October 5, 2020

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1736-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Department of Health and Human Services Proposed Regulations Regarding Medicare Program -- Calendar Year 2021 Hospital Outpatient Prospective Payment Systems and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (RIN 0938-AU12)

Dear Sir or Madam,

We write on behalf of the American Benefits Council ("the Council") to provide comments in connection with the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicare Program Hospital Outpatient Prospective Payment Systems and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs proposed regulation ("proposed regulation"), published in the Federal Register on August 12, 2020. The proposed regulation addresses, among other things, the quality reporting programs under Medicare, as well as CMS' previously implemented changes to payments for clinic visits furnished in the off-campus hospital outpatient setting. As most relevant to employer plan sponsors, these aspects of the proposed regulation are the focus of the Council's comments.

The Council is dedicated to protecting employer-sponsored benefit plans. The Council represents more major employers – over 220 of the world's largest corporations – than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or support health and retirement plans covering virtually all Americans participating in employer-sponsored programs.

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The Council appreciates the opportunity to provide comment with respect to the proposed regulation, specifically regarding integrating equity into hospital quality transparency and regarding site-neutral payment reform. Employers pay close watch to Medicare policies because Medicare payment policies not only affect consumers that receive services from health care providers participating in the Medicare program. In some cases, these policies also affect private health coverage. Commercial payers, including employers, often utilize Medicare provider reimbursement standards to inform reimbursement rates for private coverage. In addition, employers who provide health coverage to their employees have a strong interest in improving the quality of health care. Medicare quality ratings that are publicly available provide data for all consumers seeking health care services, including employees in employer-sponsored health care. Providing this information allows individuals to make informed decisions regarding the quality of health care providers and services based on standardized measures of quality and safety.

In addition to Medicare, employers play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide health coverage to over 183 million Americans. Increasing health care costs is a significant issue for employers and most employers that have had success decreasing the rate of health care spending have started by focusing on health care costs for certain services and the quality of health care services. They do this to better understand how much they are spending for various services delivered in different settings and, ultimately, to steer their enrollees to higher-value providers operating in higher-value settings.

As such, we are submitting these comments due to the importance of efforts to support quality health care – including for vulnerable populations – and site-neutral payment reform. In addition, in this letter, we take the opportunity to encourage CMS to make efforts to use the Medicare quality reporting program to identify and ultimately help address inequities in health care, which is an important area of focus for employer plan sponsors as well.

QUALITY REPORTING

Providers and suppliers participating in Medicare must comply with various CMS regulations to participate in the Medicare program. CMS regulations include health and safety standards, which are the foundation for improving quality and protecting the health and safety of beneficiaries, and CMS seeks to promote higher quality and more efficient healthcare for Medicare beneficiaries. Consistent with these goals, and pursuant to the Tax Relief and Health Care Act of 2006, CMS has implemented quality reporting programs for multiple care settings including for hospital outpatient care and ambulatory surgical centers. Under these quality reporting programs, the data is made

publicly available on Medicare's hospital compare website.[1] Medicare also provides increased payment rates for facilities that meet the quality reporting requirements and reductions in payments for facilities failing to meet reporting requirements.

In the proposed regulation, for the hospital outpatient care and ambulatory surgical center quality reporting programs, CMS proposes to update and refine requirements to further meaningful measurement and reporting for quality of care provided in these outpatient settings while limiting compliance burden, but CMS is not proposing any measure additions or removals for either program.[2]

CMS also provides Overall Star Ratings for hospitals providing care for Medicare beneficiaries, the goal of which is to summarize quality of care at hospitals providing acute inpatient and outpatient care. The Overall Star Rating includes measures that capture quality of care at hospitals and facilities providing acute inpatient and outpatient care and the rating is publicly reported on Medicare's hospital compare website. While this quality reporting system has been in place for years, in the proposed regulation, CMS proposes to establish the methodology through regulations and to update the methodology beginning in 2021, retaining certain aspects of the current methodology and proposing updates to certain aspects. The updates are intended to simplify the methodology and, therefore, reduce provider burden, improve the predictability of the star ratings and increase the comparability between hospitals.

Greater quality transparency in health care is an area of critical importance for employer plan sponsors and the Council has long supported increased, standardized quality transparency as a means to achieving the goals of lowering the cost and improving the value of health care.[3] As such, we generally support CMS' ongoing efforts to improve and refine the quality reporting under the Medicare program.

More generally, we note that meaningful and aligned quality measures are a foundation of value-based purchasing decisions. As more large employers implement innovative payment reforms, like direct contracting or accountable care organizations, quality measures should be aligned across public programs and private plans to help lay a strong foundation to achieving more meaningful payment reforms. To that end, we note that the Council is a member of the Core Quality Measures Collaborative

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[1] See https://www.medicare.gov/hospitalcompare/search.html.

[2] See https://www.qualitynet.org/outpatient/oqr/measures; https://www.qualitynet.org/asc/ascqr/measures.

[3] See the Council's long-term strategic plan published in 2014, *A 2020 Vision: Flexibility and the Future of Employee Benefits at* https://www.americanbenefitscouncil.org/pub/?id=E6154447-F3DA-EAEE-A09E-FBCC312A0E91. See also the Council's comment letter on the HHS proposed Transparency in Coverage Rule, at https://www.americanbenefitscouncil.org/pub/?id=7BF19916-1866-DAAC-99FB-43AFBB87FE4E.

(CQMC), a broad-based coalition of health care leaders, including CMS, insurance providers, medical providers, consumers and purchasers, promoting alignment of quality measures across public programs and the private sector. We encourage CMS to work with the CQMC on its various quality transparency and reporting initiatives.

At the same time, we want to take this opportunity to encourage CMS to consider ways in which the Medicare quality reporting system could be updated and augmented to address a critical issue – inequities in health care, including those that derive from social, economic and other factors that exist outside of the acute health care setting. Disparities in health care quality and outcomes have long existed but the disproportionate impact of COVID-19 on vulnerable populations has shined a light on the nation's social disparities and the role that social determinants – such as economic stability, neighborhood and physical environment, education, food and community and social context[4] – play in health outcomes. The convergence of the pandemic and the greater awareness of social justice matters more broadly makes it important and timely for CMS to examine how it might be able to use the quality reporting systems under Medicare to identify disparities and promote their reduction.

As such, we strongly encourage CMS to consider ways in which it can integrate health equity related information into the Medicare hospital quality reporting systems, to incentivize reduced health care disparities and improve health outcomes for all populations. These efforts could include hospital data reporting on patient social and behavioral risks, with appropriate privacy and antidiscrimination protections. In addition, HHS could consider requiring quality reporting to be stratified to illustrate and quantify inequities, including by race, ethnicity, gender identity and geographic location, among others, and to itself provide the ability to display data in this way on the Medicare hospital compare website.

We understand that under the CMS Office of Minority Health CMS previously began work to address these issues, including as part of a 2015 CMS initiative: *CMS Equity Plan for Improving Quality in Medicare,*[5] which included a three-part "path to equity" framework. This framework involved increasing understanding and awareness of disparities, developing and disseminating solutions and taking sustainable action and evaluating progress. CMS' plan included as priority areas expanding the collection, reporting and analysis of standardized data and evaluating disparity impacts and integrating equity solutions across CMS programs, including Medicare. The Council agrees that the collection and analysis of this data will support the integration of health equity solutions in the Medicare program and, to the extent health care providers

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[4] See Kaiser Family Foundation Issue Brief on Social Determinants of Health at http://files.kff.org/attachment/issue-brief-beyond-health-care.

[5] See the CMS Equity Plan for Improving Quality in Medicare at https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf.

incorporate such solutions more broadly, this will also provide benefits to employers and their employees through the health care they receive at hospitals across the country. We encourage CMS to continue with these efforts.

We also note that we are not only encouraging CMS, through Medicare, to take a close look at health care inequities, but that we are also doing this work ourselves. That is, the Council and its employer plan sponsor members are committed to making efforts to identify and eliminate inequities in benefit plan design and operation and to address social determinants of health to improve health outcomes for employees and their families in communities across the country. Both CMS (through Medicare) and employers have an important role to play in promoting health equity and we of course would be happy to discuss our efforts in this regard with CMS if that would be helpful.

SITE-NEUTRAL PAYMENT REFORM

In the proposed regulation, CMS continues to promote site-neutral payment policies. Specifically, the proposed regulation acknowledges CMS' previously implemented method to reduce unnecessary utilization in outpatient services by using a Medicare Physician Fee Schedule (PFS)-equivalent payment rate for a hospital outpatient clinic visit when it is furnished by off-campus provider-based departments. This policy had a two-year phase-in, completed in 2020, and it appears the policy will continue into the future, including for 2021. Prior to implementing this site-neutral payment policy, Medicare would pay higher rates for the same services performed at hospital outpatient departments compared to physician offices, even though physician offices can deliver many of these services at the same quality, but at a lower cost to the Medicare program.

The Council is a strong advocate of site-neutral payment reform and, to that end, is a member of the Alliance for Site-Neutral Payment Reform. We strongly support CMS' continuing use of a method to reduce unnecessary utilization of outpatient services by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting. And the Council was encouraged to see the recent decision by the United States Court of Appeals for the District of Columbia, which ruled in favor of CMS' method of site-neutral payments, holding that the regulation was a reasonable interpretation of the statutory authority.

Site-neutral payment policy is closely tied to an issue our members are very concerned about - the impact that provider consolidation has had, and continues to have, on health care prices.[6] In light of this, the Council continues to encourage change

[6] See https://www.nihcm.org/topics/cost-quality/how-are-health-care-prices-related-to-physician-practice-consolidation-and-integration-with-hospitals.

to policies that foster competition and benefit consumers and plan sponsors. The Council has urged Congress to decrease incentives that are leading to increased consolidation in health care providers by expanding implementation of site-neutral payment reform. The Council supports site-neutral payment reform and specific policies that reduce payment differences based on the health care setting without having the unintended consequence of pushing more cost to plan sponsors. The Council believes policies that reduce payment disparities based on health care setting will help to address over-concentration and higher costs for health care services.

The need for site-neutral payment reforms is evident. Payment policies that support higher reimbursement in the hospital outpatient department setting have resulted in increased costs to patients, employers and taxpayers. Prior to site-neutral payment reform, patients and the Medicare program paid more when the same services were delivered in the hospital outpatient department setting instead of independent physician practices for a wide variety of services. For example, in 2017, for evaluation and management of an established patient, hospital affiliated outpatient departments received 114% more in reimbursements per patient for the same service than free-standing physician offices.[7] The increased cost to both patients and Medicare has been substantial. Over a three-year period, Medicare paid an additional $2.7 billion on services and patients spent $411 million more in out-of-pocket costs when services were delivered in a hospital-owned setting.[8]

Congress recognized the negative consequences these payment disparities have on patients, taxpayers and businesses by directing CMS to institute site-neutral payments for newly acquired and newly built off-campus provider-based hospital outpatient departments. However, these reforms represented only a small step in the right direction. The majority of existing provider-based off-campus facilities and those that were mid-build were "grandfathered" and able to continue billing Medicare at the much higher rate for the same services. As such, these exempted facilities still had a strong incentive to purchase physician practices and move them into existing hospital outpatient departments, which is why the CMS rule to address this issue was so essential.

Notably, the issue of site-neutral payment reforms has long had bipartisan support from policymakers, health care economists, regulators and the Medicare Payment Advisory Commission (MedPAC). In terms of savings, a recent projection from the Congressional Budget Office suggests site-neutral payments for outpatient services

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[7] See American Hospital Association, et al., v. Azar, No. 19-5352 (D.C. Cir. (July 17, 2020)).

[8] See Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017 at http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf.

have the potential to save $13.9 billion over 10 years.[9] The Council strongly supports regulatory changes to promote site-neutral payment reform, both the one that CMS has implemented as acknowledged in the proposed regulation, as well as expansions to other provider-based departments, as appropriate.

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Thank you for the opportunity to comment on this proposed regulation. We appreciate the Administration's continued efforts to improve quality reporting under Medicare and we encourage CMS to harness the power of that program to identify and address health care inequities. We also strongly support CMS' efforts regarding site-neutral payments as a step to reducing health care costs. We appreciate your attention to these comments among the many other essential matters before you.

If you have any questions or would like to discuss these recommendations further, please contact us at (202) 289-6700.

Sincerely,

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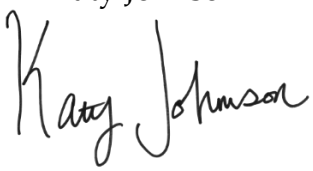

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[9] See Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2019 Budget at https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf.