THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

February 19, 2016

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Subcommittee Chairman Pitts:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to provide feedback regarding Section 603 of the Bipartisan Budget Act of 2015, as well as other so-called site-neutral payment proposals raised in your February 5 letter to the health care community.

The fundamental underpinnings of site-neutral payment policies are erroneous. Sites are not neutral and should not be reimbursed as such.

- Hospitals treat sicker, higher-severity patients for whom the hospital is the appropriate setting.
- The hospital has 24/7 emergency stand-by capacity that provides a safety net for vulnerable patients, and provides specialized services such as trauma, psychiatric, obstetrics and pediatric emergency care.
- Hospitals play a critical role in our emergency preparedness structure as evidenced by the Ebola crisis.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements.

All of these costs and capacities are and must be reflected in the hospital payment rates. HAP strongly urges Congress to reject any further site-neutral payment policies.

Section 603 of the Bipartisan Budget Act

Section 603 of the Bipartisan Budget Act (P.L. 114-74) imposes a new site-neutral payment policy which will result in reduced payment rates beginning January 1, 2017 for Medicare services furnished in new off-campus hospital outpatient departments (HOPDs). Off-campus, provider-based HOPDs are defined as departments that are not on the main campus of a hospital and are located more than 250 yards from the main campus.

Under this policy, instead of providing payment through the outpatient prospective payment system (OPPS) for those services, payment would be made under other Medicare Part B payment systems, such as the physician fee schedule (PFS), ambulatory surgical center payment system, or clinical laboratory fee schedule.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
haponline.org

Payment for existing provider-based, off-campus outpatient departments, departments billing covered HOPD services prior to November 2, 2015, will continue to be made under the OPPS. Payment for dedicated emergency department (DED) services will continue to be made under the OPPS.

HAP fundamentally disagrees with the premise of the policy and believes Section 603 should be reconsidered. In the immediate, HAP urges:

- Congress to enact legislation to ensure hospitals that were in various stages of project development for outpatient programs—but not completed as of November 2, 2015—will be able to continue to operate under the payment expectations relied upon when hospitals made commitments and investments to expand access to care through additional outpatient services
- The U.S. Department of Health & Human Services (HHS) to implement the law in a manner that fulfills the intent of the grandfather provision

HAP believes that, under Section 603 as written, changes in ownership of a facility, or the modification of service offerings, do not impact the grandfathered status of an HOPD and that grandfathered HOPDs may relocate when they meet criteria determined by HHS. Permissibility of relocation of grandfathered facilities is consistent with past Centers for Medicare & Medicaid Services (CMS) interpretation of moratorium provisions. For example, CMS has written extensive rules about when and whether a critical access hospital (CAH) can relocate or rebuild and still maintain its necessary provider designation even though the legislative moratorium on new necessary provider CAHs did not specifically address relocating facilities.

An additional concern is, as proposed, the site neutral policy could have a significant and negative impact on hospital 340B programs, especially those providing oncology services in HOPDs (due to the high utilization of costly cancer pharmaceutical products). Depending on how CMS implements this proposal, it could impact 340B eligibility for hospital outpatient departments (commonly referred to as child sites) created after the date on enactment. Under the current 340B program, only those outpatient locations of an eligible “parent” hospital that are reported as Medicare-reimbursable outpatient locations on the hospital’s Medicare cost report are able to access the 340B discounts. The 340B program is a vital part of the nation’s safety net, gives patients better access to drugs they need for their care and helps hospitals enhance care capabilities by stretching scarce federal resources. As drug prices continue to rise, this program becomes even more critical to vulnerable patients and communities.

Under Development: HAP believes off-campus HOPDs already under development when the Bipartisan Budget Act of 2015 was signed into law should receive grandfathered status. Section 603 unfairly changed the rules for these facilities in the middle of the game. They embarked upon commitments and investments to expand access to care in their communities with a reliance on certain payment expectations. These hospitals received no grace period or time to adjust their plans according to the new payment policy.

As a particularly salient example, one hospital in Pennsylvania opened a new, off-campus HOPD on November 10, missing the November 2 cut-off for grandfather status by mere days. The hospital invested more than $7 million in a carefully considered effort to expand access to care in underserved communities.

Congress has historically protected both existing facilities and those under development when it has passed moratoriums on new facilities. The treatment of off-campus HOPDs under the Bipartisan Budget Act of 2015 is in stark contrast with previous grandfather provisions included in legislation changing Medicare payment for physician-owned hospitals and long-term care hospitals (LTCH), in which Congress protected facilities under development for physician-owned hospital and LTCH moratoriums.

As a matter of fairness, facilities that were under development when the law was enacted should be given the same treatment and extended grandfather status consistent with past policy precedent.

HAP urges Congress to act expeditiously on this. These under-development HOPDs have had a significant financial change thrust upon them with no notice, and their financial commitments remain outstanding. As a result, if Congress does not act swiftly, hospitals may be forced to reconsider or reshape their investments. This could result in the elimination of health care sector jobs, scaled back financial commitments in needy communities, and reduced patient access to care. These are stated priorities of the Committee, and we appreciate your interest and sense of urgency in moving legislation during the next few months that addresses the under-development problem.

Shift in Outpatient Services: Section 603 is contrary to delivery system reforms underway in an effort to shift care into outpatient settings and manage population health. By cutting payment to new facilities beyond the main campus of a hospital, this policy will force migration of outpatient services to those campuses over time. This is directly counter to modern clinical care where it has been repeatedly proven that patients are more likely to receive needed care the closer that care is available to where they reside. Couple this with the clinical movement of services out of the inpatient setting into the outpatient setting, and the problem is multiplied.

Section 603 will mean, as populations grow and new outpatient services are needed, hospitals may be challenged in meeting those needs in the rural and underserved communities where they exist.

Ultimately, this policy will mean longer travel times for patients to receive care, which may reduce access to health care services in rural and underserved areas.

One Pennsylvania hospital is in the midst of a multi-year initiative to move outpatient services closer to where patients live in an effort to meet its community's needs. Section 603 threatens the financial viability of this initiative.

Integrated care and a movement from fee-for-service (FFS) payment to outcome and alternative payment methods (APM) has been a keen interest of the committee, and one of the most significant legislative achievements of Congress last year in the Medicare Access and CHIP Reauthorization Act (MACRA). But Section 603 will only make progress away from FFS and toward APMs more difficult. According to the Medicare Payment Advisory Commission (MedPAC), hospital outpatient margins in Medicare are negative 12.4 percent. The Congressional Budget Office estimates that Section 603 will cut payments an additional $9.3 billion. The answer to double-digit underpayments by Medicare is not further cuts.

APMs should include integration of care, in community settings, crossing the inpatient, outpatient, physician's office, and other settings. Section 603 forces care away from community settings to one geographic setting, and cuts funding to an already underpaid sector of Medicare. All of these results will reinforce the FFS system rather than incentivize hospital migration to APMs.

Site-Neutral Payment Proposals for HOPDs

The committee's letter draws attention to previous MedPAC proposals to cap HOPD payments for:

- Evaluation and management (E/M) clinic visit services at a residual of the PFS payment;
- A set of 66 outpatient ambulatory payment classifications (APC), including certain cardiac imaging services, at a residual of the PFS payment
- Twelve outpatient surgical procedures at the ambulatory surgery center (ASC) payment rate.

In addition, MedPAC has discussed reducing payment for oncology services furnished in HOPDs while simultaneously increasing payment for oncology services furnished in physician offices.

Moreover, hospitals already are paid less than the cost of care for services provided to Medicare patients in HOPDS. Additional payment cuts would threaten beneficiary access to outpatient services. The American Hospital Association (AHA) estimates that enacting the three MedPAC site-neutral payment proposals bulleted above would further reduce HOPD margins from negative 12.4 percent to negative 21.2 percent - an alarming level that could force hospitals to curtail these services and threaten seniors' access to care.

In addition, while discussions at MedPAC and elsewhere have centered on whether, as a prudent purchaser, Medicare should refrain from paying more for a service in the HOPD setting than in the physician office setting, it is important to determine whether payment is actually adequate in the setting that is paid the lower amount. MedPAC has assumed that the Medicare PFS payment rate or the ASC payment rate reflects the correct rate to pay for outpatient services but, in actuality, it is impossible to determine how well these payment

rates reflect providers' actual costs because physicians and ASCs do not submit cost data to Medicare. In addition, the PFS, and specifically its practice expense component, is based on voluntary responses to a physician survey. In contrast, HOPD payment rates are based directly on hospital data - audited cost reports and claims data - and have been found by MedPAC to be significantly below cost.

E/M Services: The committee notes in the February 5 letter a 2012 MedPAC recommendation that would cap total payment for non-emergency department E/M clinic visit services in HOPDs at the rate paid to physicians for providing the services in their private offices. Cuts to E/M services would create even greater shortfalls in Medicare payments and would hamper hospital-physician care integration.

Costs in these hospital-based clinics are higher than in physician offices due to greater regulatory requirements, more medically complex and chronically ill patient populations, stand-by capacity costs related to offering emergency department and other services 24 hours a day, 365 days a year, and the costs of unreimbursed "wrap-around" services needed to support these vulnerable patient populations - such as transportation, case management, and translation services. These costs are spread across all hospital services, including outpatient E/M services.

Of note, it is unclear how Congress would enact these ill-advised recommendations to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. This is because in the calendar year 2014 OPPS final rule, CMS collapsed the ten separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the OPPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement the recommendations, and neither MedPAC nor the Government Accountability Office (GAO) described a way to address this limitation.

Additional Hospital Outpatient Services Identified for Site-Neutral Cuts: MedPAC also has discussed two additional site-neutral policies: 1) broadening the application of its site-neutral payment policy for HOPD services to an additional 66 payment categories, and 2) reducing HOPD payments for 12 APCs that are commonly performed in ASCs to the ASC payment rate.

During the last several years, CMS has implemented sweeping change to hospital OPPS payment policy that would have a substantial impact on MedPAC's site-neutral payment policies and the associated savings estimates. These changes include expanded packaging policies, the use of composite APCs and the implementation of a set of comprehensive APCs that package an expanded number of related items and services contained on the same claim into a single payment for a comprehensive primary service under the OPPS. In general, as CMS carries out its intentions to shift the OPPS away from per-service fee schedule to a prospective payment system with large payment bundles, the package of

services paid under the OPPS will become less comparable to those paid under the PFS and the ASC payment system. As a result, implementing site-neutral payment policies would result in increasingly unfair and inaccurate payments. In addition, these larger payment bundles provide incentives to improve efficiency and better manage resources; however, site-neutral payment policies would hamper this innovation.

Oncology Services: H.R. 2895, the Medicare Patient Access to Cancer Treatment Act of 2015, introduced by Reps. Mike Pompeo (R-KS) and Don Beyer (D-VA) purports to ensure the availability of chemotherapy services by increasing the payments physicians receive to administer chemotherapy to cancer patients in private practice oncology clinics. However, the bill would accomplish this by cutting cancer treatment payments for HOPDs. The consequence of this legislation would be to limit access to chemotherapy services for many cancer patients who now receive their treatment in the outpatient setting of their community hospital.

Hospitals face many challenges in maintaining the full panoply of services that the public expects to receive when they are sick and need care around the clock - challenges that are not confronted by private practice oncology clinics which primarily serve patients who are privately insured. Increased demand for specialized services, staffing shortages, diminishing financial support from Medicare and Medicaid, capital expenses, increased accreditation requirements, and greater expectations for emergency preparedness are just a few of the challenges that hospitals are facing. H.R. 2895 would exacerbate these challenges and result in markedly increased financial stress on hospitals and, therefore, on the patients they serve.

Why Sites are Not Neutral

Hospitals Care for Vulnerable Populations & Treat Sicker Patients: The AHA has found that relative to patients seen in physician offices, patients seen in HOPDs are:

- 2.5 times more likely to be Medicaid, self-pay, or charity patients
- 1.8 times more likely to be dually eligible for Medicare and Medicaid
- 1.8 times more likely to live in high-poverty areas
- 1.7 times more likely to live in low-income areas
- 1.7 times more likely to be Black or Hispanic

There also are key differences between patients treated in ASCs and those receiving similar treatment in HOPDs. The AHA has found that, relative to patients treated in ASCs, patients treated in HOPDs are more likely to be dually eligible for Medicare and Medicaid, to live in areas with higher poverty and lower median household income and to be Black or Hispanic.

Site-neutral payment policies put critical hospital-based services at risk, such as care for low-income patients and underserved populations**.**

Unlike physician offices and ASCs, hospitals play a unique and critical role in their communities by providing a wide range of acute care and diagnostic services, supporting

public health needs, and offering other services that promote the health and well-being of the community. During 2013, Pennsylvania non-profit hospitals provided $6.5 billion in free or subsidized health care, medical education and research, and community improvement. By contrast, many physician offices and ASCs do not serve Medicaid or charity patients.

Hospital-based clinics provide services not otherwise available in the community to vulnerable patient populations. The reduction in outpatient Medicare revenue to hospitals would threaten access to critical hospital-based services, such as care for low-income patients and underserved populations.

Site-neutral payment cuts also would make it harder for HOPDs to continue to care for patients who are too complex for physician offices and ASCs. For example, community physicians refer patients who are too sick for physician offices or too medically complex for ASCs to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients who are burdened with more severe chronic conditions and, in Medicare, have a higher prior utilization of hospitals and emergency departments. In addition, compared to patients treated in ASCs, HOPD patients have more severe comorbid conditions and higher prior utilization of short-term acute care hospitals and emergency departments. We fear that, with a significant reduction in payment, this may no longer be an option or fallback for community physicians.

Hospitals Provide 24/7 Emergency Stand-by Services: Hospitals play a critical role in the communities they serve by providing a wide range of acute care and diagnostic services, supporting public health needs, and offering many other services that promote the health and well-being of the community. While some of these services may be offered by other types of health care providers, three are unique to hospitals. Site-neutral payment policies undercut the ability of hospitals to continue to provide emergency stand-by services that Americans rely upon, such as:

- Around-the-clock access to health care services, including specialized resources
- Safety-net services involving caring for all patients who seek emergency care, regardless of the ability to pay
- Disaster readiness and response capabilities that ensure that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions

These critical services, while often taken for granted, represent essential components of our nation’s health and public safety infrastructure. Medicare beneficiaries and the public consistently express concern that cuts to hospital payments could mean fewer nurses and longer waits in emergency departments. The public also values the safety net that hospitals provide and expects them to be open 24/7 to serve patients and their families.

However, this role is not explicitly funded; there is no payment for a hospital and its staff to be “at the ready” until a patient with an emergency need arrives. The AHA report, “Always There, Ready to Care: The 24/7 Role of America's Hospitals,” outlines the many elements of

standby capacity that allow hospitals to respond to emergencies ranging from multi-vehicle car crashes to hurricanes and terrorist attacks.

Recent events impacting Pennsylvania, like the Ebola outbreak, Hurricanes Irene, Lee and Sandy, and the Papal visit, serve as a reminder of the importance of the hospital community's response capacity.

Direct funding for this capacity is limited, and federal funding for the federal Hospital Preparedness Program declined by more than 50 percent between fiscal years 2003 and 2016. While these funds are very much appreciated by hospitals, they do not come close to meeting the costs of maintaining standby capacity and responding to disasters.

Without such explicit funding, this role is built into the cost structure of full service hospitals and supported by revenue from direct patient care - a situation that does not exist for physician offices, ASCs, or any other type of provider. Hospitals face challenges in maintaining this role, such as staffing and space constraints, greater expectations for preparedness, erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

Hospitals Are Subject to Higher Levels of Oversight: HOPDs must comply with a much more comprehensive scope of licensing, accreditation, and regulatory requirements than do freestanding physician offices and ASCs. While many of these requirements help to ensure a higher level of quality and patient safety, they all impose additional costs. These requirements are important and reflect the broad mission of hospitals to protect and care for their community, patients, staff, and visitors at all times.

Some of the key differences HOPDs face compared to ASCs and physician offices concerning regulatory requirements include:

- Complying with the Emergency Medical Treatment and Active Labor Act (EMTALA)
- State hospital licensure requirements
- Medicare conditions of participation
- Medicare cost reporting requirements

The higher costs associated with these regulations are legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to freestanding physician offices and ASCs.

Site-Neutral Payment Proposals for Post-acute Care

LTCH Site-Neutral Payment: With the passage of the Bipartisan Budget Act of 2013, Congress authorized a transformative form of site-neutral payment for LTCHs. In October 2015, the implementation of LTCH site-neutral payment began and is projected to lower Medicare payments to LTCHs by 73 percent for one out of two current LTCH cases. The

much lower site-neutral rate is similar to the inpatient PPS rate and, in general, applies to lower acuity patients treated in LTCHs. This major change in LTCH payment is subject to a two-year transition that starts with cost reporting periods beginning October 1, 2015, after which LTCH site-neutral payment will be fully phased in.

Given that this major site-neutral change began only recently, now is not the time to expand site-neutral policy in the LTCH PPS. Rather, policymakers should support and study the implementation of this new payment system to ensure that all LTCH patients are able to maintain appropriate access to care, given their high medical acuity.

Site-Neutral Payment under IMPACT Act: Congress initiated additional site-neutral policymaking for post-acute care through the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, enacted in October 2014. Under the IMPACT Act, MedPAC and CMS are required to develop a new post-acute payment system that would base payments on the clinical characteristics of patients, rather than on the setting of care - essentially a site-neutral payment system for all post-acute services.

The first stage of this policy work is underway and will result in a MedPAC report to Congress in June. Following MedPAC's report, CMS will use MedPAC's prototype as a foundation for the development of a full-scale post-acute payment model. Thus, the implementation of the site-neutral mandate in the IMPACT Act already is well underway.

Congress already has charted a course toward comprehensive site-neutral payment for all post-acute providers. Now is not the time to alter this course; rather, policymakers should focus on supporting and engaging in this joint MedPAC and CMS effort to ensure a reliable, accurate, evidence-based and patient-centered outcome.

Additional Site-Neutral Policy Considerations for Post-Acute Care: During 2014, MedPAC made recommendations around site-neutral payment for inpatient rehabilitation facilities (IRF). HAP believes the recommendations are ill-advised. HAP urges consideration of the following issues in the context of site-neutral policies for post-acute care.

- **Match Payment and Regulatory Levels**: Policymakers must pair site-neutral payment with site-neutral regulatory requirements. Absent this parity, true site neutrality cannot be achieved, and instead, an uneven regulatory environment would be created that favors one setting over another. Further, it is imperative to shape any such proposal to fit with existing policies. For example, when implementing LTCH site-neutral payment, substantial and appropriate regulatory relief was provided for cases subject to the far lower site-neutral rate.

- **Common Post-Acute Quality and Patient Assessment Metrics Are Still In Process:** A key component of fair site-neutral payment is the ability to accurately and reliably assess patients' medical needs. However, such assessments for post-acute patients are not yet fully achievable, given risk adjustment limitations and the in-development status of common post-acute patient assessment and quality measures. The IMPACT Act

mandated the implementation of common patient assessment and quality measures for post-acute care, but thus far, CMS has only begun to implement common quality measurement metrics in three of the six mandated domains (functional status, skin integrity, and major falls), and has yet to propose common patient assessment metrics.

- **Include Functional Status When Comparing Post-Acute Services and Payments:** When considering which payment level fits selected groups of post-acute patients, it is inappropriate to group patients solely based upon a patient's prior acute care hospital discharge diagnosis. Doing so has widely recognized limitations because a patient's prior hospital diagnosis is often unrelated to the patient's post-acute diagnosis, which addresses a different recuperative stage in the episode of care. Diagnosis alone - whether a diagnosis from the prior hospital stay or a post-acute discharge - does not reflect functional status, which is critical to post-acute treatment decisions. In addition, cross-setting comparisons of post-acute patients are hampered by the incompatible patient classification systems used in the four post-acute settings, whose systems have widely varied numbers of payment categories and design elements.

- **Most Current Data Is Needed to Capture Recent Changes in the Hospital Field:** It is critical to use the most recent data when considering a major transformation like site-neutral payment. Failure to do so will result in unreliable and misleading results, as the patient populations in the four post-acute systems are in flux due to regulatory pressures and changes in the marketplace, such as bundled payment and the emergence of post-acute provider networks. Collectively, these changes are resulting in higher-acuity case mixes for each of the post-acute settings, as lower-acuity patients in each setting are being transferred to less-intensive sites of care. This rise in overall patient acuity for the four post-acute settings has been validated by MedPAC.

- **Robust Risk Adjustment is Critical:** Policymakers widely acknowledge today's risk adjustment methodologies are lacking. Further resources need to be dedicated to develop and refine the hierarchical condition categories (HCC) risk-adjustment methodology. Better risk-adjustment is needed to ensure that post-acute services are paid accurately, which is critical to support medically appropriate post-acute placements and to prevent unintended barriers to access for high-acuity post-acute patients.

- **Examine Longer Episodes:** When studying post-acute patients to identify conditions that may be considered for site-neutral payment, it is important to study various episode lengths to better capture outcomes for the wide array of post-acute cases, which range from chronic care to post-surgical to extreme medical severity. For example, episode lengths longer than 30 days should be used to examine skilled nursing facility (SNF) services, as one-third of SNF stays exceed 30 days in length. In addition, readmissions patterns for this material portion of SNF stays are not included in MedPAC's 30-day readmissions data.

Thank you for consideration of HAP's comments and concerns, and the impact on hospitals and health systems and the patients they serve in Pennsylvania. If you have any questions,

please feel free to contact me or Laura Stevens Kent, vice president, federal advocacy, at (202) 863-9287.

Sincerely,

Jeffrey W. Bechtel
Senior Vice President, Health Economics and Policy