AdvaMed
Advanced Medical Technology Association

Comments to
Centers for Medicare and Medicaid Services
Advisory Panel on Hospital Outpatient Payment
March 11th-12th, 2013

Submitted By: DeChane L. Dorsey, Esq. and Chandra Branham Esq. on January 25, 2013

On behalf of the
Advanced Medical Technology Association (AdvaMed)

AdvaMed appreciates the opportunity to address the Advisory Panel on Hospital Outpatient Payment (the Panel) and commends the Panel on its efforts to evaluate and improve the APC groups under the hospital outpatient prospective payment system (OPPS) and to ensure that Medicare beneficiaries have timely access to new technologies.

AdvaMed member companies produce the medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

AdvaMed is committed to ensuring patient access to life-saving and life-enhancing devices and other advanced medical technologies in the most appropriate settings and supports a system with payment weights and payment rates that include sufficient resources to account for the costs of the medical technologies associated with hospital outpatient and ambulatory surgical center procedures.

Our comments today will address three key topics:

- **Reconfiguring APCs**
- **Improving the Data Used to Determine APC Rates**
- **Comments on Specific APCs**

I. Reconfiguring APCs

There is one issue related to reconfiguring APCs that we would like to address today.

Payments for Packaged Services-- AdvaMed appreciates and supports CMS's response to the Panel's recommendation to analyze the impact of packaging on net payments for patient care. We also support the agency's decision to not expand packaging policies to any additional categories of services for CY 2013. AdvaMed remains concerned that the implications of the packaging policies are not known and seeks greater transparency in rate setting.

- ***AdvaMed recommends that the Panel urge CMS to make the data underlying payments for packaged services, including utilization rates and estimated median costs, publicly available.***

II. Improving the Data Used to Determine APC Rates

AdvaMed appreciates the significant effort on the part of CMS to stabilize variation in APC payment rates. We would like to raise three issues, related to the data used to determine the APC rates.

First, AdvaMed commends CMS on their decision to continue using the single and "pseudo" single procedure claims rate-setting methodology which has yielded data that appears to more accurately capture the estimated costs of procedures. We do however have concerns that all of the codes associated with a procedure are not being reported. This is especially a concern with regard to supply codes. Code utilization data is used by CMS to identify the resources associated with a procedure and ultimately to appropriately adjust the APC Payment.

- ***AdvaMed recommends that the Panel urge CMS to continue to focus on coding education as it impacts the use and development of HCPCS supply codes so that these codes are appropriately reported by hospital coders.***

Second, AdvaMed commends CMS's decision to use data from the implantable device cost center in setting the rates for certain OPPS services starting with CY 2013.

Despite expected improvement in reporting, using the cost center over time, AdvaMed believes that additional educational efforts are still needed to ensure that hospitals complete the implantable device cost center, thereby improving the validity of payment weights based on estimated costs. Additionally, AdvaMed believes that CMS should continue to work to ensure the validity of the data collected through the new cost center.

AdvaMed therefore makes the following additional recommendations related to the use of the cost center:

- ***AdvaMed recommends that the Panel urge CMS to initiate actions to undertake additional outreach and educational activities (beyond the distribution of Bulletins) to ensure that hospitals and the Medicare Administrative Contractors (MACs) are educated fully about the cost center requirements to ensure common knowledge, consistent and accurate audit processes, and to ensure that cost report changes are implemented effectively and accurately.***

- ***AdvaMed recommends that the Panel urge CMS to continue to monitor the accuracy of data reported under the cost center to ensure that it is correct and leads to more accurate rate-setting.***

III. Comments on Specific APCs

Appropriate Payment for Level I & II Proton Beam Radiation Therapy (APC 664 & 667)

In the CY 2013 OPPS Final Rule (Final Rule) CMS reduced payment rates for Level I & II Proton Beam Radiation Therapy (APC 664 & 667).

The hospital reimbursement rates for proton therapy are based on cost reports submitted by only three hospitals. The cost reports submitted by one of these hospitals, the Hospital of the University of Pennsylvania ("UPenn"), contained flawed data. UPenn presented information to the Panel on August 27, 2012 indicating that it submitted a cost report that mistakenly miscoded certain services and wrongly assigned proton therapy costs. As a consequence, UPenn's cost report significantly understated the cost of proton therapy. In light of this, and given the severity of the error's impact, the Panel recommended that CMS maintain the CY 2012 rates for proton therapy for CY 2013.

CMS did not accept the Panel's recommendation stating in the Final Rule, "We appreciate the public comments and the HOP Panel's recommendation. After consideration of the public comments we received, we are updating the payment rates for proton beam therapy for CY 2013 to reflect the most recently available claims data from all providers. Therefore, we are not maintaining the CY 2013 payment rates at CY 2012 levels, and we are not excluding the reportedly erroneous data from the rate setting process." As a consequence of CMS's determination, the CY 2013 proton therapy rates were generated using the flawed UPenn data resulting in a fifty five percent lower payment rate for Level II Proton Beam Radiation Therapy (APC 667). This payment rate is less than that for Level I Proton Beam Radiation Therapy (APC 664), a less complex treatment.

AdvaMed has concerns regarding the negative impact that this rate cut could have on Medicare beneficiaries and other vulnerable populations.

- **AdvaMed urges the Panel to recommend that CMS reimburse proton beam therapy at CY 2012 levels for CY 2014 and beyond if the claims data errors are not corrected and that CMS create a mechanism for allowing corrected data to be used in future rate setting.**

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AdvaMed encourages the Panel to continue to recognize the unique challenges associated with device-dependent procedures and urges the Panel and CMS to carefully consider the timeliness, adequacy, and accuracy of the data and the unique perspective that manufacturers bring to these issues.

Thank you.

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