure name
OP-4/NQF # 0286	Aspirin at Arrival
OP-6	Timing of Antibiotic Prophylaxis
OP-7/NQF # 0528	Prophylactic Antibiotic Selection for Surgical Patients

The AAMC agrees that topped out measures, or those measures where "performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made," should not be included in the OQR program. The Association supports CMS' decision to remove these measures in the rule. The AAMC also asks CMS to consider removing seven measures that had been recommended for removal by the MAP in 2012.[6] CMS has not recommended the removal of any of these measures in the most recent OPPS proposed rule.

Identifier	Measure Title
OP-9	Mammography Follow-Up Rates
OP-10	Abdomen CT-Use of Contrast Material: For Diagnosis Of Calculi In The Kidneys, Ureter, And/Or Urinary Tract—Excluding Calculi Of The Kidneys, Ureter, And/Or Urinary Tract
OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
OP-15	Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache
OP–20	Door to Diagnostic Evaluation by a Qualified Medical Professional

[6] http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx

Identifier	Measure Title
OP–22	ED–Patient Left Without Being Seen
OP-25	Safe Surgery Checklist

CMS has stated in previous rulemaking (CY 2013 OPPS final rule, at 68472-68473) that the Agency "did not include any proposals regarding the 7 measures that the commenters mentioned in the CY 2013 OPPS/ASC proposed rule. As such, we are not making any revisions to these measures in this rulemaking. However, we thank the commenters for these measure removal suggestions and will take them into consideration for future measure removal." To the best of our knowledge, CMS has not publicly considered the removal of these measures or stated the reasons for keeping these measures in the program. As an example, public reporting on OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache has been deferred for multiple years, without CMS' providing a rationale for continued inclusion in the outpatient measure set. The AAMC strongly urges CMS to consider these MAP recommendations and justify decisions that diverge from the MAP's input.

FUTURE MEASURE TOPICS

CMS Should Not Propose PHP Measures Without Additional MAP Review

In the proposed rule, CMS requested feedback on future topics relating to: electronic measures, partial hospitalization programs (PHP) measures, and behavior health measures. No specific measures were proposed relating to these topics. The Agency did, however, request public comment on three PHP measures that were submitted to the MAP for consideration in December 2014:

- 30-Day Readmission
- Group Therapy
- No Individual Therapy

PHPs are psychiatric services for patients with acute mental illness that are offered as an outpatient alternative to inpatient psychiatric care. CMS acknowledges that PHP use has declined but continues to believe that PHPs are an important alternative to inpatient services for those afflicted with mental illness. The AAMC urges CMS to only adopt NQF-endorsed PHP measures, and to ensure that the measures are approved by the MAP. The Hospital MAP workgroup reviewed these three measures and did not recommend them for the OQR program, either because they were not well defined or because the workgroup requested additional evidence relating to the value of the individual measures. CMS should address these concerns before these measures are proposed for this program.

HEALTHCARE PERSONNEL INFLUENZA MEASURE

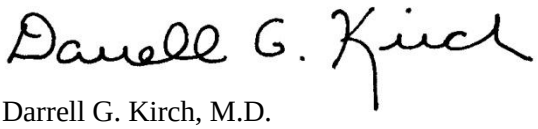
CMS Should Clarify Measure Reporting Requirements in OQR Final Rule

In the proposed rule, CMS stated that facilities submitting health care personnel influenza vaccination data only need to collect and report a single vaccination count, by CMS Certification Number (CCN). The AAMC appreciates that CMS simplified the reporting guidance for this measure. However, in the FY 2015 IPPS final rule, CMS clarified that hospitals "should report a single count per enrolled facility, and not CCN" and that facilities should "collect and submit a single vaccination count for each health care facility enrolled in NHSN by facility OrgID." The AAMC asks that this change be clarified in the final OPPS rule.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Lori Mihalich-Levin, J.D. at 202-828-0599 or lmlevin@aamc.org regarding payment related issues and Mary Wheatley at 202-862-6297 or mwheatley@aamc.org regarding quality related issues.

Sincerely,



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