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August 23, 2011

Donald Berwick, M.D

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Room 445-G, Hubert H. Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

Re: CMS-1525-P: Hospital Outpatient Prospective Payment System Proposed Rule for CY 2012

Dear Dr. Berwick:

National Patient Advocate Foundation (NPAF) is the voice for millions of patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained services from Patient Advocate Foundation (PAF), which provides professional case management assistance to patients with chronic, debilitating or life-threatening conditions. In 2010, PAF resolved 82,963 patient cases and received more than four million additional inquiries from patients nationally. About 25% of the individuals receiving direct professional intervention from PAF were Medicare beneficiaries, with approximately 41% of them being individuals who qualified for Medicare based on disability and about 71% being individuals dealing with a diagnosis of cancer.

On behalf of those patients who encounter obstacles in accessing health care daily, we appreciate the opportunity to comment on the Proposed Rule CMS-1525-P, "Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Provider Agreement Regulations on Patient Notification" published in the *Federal Register* on July 18, 2011.¹ We have divided our comments by issue and have included an Executive Summary to facilitate your review of our input.

EXECUTIVE SUMMARY

Payment Rate for Separately Payable Drugs

NPAF agrees with the need to address the problem of charge compression and its distortion of pharmacy overhead costs associated with the provision of separately payable drugs in hospital outpatient departments. We are pleased the Centers for Medicare & Medicaid Services (CMS) has decided to increase the reallocation of such costs for 2012 to account for

¹ 76 *Fed. Reg.* 42170 (July 18, 2011)

inflation. Nonetheless, we question the end result of CMS' overall methodology for setting hospital outpatient prospective payment system (HOPPS) drug payment rates and its conclusion that a payment rate of ASP + 4% is appropriate.

We doubt the sufficiency of the proposed inflation-adjusted base amount CMS has slated for reallocation from packaged to separately payable drugs. After all, the Advisory Panel on Ambulatory Payment Classification Groups (APC Panel) recommended increasing that amount at its February 2010 meeting. We also know estimates of drug acquisition costs extrapolated from hospital claims data using cost-to-charge ratios are skewed downward by the inclusion of costs from hospitals that purchase drugs at deep discounts under the 340B program.

We are concerned by a recent report showing increasing numbers of office-based medical oncology practices are closing or selectively referring underinsured patients, including Medicare beneficiaries without secondary insurance, to hospital outpatient departments for treatment. We worry about the capacity of hospital outpatient departments to accept the growing patient load. We worry too about transportation issues and the burden that having to travel further for treatment can put on patients and their caregivers. We wonder too about the ability of hospitals that cannot access 340B pricing to shoulder the cost of treating a higher proportion of underinsured patients at a proposed payment rate of ASP + 4%.

In NPAF's view, the only reasonable way to avoid unstable HOPPS reimbursement for drugs, patient steering and site of service shifts driven purely by financial considerations is to equalize the payment systems between physicians and hospitals. To that end, CMS should use its authority under Social Security Act § 1833(t)(14)(A)(iii)(II) to set the CY 2012 payment rate for separately payable drugs under the HOPPS at ASP + 6% in 2012. CMS also should increase the reimbursement for chemotherapy drug administration services in both the physician office and the hospital outpatient settings to levels that cover the costs of furnishing those services.

NPAF appreciates that higher hospital outpatient department reimbursement for separately payable drugs and drug administration services will increase the cost-sharing obligations of Medicare beneficiaries. We are extremely sensitive to the burdens of co-payments for expensive drugs because PAF routinely assists patients dealing with such concerns through its Co-Pay Relief Program. Nonetheless, patients and their families could be left with no or limited service options in their communities if inadequate drug and drug administration reimbursement forces hospitals to trim standard-of-care therapies from their formularies or, worse yet, shut their outpatient infusion centers.

Payment Adjustment for PPS-Exempt Cancer Hospitals

We are pleased CMS is proposing to provide a payment adjustment to better align the HOPPS payment-to-cost ratios for PPS-exempt cancer hospitals with those for other hospitals. Such an adjustment should help further the vital clinical mission and the research work of these centers for excellence. That said, we are concerned that equalizing HOPPS payments to cancer hospitals will come at the expense of a 0.6-0.7% reduction in payments to all other hospitals subject to the HOPPS because of the way CMS has elected to apply the budget neutrality requirements of Social Security Act §188(t)(2)(E). This reduction represents a significant proportion of the 1.5% increase in the conversion factor otherwise proposed for 2012. We are particularly concerned about the access implications of the payment changes in the Proposed Rule, including the cancer hospital adjustment, on those rural hospitals that are

not eligible for the 7.1% adjustment to rural sole community hospitals (SCHs) and Essential Access Community Hospitals (EACHs).

CMS has the statutory authority to interpret the budget neutrality obligations associated with the proposed payment adjustment for PPS-exempt cancer hospitals in a way that would reduce the negative impact of the adjustment on other hospitals. To be consistent with Congressional intent and to ensure appropriate payment to both PPS-exempt cancer hospitals and other hospitals subject to payment under HOPPS, especially those in rural areas, NPAF recommends that CMS include the \$159 million in Transitional Outpatient Payments for the cancer hospitals in its adjustment calculations. Doing so would require a somewhat smaller additional payment to the PPS-exempt cancer hospitals, but it would lead to a significantly smaller offset for other hospitals and still be budget neutral.

DETAILED DISCUSSION

Payment Rate for Separately Payable Drugs

In calendar year (CY) 2010, CMS began correcting the payment methodology for separately payable drugs under the HOPPS to adjust for charge compression by reallocating some pharmacy overhead and handling costs from packaged drugs to drugs that are separately payable.² This correction involves redistributing between a third and a half of the estimated overhead costs associated with lower cost packaged drugs and biologicals to more expensive separately payable products without pass-through status. In 2010, the end result of the reallocation of \$200 million in costs was a reimbursement rate for separately payable drugs set at ASP + 4%. According to CMS, this payment rate covered both the acquisition cost of the drugs themselves, which CMS' usual claims-based payment methodology pegged at ASP – 2%, and the pharmacy overhead associated with furnishing them.³ CMS applied the same adjustment methodology in CY 2011, again redistributing \$200 million in costs. This time, the approach led to a combined payment rate for drugs and pharmacy overhead of ASP + 5%.⁴

The story is similar again this year, although CMS has proposed to account for the inflation that has occurred since the overhead redistribution amount of \$200 million was set in 2010 by adjusting the amount, using the Producer Price Index for Pharmaceuticals for Human Use published by the Bureau of Labor Statistics, to \$215 million.⁵ As a result of this adjustment, the Proposed Rule projects a payment rate for separately payable drugs of ASP + 4% in CY 2012.

NPAF agrees with the need to address the problem of charge compression and its distortion of pharmacy overhead costs associated with the provision of separately payable drugs in hospital outpatient departments. We know from research carried out by the Global Access Project under NPAF's auspices that such costs can be significant for chemotherapy regimens.⁶ We are pleased too that CMS has decided to increase the reallocation amount for 2012 to account for inflation. Nonetheless, as we did when we commented on both the CY 2010 and CY 2011 Proposed Rules, we must question the end result of CMS' overall methodology for setting HOPPS drug payment rates. Simply put, we are convinced

² 76 *Fed. Reg.* at 42258.

³ *Id.*

⁴ 76 *Fed. Reg.* at 42259

⁵ 76 *Fed. Reg.* at 42261

⁶ GAP Study, "Documentation of Pharmacy Cost in the Preparation of Chemotherapy Infusions in Academic and Community-Based Oncology Practices," D. Brixner, *et al.*, University of Utah Pharmacotherapy Outcomes Research Center. For complete study, visit http://www.npaf.org/images/pdf/gap/utah_study.pdf

that reimbursement at ASP + 4% understates the true costs of both pharmacy handling services and separately payable drugs themselves and, as such, raises concerns about adequate access to care, particularly for individuals who are uninsured or underinsured.

We doubt whether the inflation-adjusted base amount slated for reallocation is sufficient to account to the charge compression distortion of pharmacy overhead costs. We note that the Association of Community Cancer Centers (ACCC) presented data at the February 2010 meeting of the APC Panel developed by Direct Research, LLC and The Moran Company suggesting the overhead reallocation that CMS has been using for packaged drugs without HCPCS codes is inadequate. We note too that the APC Panel recommended that CMS reallocate a larger portion of pharmacy overhead costs from packaged drugs to separately payable drugs.⁷

Despite our concerns about the inadequacy of the proposed ASP + 4% payment rate, we recognize that “in past years, the proposed ASP + X amount has decreased by at least 1 percentage point when we [CMS] updated the ASP data, claims data, and cost report data between the proposed rule and the final rule with comment period.”⁸ We take this warning seriously. We urge CMS to take steps to avoid promulgating a Final Rule calling for HOPPS drug payments at ASP + 3% by rejecting the use of the most currently available ASP data files to calculate hospital costs. Instead, CMS should use ASP data files that are better aligned with the two-year old claims data that is used to develop the proposed 2012 APC payment amounts.

NPAF also encourages CMS to recognize that estimates of drug acquisition costs extrapolated from 2010 hospital claims data using cost-to-charge ratios from cost reports are skewed downward by the inclusion of drugs purchased at deep discounts by hospitals eligible to buy under the 340B program. By some accounts, the ASP – 2% estimate that CMS asserts approximates drug ingredient costs in hospital outpatient departments for CY 2012 could understate those costs by as much as 9-10%.⁹ We fail to understand why CMS regards access to 340B pricing significant enough to justify an annual recalculation of the payment-to-cost ratios for PPS-exempt cancer hospitals eligible for payment adjustments,¹⁰ but does not find it appropriate to correct for the impact of 340B pricing when it sets APC payments for separately payable drugs. NPAF strongly encourages CMS to remove data from 340B-eligible hospitals from the data pool used to calculate the APC payment amounts for separately payable drugs. We would argue that doing so does not require CMS to set separate payment rates for 340B-eligible and non-340B-eligible hospitals since the purpose of the 340B program is to allow safety net hospitals to “stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”¹¹ It would, however, lead to fairer payment rates for the majority of hospitals that are required to pay market prices for the drugs they purchase.

⁷ APC Panel February 17 & 18, 2010 Agenda, Recommendations and Report, available at <http://www.cms.gov/FACA/APC/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237156&intNumPerPage=10>.

⁸ *Id.*

⁹ B. Cote, “Expansion of Section 340B Raises New Questions for Cancer Stakeholders,” *Oncology Business Review* (May 2010), available at http://www.oncbiz.com/documents/OBR_may_81295_340B.pdf, (quoting Matt Farber, Director of Provider Economics & Public Policy, Association of Community Cancer Centers saying “[I]f you took 340B drugs out of the ASP plus calculation, you’d be at ASP plus 7% to 8%).

¹⁰ 76 *Fed. Reg.* at 42221.

¹¹ H.R. Rep. 102-384, 102nd Cong. Pt. 2, p 12 (2nd Session 1992).

We would be remiss if we failed to raise our concerns about a recent report prepared for the Community Oncology Alliance showing increasing numbers of office-based medical oncology practices are closing or are being forced for financial reasons to selectively refer underinsured patients, including Medicare beneficiaries without secondary insurance, to hospital outpatient departments for treatment.¹² We worry about the capacity of hospital outpatient departments to accept the growing patient load. We worry too about transportation issues and the burden that having to travel further for treatment can put on some patients and their caregivers. Given the proposed payment rate of ASP + 4%, we are concerned about the ability of hospitals that cannot access 340B pricing and of safety net hospitals as well to shoulder the cost of treating a higher proportion of underinsured patients. We understand that some 340B hospitals question whether payments at this level will be sufficient to cover their costs even with 340B pricing¹³ because of the continued underestimate of pharmacy handling costs included in that payment amount.

In NPAF's view, the only reasonable way to avoid unstable HOPPS reimbursement for drugs as well as patient steering and site of service shifts driven purely by financial consideration is to equalize the payment systems between physicians and hospitals. To that end, CMS should use its authority under Social Security Act § 1833(t)(14)(A)(iii)(II) to set the CY 2012 payment rate for separately payable drugs under the HOPPS at ASP + 6%. This payment rate is on a par with drug reimbursement available to physician practices that furnish chemotherapy and other drug administration services.

CMS also should take steps to increase the reimbursement for chemotherapy drug administration services in both the physician office and the hospital outpatient setting to levels that cover the costs of furnishing those services. Any other approach jeopardizes access to care for the growing numbers of Medicare beneficiaries with cancer. We raise this concern because a recent study by Avalere Health indicates Medicare payments for chemotherapy administration in physician offices and freestanding cancer centers in 2009 covered only 57% of the associated costs.¹⁴

NPAF appreciates that higher hospital outpatient department reimbursement for separately payable drugs and drug administration services will increase the cost-sharing obligations of Medicare beneficiaries. This is an important issue as PAF data reveal Between 2008 and 2010 PAF Advocate Foundation saw a 26.9% decline in patients reporting overall hospital services, while those patients reporting outpatient hospital services has in-creased by 51.8%. Please see the attached PAF Hospital Outpatient Services Report.

We are extremely sensitive to the burdens of co-payments for expensive drugs because PAF routinely is called upon to assists patients dealing with such concerns. In 2010 alone, PAF provided assistance through its Co-Pay Relief Program to 13,848 patients who could not afford the cost sharing associated

¹² "Community Oncology Cancer Care Practice Impact Report,"(hereafter COA Report), Community Oncology Alliance (March 31, 2011), available at [http://www.communityoncology.org/UserFiles/files/87f3205e-ee73-4b03-85fb-094870cc430d/COA%20Community%20Oncology%20Practice%20Impact%20Report%203-31-11\(1\).pdf](http://www.communityoncology.org/UserFiles/files/87f3205e-ee73-4b03-85fb-094870cc430d/COA%20Community%20Oncology%20Practice%20Impact%20Report%203-31-11(1).pdf).

¹³ B. Cote, "Expansion of Section 340B Raises New Questions for Cancer Stakeholders," *Oncology Business Review* (May 2010), available at http://www.oncbiz.com/documents/OBR_may_81295_340B.pdf, (quoting Scott Smith, Oncology Service Line Director, Forrest General Cancer Center, a 512-bed county hospital in Hattiesburg, MS).

¹⁴ See Avalere, "Providing High Quality Care in Community Oncology Practices/An Assessment of Infusion Services and Their Associated Costs, (Feb. 2010), available at <http://www.communityoncology.org/docs/Avalere-COA-Components-of-Care-Study-Final-Report.pdf>.

with their prescription drugs. Over 58% of these individuals were Medicare beneficiaries.¹⁵ We are aware, as should CMS be, that testimony was presented to the APC Panel in August 2010 by an ACCC member hospital indicating that even with ASP + 6% reimbursement, its pharmacy is spending more than it is reimbursed on 44% of outpatient drugs and biologicals.¹⁶

NPAF knows from experience that inadequate reimbursement can force hospitals to impose formulary restrictions on specific drug products. We note that in the second of a three year series of surveys conducted by Kantar Health for ACCC in 2010, a quarter of the participants reported they now restrict access to certain injectible products.¹⁷ This statistic is particularly concerning from an access perspective since in many areas throughout the United States, hospital infusion centers are the sole site of service for Medicare beneficiaries in need of chemotherapy. Patients and their families could be left with no or limited service options in their communities if the inadequate drug reimbursement contemplated in the Proposed Rule forces hospitals to trim standard-of-care therapies from their formularies or, worse yet, shut their outpatient infusion centers.

Payment Adjustment for PPS-Exempt Cancer Hospitals

Section 3138 of the Affordable Care Act,¹⁸ as amended,¹⁹ requires the Department of Health and Human Services (HHS) to study whether the 11 PPS-exempt cancer hospitals incur higher outpatient costs than do other hospitals. The statute also requires CMS to provide for an adjustment to the APC payments available to the cancer hospitals if the study confirms they are underpaid relative to their costs. NPAF supported the inclusion on this provision in the ACA because the PPS-exempt cancer hospitals are critical to many patients battling the toughest or most advanced cancers. They also conduct substantial amounts of clinical research that often underlies significant advances in cancer care. We therefore see their continued financial viability as critical to the cancer community.

We are not surprised CMS has concluded that the cost of care at each of the cancer hospitals is proportionally high enough to justify payment adjustments in CY 2012 ranging from 10% to almost 62%, depending on the specific hospital.²⁰ Given our concerns, discussed above, about the skewing of the APCs for separately payable drugs by the inclusion of 340B pricing in CMS' determination of the payment amounts for such products, we understand and agree with CMS' decision to recalculate the cancer hospital payment adjustment annually to address the 340B pricing advantage they now enjoy under ACA.

Despite our support for the provision of adequate reimbursement to the cancer hospitals, we are concerned equalizing HOPPS payments to them will come at the expense of a 0.6-0.7% reduction in payments to all other hospitals subject to the HOPPS²¹ because of the way CMS has elected to apply the budget neutrality requirements of Social Security Act §188(t)(2)(E). A reduction of this magnitude represents a loss of a significant proportion of the 1.5% conversion factor update nominally available to

¹⁵ Patient Advocate Foundation, "Patient Date Analysis Report 2010," pp 75-76

¹⁶ APC Panel August 23 & 24, 2010 Agenda, Recommendations and Report, available at http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.

¹⁷ Association of Community Cancer Centers, "2010 Cancer Care Trends in Community Cancer Centers," (July 2010), available at www.accc-cancer.org/surveys/pdf/Cancer_Care_Trends-2010-Gatefold.pdf.

¹⁸ Pub. L. 111-148.

¹⁹ Pub. L. 111-226.

²⁰ 76 *Fed. Reg.* at 42221 (Table 13).

²¹ 76 *Fed. Reg.* at 42376.

all hospitals in 2012 under the Proposed Rule. We are particularly concerned about the projected impact of all the payment changes in the Proposed Rule, including the cancer hospital adjustment, on those rural hospitals that are not eligible for the 7.1% adjustment to rural sole community hospitals (SCHs), including Essential Access Community Hospitals (EACHs). Such hospitals are expected to see only a 0.8% increase in their HOPPS payments next year.²² NPAF finds this disconcerting from an access perspective.

Slightly less than a fourth of the U.S. population lives in rural areas and “depend[s] upon the hospitals serving their community as an important, and often only, source of care.”²³ Rural populations tend to be older and poorer than their urban counterparts.²⁴ More rural residents are uninsured or underinsured and more have chronic diseases.²⁵ Rural hospitals are typically smaller than urban facilities and since they must spread their fixed cost over a proportionally smaller patient base, their costs per case tend to be higher.²⁶ They also have seen a much more dramatic shift of care delivery to the outpatient setting than have urban hospitals because specialized inpatient services have remained concentrated in the cities.²⁷ Overall, approximately 60% of the revenues earned by rural hospitals come from Medicare and Medicaid because of the older age and poorer finances of their patient bases.²⁸ As CMS acknowledges in the Proposed Rule, in the aggregate Medicare HOPPS payments to the non-cancer hospitals only covers approximately 90% of their outpatient costs.²⁹ We suspect the Medicare percentage is lower for rural facilities. The adequacy of reimbursement under Medicaid to all hospitals is typically even less. The expansion of insurance coverage under ACA will likely put even more pressure on the finances of rural hospitals since rural areas are expected to see larger gains in coverage, with a higher proportion of that coverage expansion coming through Medicaid.³⁰

We are convinced CMS has the statutory authority to interpret the budget neutral obligations associated with the proposed payment adjustment for PPS-exempt cancer hospitals differently. Doing so could reduce the negative impact of the cancer hospital adjustment on other hospitals. When Congress required the cancer hospital adjustment to be budget neutral, it did not intend for CMS to pull nearly \$159 million of permanent Transitional Outpatient Payments (TOPs)³¹ out of the aggregate pool of funding flowing to hospitals prior to the implementation of the adjustment. If it had, the Congressional Budget Office would not have concluded that ACA §3138 did not affect spending.³² Rather, the provision would have been scored as a “cost saver.” To be consistent with Congressional intent and to ensure appropriate payment to both PPS-exempt cancer hospitals and to other hospitals subject to

²² 76 *Fed. Reg.* at 42377-78 (Table 51).

²³ American Hospital Association Trendwatch, “The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform” (April 2011), p 2, available at <http://www.aha.org/aha/trendwatch/2011/11apr-tw-rural.pdf>.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*, p 3.

²⁷ *Id.*, pp 3-4.

²⁸ *Id.* p 4.

²⁹ 76 *Fed. Reg.* at 42222.

³⁰ American Hospital Association Trendwatch, “The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform” (April 2011), p 9, available at <http://www.aha.org/aha/trendwatch/2011/11apr-tw-rural.pdf>

³¹ OPSS NPRM Cancer Adjustment Analysis File, available at <https://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1249172&intNumPerPage=10>.

³² CBO, Cost estimate for H.R. 3590, the Patient Protection and Affordable Care Act, as passed by the Senate on Dec. 24, 2009 (March 11, 2009), p 19, available at http://cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

payment under HOPPS, especially those in rural areas, NPAF recommends that CMS calculate the adjustment by including the TOPs for the cancer hospitals. This would require a somewhat smaller additional payment to the PPS-exempt cancer hospitals, but it would lead to a significantly smaller offset for other hospitals and still be budget neutral. We recognized there are methodological difficulties associated with this recommendation, but CMS routinely develops complex approaches for allocating funds in the various fee schedule methodologies and it should be able to do so in this case as well.

* * * * *

NPAF sincerely appreciates the opportunity to share its views on this matter. If we can be of assistance to CMS, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy Davenport-Ennis". The signature is written in a cursive style with a large initial 'N'.

Nancy Davenport-Ennis
Chief Executive Officer



Solving Insurance and Healthcare Access Problems | since 1996

Hospital Outpatient Services 2008-2011

Founded in 1996, Patient Advocate Foundation (PAF) is a national non-profit, 501©3 direct patient services organization with a mission *“to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.”* PAF serves as an active liaison between patients and their insurer, employer and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis through professional case managers and a national network of health care attorneys. PAF case managers work with patients and their providers to identify local, state, and federal programs that provide assistance for their individual needs, ensure appropriate reimbursement for healthcare services by their insurers and educate them on their employment rights during an illness.

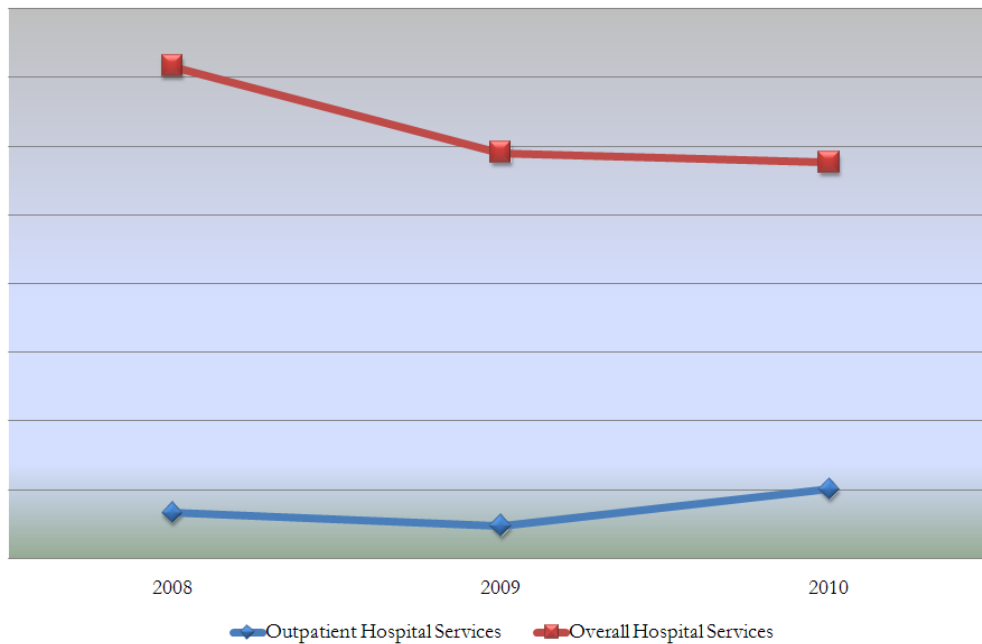
Direct Patient Services are provided **nationwide at no cost to the patient**. PAF case managers are specialized in the areas of oncology nursing, coding and billing, pre-authorization approvals, expedited appeals, expedited application for federal and state assistance and disability. They resolve debt crisis matters related to a diagnosis; mediate insurance appeals; negotiate access to pharmaceutical agents, chemotherapy, medical devices and surgical procedures; broker resources to supplement the limits of insurance and to assure access to care for the insured, uninsured and underinsured.

PAF offers twenty-one unique programs for patients including the Senior Services Division where case managers assist senior citizens and the disabled with insurance and access to care issues. The case managers can assist with issues around Medi-gap plans, Medicare part D prescription plan enrollments and the Low Income Subsidy (LIS). The case managers provide education and guidance regarding Medicare savings programs (help with premium assistance), Social Security application and appeals assistance, coordination of benefits and enrollment into state pharmaceutical plans.

Additionally, PAF case managers routinely assist patients by screening and enrolling them into appropriate Medicaid programs for which they may be eligible such as, Traditional, Spend-down, Medicare Savings Plans and Health Insurance Premium Payment (HIPP) programs, ensuring access to care. The case managers review eligibility criteria, state and local policies, processing timelines and documents necessary to establish eligibility for programs. The patients are also guided through the application process. The case manager also provides appeal assistance and follow-up with Department of Social Services workers regarding questions about decisions rendered on cases.

Between 2008 and 2010 Patient Advocate Foundation saw a 26.9% decline in patients reporting overall hospital services, while those **patients reporting outpatient hospital services has increased by 51.8%** (Exhibit 1). Additionally, the ratio of patients treated in hospital for outpatient services versus other hospital services has increased from 10.22% in 2008 up to 21.23% in 2010 (Exhibit 2).

**Exhibit 1: PAF Patients Receiving Hospital Services
2008 - 2010**



**Exhibit 2: PAF Patients Treated in a Hospital for Outpatient Services
2008 - 2011**

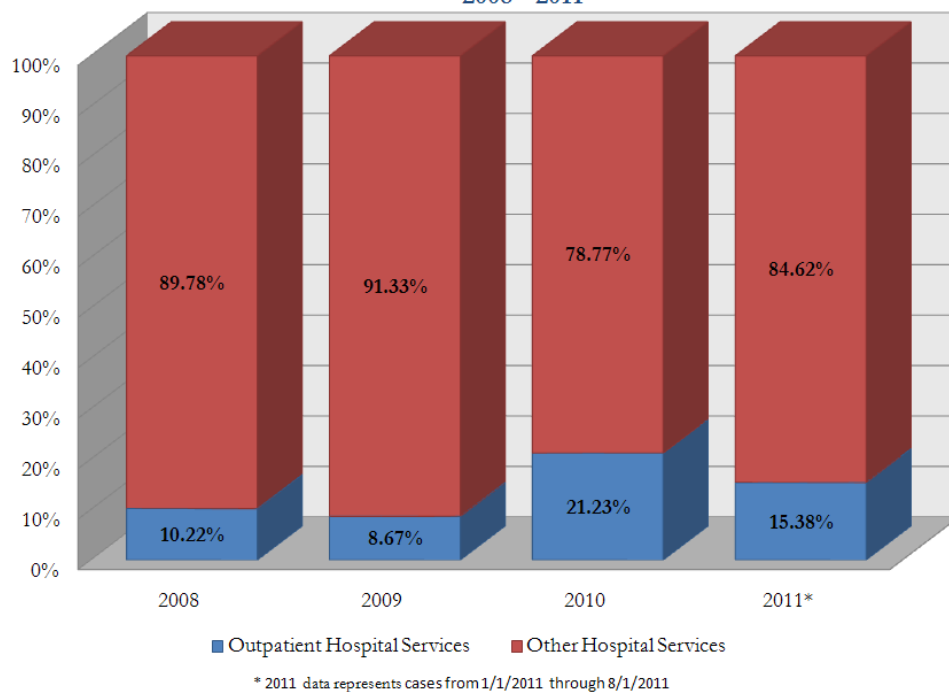


Exhibit 3 shows the insurance status of PAF patients who have been treated in a hospital for outpatient services between 2008 and 2011.

**Exhibit 3: Insurance Status of PAF Patients Treated in a Hospital
for Outpatient Services: 2008 - 2011**

Commercial Insurance	34.84%	33.50%	41.40%	36.69%
Medicaid	12.26%	11.00%	9.58%	12.04%
Medicare	19.03%	20.29%	18.95%	21.57%
Military Benefits	0.81%	0.98%	0.82%	0.84%
Uninsured	33.06%	34.23%	29.25%	28.85%

