



September 6, 2016

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: 1656-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

File Code: CMS-1656-P

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program

Dear Mr. Slavitt:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the 2017 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program (hereafter referred to as the Proposed Rule) published in the *Federal Register* on July 14, 2016.

HFMA is a professional organization of more than 40,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

### **Introduction**

HFMA would like to commend CMS for its thorough analysis and discussion of the myriad Medicare reimbursement decisions addressed in the 2017 Proposed Rule. Our members would like to comment on the proposals related to:

- Implementation of Section 603 of the Bipartisan Budget Act (BiPA) of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider
- Removing Total Knee Arthroplasty (TKA) from the Inpatient Only List

- New Quality Measures for the Outpatient Prospective Payment System (OPPS) and ambulatory surgery centers (ASCs)

Below please find specific comments on the items listed above.

*Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider*

HFMA is concerned by CMS's proposal to implement section 603 of the BiPA of 2015. We believe CMS has interpreted the statute too broadly. If the rule is implemented as proposed, it will have the effect of phasing out all off-campus provider-based clinics, not just new ones (see below for additional discussion). However, that was not Congress's intent when it passed the law. As CMS acknowledges in the background section, Congress's intention in passing the legislation was to foreclose hospitals' ability in the future to purchase freestanding physician practices and convert them to provider-based clinics. The alleged sole purpose of this transaction was so the "technical component" of the services provided in the newly provider-based clinics could be billed under the OPPS. **Our members encourage CMS to hew to Congress's original intent and simplify the implementation of section 603 of BiPA. HFMA believes CMS should simply no longer accept provider enrollment applications for off-campus hospital outpatient departments that are located more than 250 yards from a hospital's campus.**

If CMS elects to move forward with the proposed rule to implement section 603, HFMA's members fully appreciate both the regulatory and IT systems challenges CMS is facing as it attempts to respond to this Congressional mandate. Due to the complexity of CMS's proposals, HFMA's members are facing similar issues. In the future, our members ask CMS to make these issues public. The delay in discussing them with impacted providers increases not only the cost of implementing a workaround (if a sufficient one can be readily developed) but also adversely effects the cash flow of impacted providers. We are particularly worried about rural PPS hospitals and critical access hospitals that frequently employ physicians to ensure access in their communities. While larger systems are better positioned to tolerate a short-term disruption in cash flow, many of these safety net providers lack the financial wherewithal to incur the expenses necessary to provide medically necessary services to Medicare beneficiaries without prompt payment. As a result we are concerned the difficulties associated (as discussed above) with CMS's proposed plans to pay providers for non-excepted services will threaten the economic viability of some types of hospitals. If CMS insists on implementing section 603 as proposed, HFMA's members believe its approach must be changed in the following ways:

- 1) *Delay Implementation of Proposed Rules for Section 603 Until a Straightforward Plan to Pay Non-Excepted Clinics for Services Provided Can be Established:* Due to a variety of technical issues, which CMS discusses, the proposed rule states "we do not believe that, under current systems, an off-campus provider-based department could be paid for its facility services under the MPFS, but are actively exploring options that would allow for this beginning in CY 2018." **Our members believe it is unacceptable that CMS's plans to pay providers for medically necessary services provided to eligible Medicare beneficiaries involve significant workarounds that are fraught with both regulatory and operational complexity.** Section 603 is clear that hospitals shall still receive payment for services furnished at non-excepted provider-based departments, even if that payment is equal to the Medicare Physician Fee Schedule rate.

The rule discusses two potential workarounds that CMS suggests non-excepted provider-based clinics use to bill items and services provided. However, as discussed in detail in the sections below, the proposed work-arounds are fraught with regulatory and operational challenges given the limited amount of time providers have to implement them.

- A. *Change Provider Type*: CMS suggests impacted providers could enroll non-excepted clinics as a different provider type (e.g., physician group practice) and bill the non-facility fee from the physician fee schedule as a freestanding entity. Setting aside the potential loss of 340B eligibility for those facilities that qualify, this seems like the most straightforward path. However, converting from a provider-based clinic to a freestanding clinic will require the provider to file CMS enrollment application 855B. Filing the form is a complex process and it is not uncommon for it to take up to a year or more for a Medicare administrative contractor (MAC) to process the change, under normal circumstances. HFMA believes that in the wake of the proposed and final OPPS rules MACs will receive an extraordinary number of 855Bs that they must process as impacted facilities attempt to comply with regulatory requirements to receive payment for medically necessary services provided to eligible Medicare beneficiaries. It's reasonable to assume that this increased volume will significantly increase the time it will take for MACs to process these changes of enrollment.

Beyond the exercise of completing the enrollment process so that the non-excepted clinic can bill under the appropriate payment system, impacted clinics will need to reconfigure their coding and revenue cycle systems. Our members estimate that per impacted clinic it will require approximately 300 to 400 labor hours, costing between \$35,000 to \$45,000 per impacted clinic. These are human and capital resources that are members will have to repurpose from other efforts like improving the meaningful use of EHRs, developing the IT infrastructure to support alternative payments, and improving the overall quality of care delivery.

- B. *Assign Billing to Physician Groups that Practice in Non-Excepted Clinics*: In the proposed rule CMS seems to suggest hospitals might assign billing for the non-facility fee for services provided in non-excepted clinics to the physicians and providers that perform them. The proposed rule seeks feedback on a range of compliance issues related to fraud and abuse. In general, our members do not believe that CMS has the statutory authority to provide a blanket safe-harbor for these types of billing arrangements. Even if it did, negotiating these contracts with one or more physician groups will require more than four months' lead time and require hospitals to incur significant legal fees. Specific issues that CMS will need to address include, but are not limited to, the following:
- i. *Service Fees to Billing Provider*: Physician practices that accept assignment for billing the non-facility fee and then remit the technical component to the hospital will incur additional costs related to their revenue cycle processes on behalf of the hospital. Given that the billing fees will be directly correlated to the physicians' referrals, hospitals will need an Office of Inspector General (OIG) opinion on what's an acceptable framework for establishing the fair market value of billing services provided by a physician practice that is billing on behalf of a non-excepted provider-based clinic.

- ii. *Patient Cost Sharing*: In addition to billing CMS for the non-facility fee, the physician practice will likely be responsible for billing the Medicare beneficiary for their cost sharing. Given that some patient cost sharing is uncollectible, hospitals will also need an OIG opinion outlining an appropriate framework for estimating the collected patient cost-sharing that is included in remitted amounts. Or should physician practices billing patients for cost sharing on behalf of hospitals for services provided in non-exempt clinics only remit the actual cash collected? If the contracts for patient cost sharing should be structured on a “cash-only” basis, how should any outstanding patient cost sharing be valued if the assigned practice elects to sell any related bad debt to a third party “recovery” agency?
- iii. *Liability for Billing Errors*: In the event the physician practice is assigned billing rights by the hospital and bills claims for services provided at the non-exempt provider-based sites in error, who is liable for any related fraud and abuse issues?

Beyond fraud and abuse, assigning billing for services provided in a non-exempt clinic poses other regulatory issues:

- A. *Provider-Based Status*: If a provider-based clinic assigns its billing, and the cost sharing is collected by an independent physician group that practices in the clinic, does it still qualify for “provider-based status?” It appears under the circumstances CMS contemplates in the proposed rule, the arrangement might violate the following “provider-based clinic” requirements.
  - i. Its financial operations must be fully integrated within those of the main provider.
  - ii. It’s held out to the public as part of the main hospital.

In one sense, the non-exempt clinic is simply using an outsourced revenue cycle contractor. However, the “outsourced revenue cycle contractor” in this case is not billing under the hospital’s provider number or tax ID, but that of a different provider (the physician practice) since CMS’s payment systems are not currently configured to pay for services delivered in a provider-based setting under the physician fee schedule. When this situation occurs, a key financial operation (the revenue cycle) will not be “integrated” into the operations of the main provider. The operating arrangement will be more analogous to a physician practice renting clinic space for its business as opposed to a truly “outsourced” revenue cycle function. As further evidence of this, when the independent physician practice that was assigned billing for these services attempts to collect cost sharing from a Medicare beneficiary, the clinic will not be held out to the public as part of the main hospital, but part of the independent practice. Given the non-exempt clinics will be paid under the physician fee schedule (which is a lower rate), this may be a difference without distinction. However, our members are concerned about potential violations of the False Claims Act that this might trigger. HFMA requests CMS clarify that under this situation these providers would, for compliance purposes, still be considered provider-based clinics under the current guidance.

- B. *“Child-Site” Eligibility for the 340B Drug Discount Program*: The absence of hospital billing also raises questions under the 340B Drug Pricing Program. The Health Resources and

Services Administration's (HRSA's) so-called proposed mega-guidance proposes to enroll an off-campus provider-based department as a covered entity "child site" if the provider-based department has outpatient Medicare costs and charges included on a reimbursable line of the hospital's most recently filed cost report. This proposal attempts to codify that inclusion of these charges has been HRSA's longstanding requirement.

Should CMS adopt its proposed billing solution, non-excepted provider-based departments that begin operations in CY17 may have to wait an entire year—assuming CMS implements another billing mechanism by CY18—just to generate the requisite charges. No provision of BiBA15 affects 340B eligibility or registration. Either CMS should develop a billing and cost reporting methodology that permits hospitals to include non-excepted provider-based department costs and charges on a reimbursable line of the cost report or HRSA should adopt another method of verifying that an off-campus provider-based department is "an integral part of the hospital" and thus eligible to administer 340B drugs.

Beyond the potential compliance issues discussed above, there are a number of significant operational impacts that assigning billing to a physician practice may have:

- A. *Charity Care*: While in theory beneficiary cost sharing resulting from physician fee schedule payment for the "non-facility" charge will be lower than if payment was made under OPPS, that may not always be true. If billing for services provided in a non-excepted provider-based clinic is assigned to a freestanding physician practice, it is likely the practice's financial assistance policy will be less generous than the hospital's policy (which is the typical scenario). As a result, indigent and near indigent patients will likely be billed for full cost sharing as opposed to receiving generous financial assistance under the hospital's policy.
- B. *Community Staffed Clinics*: Assigning billing for services provided in a non-exempt provider-based department will be challenging in instances where there are multiple physician groups practicing in the clinic. For each non-excepted provider-based clinic, impacted hospitals will need to develop separate contracts with each group that practices there. Hospitals will then need to track the volume of services each group provides separately in order to reconcile the payments they receive from each physician practice to ensure the payments received match the volume of services provided in the clinic. Beyond being good business practice, an exact accounting will be necessary to ensure that no inadvertent violations of Stark laws occurred. Payments from each group will likely need to be posted manually. All of this activity will add a significant administrative burden on patient accounting staff.
- C. *Employed Physician Contracts*: Assigning billing for services provided in a non-excepted clinic to a hospital-employed physician practice will likely require that the hospital alter employment contracts with the physicians associated with those services. Compensation under many of these contracts is based to some degree on RVUs. If the contracts are not amended, the impacted physicians will be compensated above fair market value. They will receive "credit" for the non-facility fee (which includes both the professional and technical component) as opposed to just the professional component. Should this situation not be corrected, it would likely trigger a Stark violation. Amending these contracts will require a significant investment of time and legal resources.

***Given that CMS’s proposed “work-arounds” are challenging from both a regulatory and operational perspective, HFMA recommends CMS delay implementation of section 603 of BiPA until it has developed and implemented a mechanism to pay non-excepted provider-based clinics for the services they provide to Medicare beneficiaries.*** The agency is subject to a congressionally legislated deadline. However, there are precedents where, due to operational issues, the agency has missed a statutory deadline. As recent examples, the OPPI and the Ambulance Fee Schedule were delayed by approximately 18 and 36 months, respectively.

- 2) If CMS, as proposed, insists on not paying claims for services provided in non-excepted provider-based departments that were formerly paid under OPPI, HFMA believes that CMS must take the following steps.
  - A. CMS has stated that it lacks sufficient information to identify non-excepted provider-based clinics from claims. It proposes that CMS submit information that can be used to identify these clinics via a website. If CMS moves forward in requiring this information to be submitted, it should link the information to the Provider Enrollment, Chain and Ownership System (PECOS) and use it to automatically update the clinic’s status for billing purposes. This would eliminate the need for a non-excepted clinic to file a CMS 855B application which would save both the MAC and impacted providers considerable time and expense.
  - B. Remove the timely filing deadline on impacted claims and allow providers the option of holding and billing claims for services provided in non-excepted provider-based departments once CMS has established an appropriate mechanism for submitting and processing these claims for payment.
  - C. Pay interest at the statutory rate for any claim impacted by this issue whose payment is delayed by more than 30 days due to either the provider’s inability to file a claim or the MAC’s/CMS’s inability to process it.
  - D. Make lines of interest free-credit for the estimated allowed amount of “held” claims available to critical access and rural hospitals as a financing bridge to help them weather any cash-flow shortfall that results from implementation of Section 603 of the BiBA of 2015.
- 3) ***Allow Existing Excepted Clinics to Relocate Without Losing Their Excepted Status:*** At some point, almost all clinics (provider based or otherwise) will relocate. The reasons for relocating are varied but include the termination of a lease, aged/outdated facilities, consolidation of multiple related practices into one location that is more convenient for patients, insufficient office space to handle a growing practice, or force majeure. CMS’s interpretation of Congress’s intent ensures over the next 20 years almost all excepted “off-campus” provider-based departments will no longer be “excepted.” **HFMA believes that if this were Congress’s intention in passing the legislation, they would have simply stated a date after which provider-based status for off-campus clinics would expire.** Beyond not aligning with Congress’s intention, our members are concerned that, as an unintended consequence, this implementation of this policy will lead to significant inflation in the rental rates for medical office buildings where excepted provider-based clinics currently are located. **Therefore, we ask that CMS in the final rule allow for exempt provider-based clinics to relocate without losing their excepted status.**



If CMS elects to require an off-campus provider-based clinic to remain in its current location to maintain excepted status CMS needs a broad set of exemptions covering the full range of circumstances beyond a hospital's control that would necessitate moving a clinic. This list should include but not be limited to the following:

- A. A declared state of emergency in the market where an excepted clinic is located.
- B. The building sustains significant damage (as evidenced by an insurance claim) as a result of fire, flood, wind, tornado etc.
- C. A utilities issue (e.g., sewage back-up) that renders the building unusable for more than a week.
- D. The neighborhood is rezoned and commercial use is no longer permissible where the clinic is located.
- E. The building no longer meets local structural codes.
- F. The practice is temporarily relocated so the building can be renovated.
- G. The locality or landlord changes the building's address or unit numbering.
- H. The landlord elects not to renew the lease for the space where the clinic is located.

4) *Clarify Questions Related to Change of Ownership:* In the proposed rule, CMS states, "We are proposing that individual excepted off-campus provider-based departments cannot be transferred from one hospital to another and maintain excepted status." HFMA's members request clarification on the following scenarios, all of which apply to an excepted clinic located within 250 yards of a hospital that is one of several hospitals operating under a single provider number, and where the hospital where the excepted clinic is located is not considered the "main campus" of the hospital:

- A. The hospital where the excepted clinic is located is sold and the new owner applies and receives a new, separate provider number for the hospital. What happens to the excepted status of the provider-based clinic located within 250 yards of the hospital?
- B. The main campus is sold to another provider and the remaining campuses are re-organized with a new main campus and provider number. What happens to the excepted status of the provider-based clinic located within 250 yards of the hospital?
- C. The excepted clinic is located within 35 miles of the "main campus" hospital. The hospital where the excepted clinic is "located" is sold but the excepted clinic does not convey with the sale and remains operating under the "main campus" provider number. What happens to the excepted status of the provider-based clinic that remains with the "main campus" hospital?

**HFMA believes that under all three scenarios the excepted clinic should retain its status.**

5) *Clarify Question Related to Expansion of Clinical Services:* With CMS taking the approach its proposed rule to limit the excepted off-campus PBDs to existing service lines, CMS notes the absence of legislative history showing Congress's clear intent for the exception. Conversely, the recent legislative action by the U.S. House of Representatives to extend "excepted" status to

**“mid-build” PBDs most definitely would impact the proposed new service line limitations. HFMA believes that mid-build PBDS should be excepted and payable under OPPTS.**

Finally, in the proposed rule, CMS asks for a specific timeframe (e.g., from at least 1/1/2013) that a provider-based clinic would need to have been billing for services under the OPPTS to qualify as an excepted clinic. The statute does not mention a specific timeframe. It simply states that provider based practices that have not billed as such prior to Nov. 2, 2015, are not eligible to be paid under OPPTS as of Jan. 1, 2017. **Therefore, HFMA believes it is inappropriate for CMS to add language to the statute that does not exist. Our members believe there should be no “qualifying time” necessary to be considered an excepted off-campus provider-based clinic.**

*Removing Total Knee Arthroplasty (TKA) from the Inpatient Only List*

In the CY17 proposed rule, CMS asks for feedback on removing Total Knee Arthroplasty (TKA), CPT Code 27447, from the Medicare Inpatient Only (IPO) list at some point in the future. This would allow the procedure to be performed as an outpatient surgery paid under the OPPTS or ASC fee schedules for patients who are healthy enough to not require an inpatient stay. **HFMA’s members conditionally support CMS’s proposal. This support is directly predicated on adequately adjusting the MS-DRG payment and target prices for Lower Extremity Joint Replacement (LEJR) episodes for this significant policy shift.**

TKA is a high-volume inpatient procedure. Using publicly available CMS data, HFMA estimates that in FY13, there were over 254,000 TKAs performed. The total allowed amount for these procedures was \$3.8 billion for MS-DRG 470 Major Joint Replacement or Reattachment of Lower Extremity w/o MCC (the most likely MS-DRG impacted by this policy shift). If this MS-DRG is mis-priced, given the volume of these procedures, it will have a significant negative financial impact on the hospitals where these procedures are performed.

Our members are concerned that TKA procedures for healthier patients will be shifted into an outpatient setting, leaving sicker, more costly patients to have their procedures performed in the inpatient setting. The “weight” for MS-DRG 470, like all MS-DRGs, is a blended historical average of all Medicare patients who have this procedure. Under the scenario described above, it will be approximately two years before MS-DRG weights are based on claims experience that incorporates this policy. In the interim, hospitals will be under-reimbursed for providing a medically necessary service to Medicare beneficiaries unless CMS proactively adjusts the weight for MS-DRG 470 to reflect this policy shift.

In addition to repricing the MS-DRG itself, CMS will need to account for this policy shift in LEJR episode target prices by adjusting for projected changes in the number of “outlier” cases, increased use of post-acute care sites of service, and a potential increase in readmissions rates for the patients who continue to have TKA procedures performed in the inpatient setting. HFMA’s members believe cases fitting the following criteria could be removed from the existing data set to determine the correct MS-DRG weight and episode pricing if CMS eventually decides to implement this policy:

- A. Cases with no listed co-morbidities listed on the claim or that have a low-risk HCC score
- B. A short length of stay (two days)
- C. No institutional post-acute care utilization



D. No readmissions

Finally, if CMS moves forward with this policy, we believe CMS will need to monitor and possibly adjust readmissions rates used in the Hospital Readmissions Reduction Program and posted on the Hospital Compare website. We are concerned that differential rates of adoption of performing LEJR procedures across and within regions could potentially skew readmission rates.

Quality Measures CY 2020 Payment Determination

CMS proposes to add new measures to both the OPPS and ASC Payment systems. While HFMA strongly supports quality measurement, we are concerned about the proposed measures. Below, please find our specific comments about each of the proposed new measures.

- 1) OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy: CMS proposed to adopt OP-35 for the 2020 payment determination and subsequent years. In the proposed rule, CMS states that, “The Measure Applications Partnership (MAP), which represents stakeholder groups, conditionally supported the measure recommending that it be submitted for National Quality Forum (NQF) endorsement with a *special consideration for SDS adjustments and the selection of exclusions*” (emphasis added). While CMS has submitted the measure to the NQF for a two-year trial, the trial has not concluded and the measure currently does not include “special consideration for SDS adjustments and the selection of exclusions.”

CMS justifies its decision to move forward with this measure in the proposed rule by stating:

“We understand the important role that SDS plays in the care of patients. However, we continue to have concerns about holding hospitals to different standards for the outcomes of their patients of diverse SDS because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of SDS on hospitals’ results on our measures.”

The proposed rule also further attempts to bolster its argument by stating that “CMS believes that the MAP’s endorsement is “consensus by stakeholders.”

**HFMA’s members believe CMS should delay incorporating OP-35 in the Outpatient Quality Reporting Program until the results of the two-year NQF evaluation are known and the learnings from that trial can be incorporated into the measure’s risk adjustment for the following reasons:**

- A. We agree with CMS that it is inappropriate to hold hospitals (or other providers) to a separate standard because of the patient populations they serve. However, that’s exactly what CMS is doing, given its continued refusal to incorporate SDS factors into the risk-adjustment mechanism for OP-35 and the entire suite of outcomes measures across its myriad payment systems. There is overwhelming evidence that individuals who are economically disadvantaged are readmitted to the hospital, are admitted to the ED, and

suffer other adverse outcomes more frequently than similarly aged patients afflicted with the same primary condition and related co-morbidities.

The reason these patients are readmitted at a higher rate is that they lack the resources (e.g., transportation, access to medications, appropriate diet), social supports, and ability (e.g., basic medical literacy) to manage the transition from the care setting to home. Given these challenges when CMS measures and compares a hospital serving an economically challenged population to one serving a more affluent population, it is implicitly expecting that hospital to invest significantly more resources in its patients' transitions into the community than a hospital serving a more affluent population. As a result of this implicit expectation, CMS holds hospitals serving economically challenged communities to a higher standard than those serving more affluent populations. While HFMA's members believe hospitals have a significant role to play in addressing unmet social needs in the communities they serve, they believe that it is inappropriate to hold hospitals fully responsible for the complex social issues impacting many communities.

- B. HFMA agrees with CMS that the MAP is a consensus organization. However, we do not believe they currently support the measure. Their support for the measure is predicated on a condition (NQF endorsement with a special consideration for SDS adjustments and the selection of exclusions) that has not been fulfilled.
- 2) OP-36: Hospital Visits after Hospital Outpatient Surgery Measure (NQF #2687): While this measure is endorsed by both the MAP and the NQF, **HFMA believes (as argued above) that CMS should delay implementing this measure until an appropriate SDS risk adjustment mechanism can be incorporated into it.** CMS even makes a compelling argument for SDS risk adjustment when it states in the proposed rule:

“Similarly, direct admissions after surgery that are primarily caused by nonclinical patient considerations (*such as lack of transport home upon discharge*) (emphasis added) or facility logistical issues (such as delayed start of surgery) are common causes of unanticipated yet preventable hospital admissions following same-day surgery.”

While patients in all communities occasionally have issues with transportation home upon discharge, our members report that it is a far more common problem in economically challenged communities.

- 3) ASC-15a-e/OP-37a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measures: Neither the ASC nor OP CAHPS have been endorsed by a consensus-based measurement evaluation body. In the proposed rule, CMS states the MAP stopped short of endorsement encouraging “further development.” CMS clarifies that the measures are now “fully specified” and will be submitted to the NQF “soon.” **HFMA believes that CMS needs to withhold the ASC-15a-e and OP-37a-e measures until they are endorsed by a consensus-based measurement evaluation body. Until that time, our members believe it is inappropriate to incorporate them into a pay-for-reporting scheme. If CMS moves forward with this un-endorsed measure, it will make results, which may not be reliable, publicly available on the Hospital Compare website.**

- 4) ASC-13: Normothermia Outcome: Currently, ASC-13 is not NQF-endorsed and only conditionally approved by the MAP. **HFMA's members believe that CMS should not include ASC-13 in the ASCQR Program until it is NQF-endorsed.**
  
- 5) ASC-14: Unplanned Anterior Vitrectomy: HFMA appreciates that an unplanned anterior vitrectomy is a likely indicator of substandard care. And when it occurs it has a significant negative impact on patients. However, CMS states in the proposed rule that the rates of UAVs are "relatively low." **HFMA's members do not support including this measure for the ASCQR 2020 ASC payment determination.** First, as alluded to above, HFMA believes that there are probably higher priority measures that impact more patients that CMS should be collecting data on. Second, the measure is not NQF-endorsed.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2017 OPPS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA  
President and Chief Executive Officer  
Healthcare Financial Management Association

### **About HFMA**

HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.