Washington State Hospital Association

September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

CMS-1676-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Ms. Verma:

On behalf of the Washington State Hospital Association and its 106 member hospitals, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule proposed rule for calendar year (CY) 2018.

Our comments focus on two specific portions of the proposed rule:

WSHA appreciates and strongly supports CMS's proposal to establish codes and allowed amounts for psychiatric comprehensive care model (CoCM) services provided by Federally Qualified Health Centers and Rural Health Clinics. We believe the proposed changes will support efforts to integrate medical and behavioral health care and will enhance sustainability and access to mental health services in rural areas. We urge you to adopt these in your final rule.

WSHA strongly opposes CMS's proposal to make a further reduction to Medicare Part B payments for nonexempted hospital outpatient department services and sites. We believe the proposal exceeds Congressional intent and will further harm access to vital services, particularly for Medicare and Medicaid enrollees.

Our more detailed complete comments on both these proposals are contained on the page two.. Please let us know if you have any questions.

Sincerely,

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New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers.

WSHA appreciates and supports CMS' proposal to establish codes and payment amount for care coordination services, particularly codes for use by RHCs and FQHC's participating in the psychiatric collaborative care model (CoCM). WSHA includes among its members 38 critical access hospitals, many of which provide all or most of the primary care available to their communities through their RHCs. The current RHC payment methodology makes it difficult for clinics to make the additional investment in these mental health services, since they exist outside the RHC encounter construct. The proposed establishment of codes and payment amounts outside of the encounter calculation will greatly enhance the sustainability and access to mental health services in rural communities and aid RHCs in their efforts to integrate medical and behavioral health services. We strongly support the inclusion of these codes in the final rule.

Proposal to further reduce non-exempted services at off-campus HOPD sites.

WSHA strongly opposes CMS's proposal to reduce the current rates for non-exempted services at off-campus HOPD by an additional 50 percent. We believe the additional reduction greatly exceeds CMS's statutory authority. CMS was tasked by Congress to determine payment rate for nonexempted services comparable to what like services would be paid under the physician fee schedule or other applicable schedule. We support the analysis previously provided by the American Hospital Association that when all costs are appropriately considered, the reduction to 50 percent of the OPPS payment for CY 2017 resulted in payment ***less*** than would be paid under the alternative fee schedule. Given this, an additional 50 percent reduction to 25% of the regular OPPS rate for CY 2018 would be result in payment significantly less than the level authorized by Congress.

We disagree with the contention that further reductions in hospital payment are necessary to discourage hospital acquisition of independent practices. This contention fails to consider many of the dynamics affecting the delivery and financing of health care services. Acquisitions of private practices by hospitals occur for many reasons unrelated to payment differential. In some cases, independent clinics were facing closure due to reaching an unsustainable payor mix, and acquisition by the hospital was necessary to preserve the services in the region. Even under standard OPPS payment, the hospitals typically financially subsidize these services to ensure availability to their communities.

Off-campus hospital departments provide geographic access to services that would not otherwise be financially sustainable or available in their community, particularly to Medicare and Medicaid patients. An example of this is wound care services. Lack of geographic access to services will ultimately result in higher costs as care is delayed, creating greater emergency department and readmission costs.
We urge CMS to delay additional cuts to payment until a more thorough and accurate calculation of the payment between hospital and non-hospital services can be obtained. We also would support a more thorough analysis of the dynamics contributing to the reduction of private practices.