AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

September 6, 2013

SUBMITTED VIA ELECTRONIC MAIL AND REGULAR MAIL

Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) Payment System for CY 2014

Dear Administrator Tavenner:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals" published in the *Federal Register* as a proposed notice on July 19, 2013. Our comments will address the following issues, in the order in which they appear in the proposed rule: (1) New comprehensive ambulatory payment classifications (APCs) and other packaging proposals; (2) OPPS payment for hospital outpatient visits; (3) OPPS payment for drugs and biologicals; (4) Hospital outpatient quality reporting program; (5) ASC 2013 proposed payment rates; and (6) ASC quality reporting program.

I. NEW COMPREHENSIVE APC's AND OTHER PACKAGING PROPOSALS

In the proposed rule CMS states that in an effort to improve accuracy and transparency of certain device dependent procedures, they are proposing 29 new comprehensive APC's to prospectively pay for the most costly device-dependent services. These will replace 29 of the most costly device-dependent APC's. A comprehensive APC would be defined to include the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Under the proposal, the entire claim, including the primary service, would be associated with a single comprehensive service and all costs reported on the claim would be assigned to that service. The comprehensive APC would treat all individually reported codes as representing components of the comprehensive service and would make a single payment based on the cost of all individually reported codes, representing provision of the primary service, as well as all adjunctive services provided to support delivery of the primary service. CMS believes this will increase the accuracy of the payment for the comprehensive service and also increase the stability of the payment from year to year. One notable APC that is impacted by this policy, and includes ENT services, is APC 0259 which includes CPT 69930 Implant Cochlear Device. CMS also proposes a host

of other packaging proposals which impact hospital payment for drugs and biologicals that function as supplies or devices when used in a surgical procedure, clinical lab tests, add on codes, ancillary services, and more.

While the Academy understands CMS' desire to pay for services in a more prospective manner under the OPPS system, the Academy is concerned that under the comprehensive APC the payment rate for APC 0259 will be decreased by 3.2% in CY 2014, which may render the 2014 reimbursement inadequate to cover actual costs. Additionally, it is unclear based on the lack of publicly available data, whether CMS accurately implemented this, and other proposed packaging policies, within the proposed rule. To that end, we encourage CMS to provide more transparency around their process of developing comprehensive APCs, and other packaging policies, should they decide to finalize this proposal and implement it as policy moving forward. Greater transparency would allow the public to review the proposals in greater detail and comment accordingly on any errors made in applying the comprehensive APC, or packaging, policy.

II. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS

For CY 2014, CMS is proposing to replace the current 5 levels of visit codes describing clinic visits, Type A and B emergency department (ED) visits, and critical care services with 3 alphanumeric Level II HCPCS G codes representing a single level of payment for three types of visits. The Agency notes that while they have previously stated their intent to work with stakeholders to create hospital-specific national guidelines for visit billing, that task has proven challenging and they feel that no single approach could consistently, and accurately, capture hospitals' relative costs. Therefore, CMS has decided to change course and proposes modification of their longstanding policies related to hospital outpatient clinic and ED visits.

It is our understanding that under this policy, physicians will still report their services using the appropriate Evaluation and Management (E/M) codes and the policy will only impact the way hospitals report their outpatient visits. Thus, physicians will continue to be paid the same physician work fee under the Medicare Physician Fee Schedule (MPFS) as they have received in previous years and hospitals would now receive a flat fee for the facility portion of the payment for outpatient visits under the OPPS, regardless of the level of visit reported by the physician. ***Therefore, the success of this proposal ultimately relies on the success and reliability of a hospital's billing system in implementing and accurately capturing the crosswalks from E/M codes to these new G codes within the proposed rule. As such, we are concerned that this policy will result in an administrative burden to hospital systems and may not be feasible to implement by January 1, 2014 without some disruption to claims processing. We are also concerned that this policy further dilutes the accuracy of cost reporting by hospitals as it is unlikely that the costs associated with visits will be reported by hospitals if they are simply paid a flat fee for their outpatient visits. This raises concern given CMS' proposals under the MPFS to tie reimbursement in physician offices to payments in the OPPS and ASC settings for some services, as this is only one example of a scenario where the hospital has no incentive to report their costs for a service and payment rates are, therefore, not based on accurate data or direct costs.***

III. OPPS PROPOSED PAYMENT FOR DRUGS AND BIOLOGICALS IN 2013

AAO-HNS is pleased that CMS has proposed maintenance of reimbursement for drugs and biologicals without pass through status, at ASP + 6% in CY 2014. ***We believe this new methodology proposed by CMS much more accurately reflects the actual costs incurred by hospitals in providing and administering drugs and biologicals, therefore we strongly urge CMS to finalize the rate of ASP + 6%***

for 2014. We believe this rate is a more accurate representation of hospitals true costs in providing and administering these drugs and biologicals.

IV. HOSPITAL QUALITY REPORTING PROGRAM (OQR)

AAO-HNS is committed to improving the quality of care through the application of measurement into continuous quality improvement programs. We have worked closely with the Physician Consortium for Performance Improvement, to shape and develop a series of measures for many Otolaryngology – Head and Neck Surgery diseases and diagnosis. AAO-HNS supports the use of outcomes measures and recognizes they are more difficult to implement and require risk adjustment. While we understand the science of performance measurement is moving effectively in this direction, ***we support a combined approach to utilizing both process and outcomes measures. Process measures, such as those developed utilizing evidence in the form of clinical practice guidelines, are valuable in understanding gaps in the delivery process and they are an important tool in the overall improvement continuum. We strongly support the alignment of measures across Medicare programs using standardized measures that are clearly applicable to, and agreed upon by, a given specialty and have been endorsed by CMS and consensus organizations, such as the National Quality Forum.***

We recognize that where multiple payment systems use different measures and varying applications of the measures, physicians are often confused by conflicting information regarding their quality performance and associated quality of care that is communicated to beneficiaries. In an effort to ease this confusion for providers who may practice in the hospital outpatient, inpatient, or ASC setting, ***we strongly encourage CMS to align the measures and reporting requirements for the various quality programs. Further, we urge CMS to avoid the removal of measures that may be reportable by hospitals to meet the 2014 reporting requirements, particularly in light of the very limited number of measures available. Specifically, we are concerned that CMS proposes to eliminate two measures, one of which was reportable by Otolaryngologists (Transition Record with Specified Elements Received by Discharged Patients). This is problematic given that the 5 measures added by CMS for 2014 are not useable by our specialty. Thus, we encourage CMS to continue the expansion of the Hospital OQR measure set to ensure that all specialties and hospitalists are able to participate meaningfully to improve the quality of patient care.***

V. ASC 2013 PROPOSED PAYMENT RATES

a. Updates to the ASC Payment System

CMS proposes an update to the ASC payment system for CY 2013 of .9%. The Academy appreciates this proposal to update the ASC payment system, but remains concerned that ASCs continue to be paid at a reduced rate compared to the hospital outpatient setting. This disparity in payment is attributable to the use of the consumer price index methodology in the ASC rather than a market basket update methodology which is used in the OPPS. ***Due to concerns regarding payment rates for services rendered in an ASC, we urge the Agency to consider other update methodologies for future rulemaking that may bring more parity to reimbursement for services provided in both the hospital outpatient and ASC setting. Specifically, we respectfully request that CMS align payments in the ASC setting with those in the OPPS.***

VI. ASC QUALITY REPORTING PROGRAM (ASCQR)

As we noted in our comments on the Hospital OQR program above, we continue to encourage CMS to align the measures and reporting requirements across all quality programs within the Medicare payment

programs. ***Thus, we recommend that CMS align the measures for ASC reporting with those of other quality programs and encourage the Agency to continue expanding the measure sets so that Otolaryngologists and other specialists have a meaningful opportunity to report.***

In addition, we are concerned with CMS' proposed new case threshold of 50% for all claims meeting ASCQR measure specifications. We believe in the second year of this program, that this threshold is excessively high and does not allow providers and ASCs enough time to familiarize themselves with reporting on these quality measures before implementing a high bar for reporting. That being said, we are appreciative that CMS has allowed an exception for ASCs with low rates of Medicare patients (less than 240 in 2013) and will hold them harmless by not applying the ASCQR requirements to them in CY 2014.

Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. If you have any questions or require further information, please contact Jenna Minton, Esq., Senior Manager of Health Policy at jminton@entnet.org or 703-535-3725.

Thank you.

Sincerely,

David R. Nielsen MD

David R. Nielsen, MD, FACS
Executive Vice President and CEO