



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

February 12, 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 American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including 1,115 inpatient rehabilitation facilities (IRFs), 271 long-term care hospitals (LTCHs) and 847 hospital-based skilled nursing facilities (SNFs), thank you for the opportunity to provide feedback to the Energy and Commerce Committee (the Committee) regarding the enactment of Section 603 of the Bipartisan Budget Act of 2015, as well as other so-called site-neutral payment proposals that were raised in the Committee's Feb. 5 letter to the health care community.

The AHA and the hospital field are extremely concerned about site-neutral payment proposals that would reimburse hospitals at the payment rates of facilities with lesser clinical capabilities. Americans rely heavily on hospitals to provide care to all patients 24 hours a day, seven days a week, to serve as a safety-net provider for vulnerable populations, and to respond to every conceivable type of natural and man-made disaster. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure, and in part, supported by revenues received from providing direct patient care across various settings. **Therefore, the AHA urges Congress to reject any further site-neutral payment policies.**

Our detailed comments below explore these issues.

SECTION 603 OF THE BIPARTISAN BUDGET ACT OF 2015

Section 603 includes payment reductions for Medicare services that are furnished in new off-campus hospital outpatient departments (HOPDs). The law excludes from these "site-neutral" payment reductions items and services that are furnished by a dedicated emergency department (DED). A "new" off-campus HOPD is defined as an off-campus department that started billing for Medicare outpatient services under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015, the date of enactment of the law. Starting Jan. 1, 2017, items and services furnished in new off-campus HOPDs (other than those furnished by a DED) will no longer be



The Honorable Fred Upton
The Honorable Joseph Pitts
February 12, 2016
Page 2 of 12

covered as OPSS services. Instead, as of that date, payment would be made under other Medicare Part B payment systems, such as the Medicare physician fee schedule (PFS), the ambulatory surgery center (ASC) payment system or the clinical laboratory fee schedule, as appropriate.

The AHA is deeply disappointed that this law will result in substantial reductions in payments for services furnished in provider-based (PB) HOPDs. The bill defines off-campus PB HOPDs as departments that are not on the main campus of a hospital and are located more than 250 yards from the main campus. The AHA believes that under Section 603 as written, changes in ownership of a facility, or the addition of services, do not impact the grandfathered status of a PB HOPD and that grandfathered HOPDs may relocate when they meet criteria determined by the Department of Health and Human Services (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.

Section 603 is problematic for a number of reasons.

Under Development. The AHA continues to support allowing off-campus PB HOPDs already under development when the Bipartisan Budget Act of 2015 was signed into law to qualify as grandfathered facilities.

Section 603 radically changes Medicare's payment to new off-campus, PB HOPDs. While the provision grandfathers existing facilities, this grandfather protection does not include facilities "under development." Congress historically protects both existing facilities and those under development in which commitments or financial investments had been made when it passes moratoriums on new facilities. The treatment of PB 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 LTCHs, in which Congress protected facilities under development for physician-owned hospital and LTCH moratoriums.

As a matter of fairness, hospitals that have made substantial investments, often tens-of-millions of dollars, in new facilities that were under development when the Bipartisan Budget Act of 2015 was signed into law should be given the same treatment and grandfathering consistent with past precedent.

A legislative fix for facilities under development is time-sensitive. These projects have had a significant financial change thrust upon them with no notice, and bank loan and other financial commitments remain outstanding. Without legislative action from Congress, these projects will begin to make "fish or cut bait" types of decisions, and some projects may be abandoned. That abandonment because of congressional inaction would mean health care sector jobs eliminated, less financial investment in 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 in the next few months that addresses the under development problem.

Systematic Problems of Section 603. There are a variety of additional systematic problems with Section 603 beyond its failing to account for under development facilities – the concept of Section 603 is fundamentally flawed. Most notably, the geographic nature of Section 603 is a bizarre and unworkable long-term plan for the development of outpatient services in the health care system.

The fundamental flaws with so-called site neutral payments will be examined in depth throughout this letter, but it is important that the Committee consider the consequences the geographic component of Section 603 will have on rural and underserved communities. 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, there will be a significant disadvantage to outpatient facilities opening away from a hospital's main geographic campus. Those new facilities will not be built in rural or underserved areas, rather, they will be built on the main campus of existing hospitals. Some hospitals are adjacent to wetlands, rivers, highways, or skyscrapers, factors that prohibit on-campus expansion – essentially land-locking certain hospitals and resulting in an inability to add new outpatient services. Section 603 also will introduce the economic inefficiency of expanding on expensive real estate. The land value to expand on campus often is far higher than building the same outpatient facility elsewhere, but Section 603 will make the inefficiency of paying higher real estate prices a rational decision for economic planners.

All of this means longer travel times for patients to receive care, which may reduce access to health care services in rural and underserved areas. This problem will get worse over time. We recognize the importance of rural health issues to the Committee, and we urge you to consider changing the unfair geographic inequalities Section 603 creates.

Integrated care and a movement from fee-for-service (FFS) payment to outcome and alternative payment methods (APMs) has been a keen interest of the Committee, and one of the most significant legislative achievements of Congress last year. The Medicare Access and CHIP Reauthorization Act and the fixing of physician payment used this concept as its policy focus. 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. Furthermore, the Bipartisan Budget Act of 2015 used Medicare savings on non-health care priorities – using Medicare as a funding source for other government programs is deeply troubling.

If the Committee wants to reform Medicare and move from FFS to APMs, it should allow for the clinical care movement of services from the inpatient to the outpatient setting. However, the negative 12.4 percent underpayment by Medicare is a clear problem. The short-term desire to find savings for other purposes will gradually siphon Medicare resources out of the program, making Medicare reform significantly harder.

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

As noted in the Committee's letter, policymakers are considering a number of site-neutral payment policies in addition to Section 603 of the Bipartisan Budget Act of 2015. These include 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 (APCs), including certain cardiac imaging services, at a residual of the PFS payment; and
- 12 outpatient surgical procedures at the ASC payment rate.

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

The AHA is deeply concerned about these site-neutral payment proposals, which would reimburse hospitals less for specific treatments while still expecting hospitals to continue to provide the same level of service to their patients and communities. Hospitals are the only health care providers that must maintain emergency stand-by capability 24 hours a day, 365 days a year. In addition, hospitals are subject to significant licensing, accreditation, regulatory and quality requirements, none of which would be reduced under the proposed site-neutral payment policies.

Hospitals are already paid less than the cost of care they provide health care services to Medicare patients in HOPDs, and additional payment cuts to HOPDs would threaten beneficiary access to outpatient services. Again, MedPAC reports that hospital outpatient Medicare margins are negative 12.4 percent. The AHA estimates that enacting the three main MedPAC site-neutral payment proposals would further reduce HOPD margins to negative 21.2 percent – an alarming level that could force hospitals to curtail these services and threaten seniors' access to care (see Attachment A). To make matters worse, according to MedPAC, payment policy changes in 2015 and 2016 are expected to reduce Medicare margins even further, and negative Medicare margins are expected in 2016, even for those providers that the commission considers to be “relatively efficient.”

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. In an environment in which hospitals already endure negative margins of 12.4 percent for treating Medicare patients in HOPDs, we are concerned that additional site-neutral cuts would threaten beneficiary access to these services.

Evaluation and Management (E/M) Services. In its letter to the health care community, the Committee notes 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. MedPAC had estimated that this recommendation would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

The Committee also references a similar recommendation to equalize payments between settings for E/M services stemming from a December 2015 Government Accountability Office (GAO) report, “Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform.” GAO used data from 2007 through 2013 to examine the trend in vertical consolidation between hospitals and physicians. It claimed that higher levels of vertical consolidation were associated with more E/M services being performed in HOPDs and that Medicare beneficiaries in counties with higher levels of vertical consolidation were not sicker than those in counties with lower levels of consolidation.

The AHA strongly opposes these approaches because:

- **Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients;**
- **Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity; and**
- **Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.**

Cuts to E/M services would create even greater shortfalls in Medicare payments and would hamper hospital-physician care integration. While the overall cut to U.S. hospitals would be a 2.8 percent cut, impact data from before CMS changed the E/M visit coding structure show that the

impact for major teaching hospitals would be double that amount, a 5.6 percent cut, and urban, public safety-net hospitals would face a 4.6 percent cut. Yet, hospital-based clinics, such as those in teaching and safety-net hospitals, provide services that are not otherwise available in the community to vulnerable patient populations. The disproportionate reduction in outpatient Medicare revenue to these hospitals would threaten access to critical hospital-based services, such as care for low-income patients and underserved populations.

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.

Contrary to the findings in the GAO report, an AHA analysis of Medicare data demonstrates that patient severity for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly 24 percent higher in HOPDs than in physician offices. HOPDs serve a higher percentage of patients who are dually eligible for both Medicaid and Medicare than physician offices.

Lastly, 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 10 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 GAO described a way to address this limitation.

Additional Hospital Outpatient Services Identified for Site Neutral Cuts. MedPAC has also discussed two additional site-neutral policies. **We strongly recommend not implementing these policies, as they would further erode HOPDs’ already substantially negative Medicare outpatient margins.**

MedPAC has recommended broadening the application of its site-neutral payment policy for HOPD services to an additional 66 payment categories. Overall, the impact of these cuts would be very significant. Specifically, MedPAC analysis shows that cuts to these services would decrease Medicare outpatient payments by 2.7 percent, or \$1.44 billion per year. Yet, the services in these 66 APCs are outpatient services that are integral to hospitals’ service mission. When combined with the E/M cuts also recommended by MedPAC, these two site-neutral payment policies would impose deep cuts of more than \$2.3 billion per year to routine outpatient services and would reduce Medicare outpatient payments by 5.5 percent.

Another MedPAC proposal would reduce HOPD payments for 12 APCs that are commonly performed in ASCs to the ASC payment rate. The impact of this approach also would be significant. Currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD, and the commission estimates that this policy would reduce hospital outpatient payment by \$590 million per year, or 1.7 percent.

In the last several years, CMS has implemented several sweeping change to hospital OPSS 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 OPSS. In general, as CMS carries out its intentions to shift the OPSS away from per-service fee schedule to a prospective payment system with large payment bundles, the package of services paid under the OPSS 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.

H.R. 2895: Medicare Patient Access to Cancer Treatment Act of 2015. H.R. 2895, 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 care for all patients who seek emergency care, regardless of their insurance status or ability to pay; maintain standby disaster readiness capacity in the event of a catastrophic occurrence; and treat patients who are too sick and require more complex services than those treated by private physician practices. In addition, HOPDs provide services to all Medicare and Medicaid patients seeking treatment, which is not the case for many private physician practices. In fact, media [reports](#) have detailed how private practice oncology clinics are turning away Medicare patients. Therefore, while HOPDs are seeing an increased number of patients, part of that is because private practice oncology clinics primarily serve only those patients who are privately insured – they are declining to care for Medicare beneficiaries. HOPDs serve patients with more complicated conditions and a higher case-mix, and do not refuse to treat Medicare and Medicaid patients.

Some have incorrectly claimed that the 340B Drug Pricing Program, which provides discounted outpatient drug prices for safety-net providers, is a main driver of consolidation in the oncology field. Rather, larger market forces have influenced independent oncology practices to merge with their community hospitals. Hospitals are strengthening ties to each other and to physicians in an

effort to respond to new global and fixed payment methodologies, as well as incentives for improved quality and efficiency, implementation of electronic health records and care that is more coordinated across the continuum. 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.

As stated above, 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. 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.

Hospitals Care for Vulnerable Populations. 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. For example, hospitals provided \$42.8 billion in uncompensated care in 2014. 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. For example, 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; and
- 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, patient 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.

Hospitals Provide 24/7 Emergency Stand-by Services. We urge Congress to consider the unique and critical role hospitals play 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 so heavily, 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; and
- 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. Despite its importance, 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 stand-by capacity that allow hospitals to respond to emergencies ranging from multi-vehicle car crashes to hurricanes and terrorist attacks. Recent events like the Ebola outbreak, Hurricane Sandy and the Boston Marathon bombings serve as a reminder that we, as a society, need this 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 year 2003 and 2016. While these funds are very much appreciated by hospitals, they do not come close to meeting the costs of maintaining stand-by 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 stand-by role.

Hospitals Treat Sicker Patients. **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 Are Subject to Higher Levels of Oversight. HOPDs must comply with a much more comprehensive scope of licensing, accreditation and regulatory requirements than do free-standing 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. Attachment A highlights some of the key differences HOPDs face compared to ASCs and physician offices concerning regulatory requirements, which include complying with the Emergency Medical Treatment and Active Labor Act (EMTALA), state hospital licensure requirements, the voluminous Medicare conditions of participation, and Medicare cost reporting requirements, among others. The higher costs associated with these regulations are legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to free-standing physician offices and ASCs.

SITE NEUTRAL PAYMENT PROPOSALS FOR POST-ACUTE CARE

In recent years, Congress has adopted site-neutral payment 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 Oct. 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 is already well underway. **Congress has already 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. In 2014, MedPAC made recommendations around site-neutral payment for IRFs. The AHA is concerned that paying for care in IRF and SNF settings in a truly site-neutral manner is extremely complex, would be difficult to achieve and is ill-advised. With that in mind, we urge Congress to consider the following cautions and concerns, with regard to both IRF site-neutral policies, as well as other post-acute site-neutral policies. **Most notably, it is imperative that, for services subject to site-neutral payments, providers face a level playing field with respect to regulatory requirements.**

- Match Payment and Regulatory Levels. If considering site-neutral payment for post-acute patients, policymakers must pair this effort 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. As noted above, the AHA is encouraging the dedication of further resources to develop and refine the 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 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 in advance for your consideration of these issues. If you have any questions, please contact me, Aimee Kuhlman, senior associate director of federal relations, at (202) 626-2291 or akuhlman@aha.org, or Roslyne Schulman, director of policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

cc: The Honorable Frank Pallone, Jr., Ranking Member
The Honorable Gene Green, Ranking Member,
Subcommittee on Health

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety net provider for vulnerable populations, and to have the resources needed to respond to disasters. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements than other settings.

Yet some policymakers want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center (ASC).

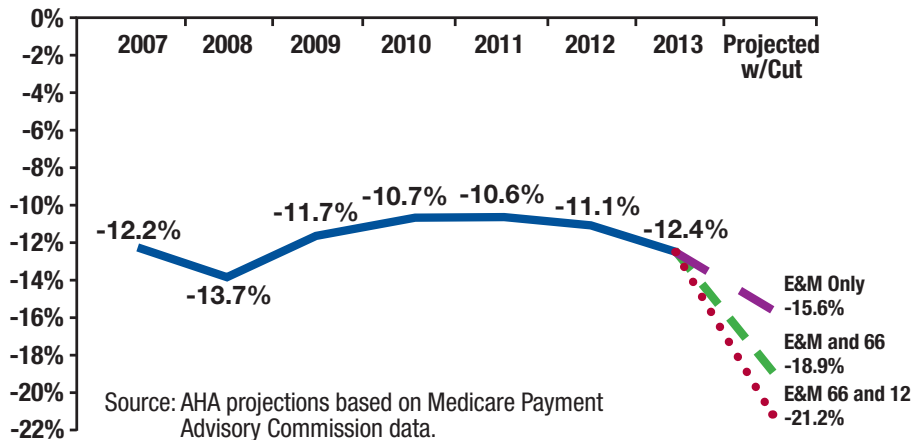
Lawmakers are considering three site-neutral payment changes that would result in lower payments to hospitals.

- Paying hospitals for evaluation and management (E/M) services in the hospital outpatient department (HOPD) setting at the physician fee schedule (PFS) amount
- Paying hospitals for 66 specified ambulatory payment classifications (APCs) at the PFS amount
- Capping hospital payments for 12 proposed APCs at the ASC rate

According to the Medicare Payment Advisory Commission, Medicare margins are already negative 12.4 percent for outpatient services.

Implementing these policies would further erode HOPDs' Medicare margins, threatening access to care.

Medicare Margins for Hospital Outpatient Department Services, 2007-2013 and Projected with Proposed Cuts



Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Back up for Complications Occurring in Other Settings	✓		
Disaster Preparedness and Response	✓		
EMTALA Requirements	✓		
Uncompensated Care/Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✓		
Infection Control Program	✓	✓	
Quality Assurance Program	✓	✓	
Joint Commission Accreditation	✓	✓	
Life and Fire Safety Codes	✓	✓	✓
Malpractice Insurance	✓	✓	✓
Admin Staff/Billing	✓	✓	✓
Medical Supplies	✓	✓	✓
Nurses	✓	✓	✓
Space and Utilities	✓	✓	✓