American Hospital Association

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March 27, 2013

Glenn M. Hackbarth
64275 Hunnell Road
Bend, OR 97701

Dear Mr. Hackbarth:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) remains extremely concerned that the Medicare Payment Advisory Commission (MedPAC) is considering broadening application of its "site- neutral" payment policy to other hospital outpatient department (HOPD) services beyond the 10 evaluation and management (E/M) services included in its March 2012 Report to Congress. Specifically, at its March 2013 meeting, the Commission discussed broadening its site-neutral policy to an additional 66 ambulatory payment classifications (APCs)[i]. It also discussed broadening the policy to 12 APCs for surgical services, presumably reducing payment for these 12 APCs to the level paid to ambulatory surgical centers (ASCs). It is our understanding that the Commissioners intend to include these discussions and their related analysis in a chapter in MedPAC's forthcoming June 2013 Report to Congress.

The AHA believes that it would be premature and ill-advised to include a site-neutral payment policy chapter in MedPAC's June 2013 report. Given the complexity involved in crafting a site-neutral payment policy, the disproportionate impact that even small methodological decisions have on the analytical outcome and on hospital payments, and the many remaining unanswered questions about the underpinning analysis, the AHA believes that an increased level of transparency regarding the Commission's methodology and a more robust analysis of impact is absolutely necessary before this issue is committed to a published chapter. Including a chapter in the June report, even with appropriate "context" and even without any recommendations, could absolutely be used to justify congressional site-neutral payment reductions to hospitals, despite assertions otherwise.

The impact of these potential cuts is very significant. Although MedPAC staff did not provide exact estimates, based on the information provided, the impact of implementing site-neutral payments for all three groups of APCs described above would likely be well over $2 billion in a single year.[ii] Together, the three policies would reduce payments to the chronically underfunded Medicare outpatient system by 5.5 percent, and reduce hospitals' Medicare outpatient margins from *negative* 11 percent to *negative* 17 percent, all else being equal. To make matters worse, this margin does not take into account additional cuts that hospitals are facing, such as the *Budget Control Act's* 2 percent across-the-board sequester, continued marketbasket cuts for productivity, cuts in disproportionate

share hospital payments, increasing readmissions penalties, meaningful use penalties, and the hospital-acquired condition policy, among others. Additional and onerous site-neutral cuts would put access to hospital services at risk, particularly considering that the Commission felt it appropriate to recommend in its March 2013 report that Congress *increase* payment rates for the outpatient prospective payment system (PPS) by 1 percent in 2014.

MORE TRANSPARENCY NEEDED REGARDING COMPLEX ANALYSIS

The complexity of the payment systems involved in MedPAC's site-neutral payment policy analysis means that any number of small technical and methodological decisions used to identify candidate APCs and calculate payment rates could have a disproportionate impact on the outcome of the analysis. **To that effect, despite considerable effort, including a meeting with MedPAC staff to discuss its methodology, the AHA cannot replicate the Commission's analysis leading to the selection of the 71 (now 66) APCs. When we modeled MedPAC's inclusion criteria, we were only able to validate 39 of the 71 APCs as meeting its criteria (see attached spreadsheet).** For example, in our analysis, APC 0269, Level II Echocardiogram, would not meet the criteria for inclusion in the policy because it is performed with an emergency department (ED) visit 20 percent of the time. This falls well outside the Commission's criterion to include APCs performed with an ED visit less than 10 percent of the time. The fact that this single APC accounts for a quarter of the overall payment impact only heightens our concern about the robustness of the Commission's analysis. More transparency is absolutely necessary.

Much of the analysis's complexity relates to the fact that each APC contains multiple Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes and the composition varies significantly each year. The definitions of the HCPCS/CPT codes also change over time as technology and clinical practice evolve. For example, in 2011, CMS moved CPT code 93307 from APC 0697, Level I Echocardiogram without contrast, to APC 0269. This same code was also redefined in 2009. It is not clear whether or how MedPAC staff accounted for these changes in their analysis, or in their data on volume changes for echocardiography as presented at the December and March meetings. In recent presentations, MedPAC staff noted changes in APC volumes for select echocardiography services from 2010 to 2011, and implied that the changes were due to hospital employment of cardiologists and incentives to shift services from a lower-paid to a higher-paid setting. However, such changes also could be due to changes in the composition of the APCs, changes in the definitions of the HCPCS/CPTs, or changes in practice that stem from advances in technology. In addition, we also note that, overall, the great majority of these cardiac imaging services (around 70 percent) were still performed in physician offices in 2011.

The fact that each APC contains multiple HCPCS codes also makes it challenging to determine what the actual payment rate to the hospital would be under this policy, as under the physician fee schedule (PFS), each HCPCS code has a unique payment rate that changes annually based on relative value units for work, practice expense and malpractice. The annual changes to the APCs and in their component CPT/HCPCS codes would mean that, from one year to the next, there could be great variation in which APCs would meet the criteria to be paid under a site-neutral policy, leading to tremendous instability in hospital payments. It also is unclear how the payment rates for all outpatient services would be updated over time, since the site-neutral policy would destroy the central mechanism of the outpatient PPS, which sets relative payments across services provided in the HOPD, and annually places clinically related services into APCs based on whether they have similar costs.

COMMISSIONERS' QUESTIONS REMAIN UNRESOLVED

We are concerned that many of the analyses requested and questions asked by Commission members at the last several meetings have not been addressed in the public meetings and related staff presentations. For instance, one Commissioner asked that the impact of the site-neutral policies on hospital Medicare margins be disclosed. Another requested an evaluation of the possibility of implementing the site-neutral policies in a budget-neutral manner so as to avoid further reductions in the already-negative Medicare outpatient and overall hospital margins. Another request involved an analysis of PFS payment for facility and non-facility practice expense for each of the APCs that met the MedPAC criteria so that this could be compared to what the hospital would receive under the site-neutral methodology. None of these analyses have been discussed publicly, yet they are critical to providing stakeholders with a full understanding of the possible impact of a site-neutral payment policy.

HOSPITALS' EMERGENCY RESPONSE CAPACITY WOULD BE ENDANGERED

HOPDs differ from ASCs and physician offices by providing a wide range of essential acute-care and diagnostic services, supporting public health needs, and providing access to care to vulnerable patient populations that is not otherwise available in the community. They also provide 24/7 access to emergency care and standby capacity for emergency and disaster response that is not separately funded and must be built into the payments for *all* services, not just for emergency services. **The commission must realize that, without adequate, explicit funding, the stand-by 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 or any other type of provider.**

PAYMENT AMOUNTS SHOULD BE SET APPROPRIATELY

The AHA strongly opposes paying for HOPD services at the ASC rate or at a rate equal to a residual amount from the PFS. MedPAC's proposals assume that the Medicare PFS and the ASC payment rates somehow reflect the "correct" rate to pay for outpatient services, when, in fact, it is difficult to determine how well Medicare payment rates reflect the actual costs of specific services. It is fair to say that the differences in the payment rates for similar services across ambulatory settings are largely artifacts of the very different and complex methodologies that Congress enacted and that the Centers for Medicare & Medicaid Services (CMS) implemented under the outpatient PPS, PFS and the ASC payment systems. But outpatient PPS payments are the only payments based directly on provider data – audited cost reports and claims data – and have been found by MedPAC to be significantly below cost. In contrast, neither physicians nor ASCs are required to report their costs to Medicare; therefore, it is not known how adequate and appropriate their payment rates are. While the Commission's discussion has 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 or ASC settings, it also should question whether the rates in the lower-payment settings are adequate and appropriate in the first place.

There also is an unresolved circularity in the notion of applying the ASC payment rates to HOPD services. ASC payments are, by law, calculated using the outpatient PPS payment weights for individual services. It is inappropriate for MedPAC to potentially recommend paying for HOPD services at the ASC rate when the ASC rate is determined based on outpatient PPS payments. We are concerned that doing so would undermine both payment systems.

We appreciate your consideration of this very important issue and urge the Commission not to include a site-neutral payment policy chapter in its June 2013 Report to Congress. A complete, transparent analysis and debate is necessary before a public chapter is issued.

If you have any questions, please feel free to contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Cc: Mark Miller, Ph.D.
MedPAC Commissioners

Attachment

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[i] MedPAC staff previously shared a list of 71 APCs with national hospital organizations. We are unclear as to which five APCs have fallen off the list due to a change in the Commission's proposed methodology.
[ii] Although the Commission staff estimated the impact of each policy separately, they stated that the impact of imposing the E/M policy, the 66 APC policy and the 12 surgical APC policy would not be additive due to overlap in some of the APCs.

Attachment

THE MORAN COMPANY

Table 7

Modeling of Site Neutral Policy -- Outpatient

What MedPAC APCs qualify based on Moran Company modeling

Prepared for AHA

Source: OPPS 2010 final data, Final CY2013 Impact file and Rule, 2010 Computed mapping, 2010 SAF

Date: January 31, 2013, revised 3/24/13 to display OPPS payment column

Note: Uses mapping of APCs that was "reverse engineered" from the 2010 SAF.

Note: These are the 71 APCs MedPAC had previously identified.

Number matching
39

Total

$ 3,790,180,749

Criteria

APC	APC Title	OPPS Payment	Less than 5% volume in global codes	Greater than 50% in office	Less than 10% in ED	Similar HCCs	**Qualify on all 3**
0001	Level I Photochemotherapy	$ 2,137,208	Yes	Yes	Yes	Yes	**Yes**
0002	Fine Needle Biopsy/Aspiration	$ 1,253,390	Yes	Yes	Yes	Yes	**Yes**
0007	Level II Incision & Drainage	$ 8,952,650	Yes	Yes	No	Yes	**No**
0012	Level I Debridement & Destruction	$ 2,366,898	Yes	Yes	Yes	No	**No**
0013	Level II Debridement & Destruction	$ 34,377,459	Yes	Yes	Yes	Yes	**Yes**
0015	Level III Debridement & Destruction	$ 41,989,211	Yes	Yes	Yes	Yes	**Yes**
0017	Level VI Debridement & Destruction	$ 9,604,889	Yes	Yes	Yes	Yes	**Yes**
0019	Level I Excision/ Biopsy	$ 17,871,425	Yes	Yes	Yes	Yes	**Yes**
0020	Level II Excision/ Biopsy	$ 54,126,368	No	Yes	Yes	Yes	**No**
0060	Manipulation Therapy	$ 296,643	Yes	Yes	Yes	No	**No**
0073	Level III Endoscopy Upper Airway	$ 3,288,610	Yes	Yes	Yes	Yes	**Yes**
0074	Level IV Endoscopy Upper Airway	$ 46,328,829	Yes	Yes	Yes	Yes	**Yes**
0078	Level III Pulmonary Treatment	$ 32,750,366	Yes	Yes	Yes	Yes	**Yes**
0096	Level II Noninvasive Physiologic Studies	$ 22,985,991	Yes	Yes	Yes	Yes	**Yes**
0121	Level I Tube or Catheter Changes or Repositioning	$ 22,535,823	Yes	Yes	Yes	Yes	**Yes**
0126	Level I Urinary and Anal Procedures	$ 5,340,303	Yes	Yes	Yes	Yes	**Yes**
0142	Small Intestine Endoscopy	$ 12,068,289	Yes	Yes	Yes	Yes	**Yes**
0146	Level I Sigmoidoscopy and Anoscopy	$ 15,030,585	Yes	Yes	Yes	Yes	**Yes**
0156	Level III Urinary and Anal Procedures	$ 11,582,952	Yes	Yes	Yes	Yes	**Yes**
0160	Level I Cystourethroscopy and other Genitourinary Procedures	$ 42,048,955	Yes	Yes	Yes	Yes	**Yes**
0164	Level II Urinary and Anal Procedures	$ 7,172,255	Yes	Yes	No	Yes	**No**
0165	Level IV Urinary and Anal Procedures	$ 7,999,650	Yes	Yes	No	Yes	**No**
0188	Level II Female Reproductive Proc	$ 3,999,465	Yes	Yes	Yes	No	**No**
0191	Level I Female Reproductive Proc	$ 236,705	Yes	Yes	Yes	Yes	**Yes**
0192	Level IV Female Reproductive Proc	$ 3,140,739	Yes	Yes	Yes	Yes	**Yes**
0203	Level IV Nerve Injections	$ 4,045,445	Yes	Yes	Yes	No	**No**
0204	Level I Nerve Injections	$ 94,876,260	Yes	Yes	Yes	Yes	**Yes**
0206	Level II Nerve Injections	$ 44,698,851	Yes	Yes	Yes	No	**No**
0207	Level III Nerve Injections	$ 394,513,093	Yes	Yes	Yes	No	**No**
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	$ 256,557,582	Yes	Yes	Yes	No	**No**

0215 Level I Nerve and Muscle Tests	$	726,632	Yes	Yes	Yes	No	**No**
0216 Level III Nerve and Muscle Tests	$	1,978,693	Yes	Yes	Yes	No	**No**
0218 Level II Nerve and Muscle Tests	$	6,754,148	Yes	Yes	Yes	No	**No**
0231 Level III Eye Tests & Treatments	$	4,246,393	Yes	Yes	Yes	Yes	**Yes**
0238 Level I Repair and Plastic Eye Procedures	$	15,677,023	Yes	Yes	Yes	No	**No**
0239 Level II Repair and Plastic Eye Procedures	$	3,204,740	Yes	Yes	Yes	Yes	**Yes**
0265 Level I Diagnostic and Screening Ultrasound	$	31,215,615	Yes	Yes	Yes	No	**No**
0267 Level III Diagnostic and Screening Ultrasound	$	174,741,217	Yes	Yes	No	Yes	**No**
0269 Level II Echocardiogram Without Contrast	$	412,349,578	Yes	Yes	No	Yes	**No**
0270 Level III Echocardiogram Without Contrast	$	56,049,559	Yes	Yes	Yes	Yes	**Yes**
0275 Arthrography	$	10,874,160	Yes	Yes	Yes	No	**No**
0288 Bone Density:Axial Skeleton	$	65,028,262	Yes	Yes	Yes	No	**No**
0300 Level I Radiation Therapy	$	7,761,488	Yes	Yes	Yes	Yes	**Yes**
0336 Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	$	480,116,997	Yes	Yes	Yes	Yes	**Yes**
0341 Skin Tests	$	209,067	Yes	Yes	Yes	Yes	**Yes**
0344 Level IV Pathology	$	15,188,139	Yes	Yes	Yes	Yes	**Yes**
0363 Level I Otorhinolaryngologic Function Tests	$	730,980	Yes	Yes	Yes	No	**No**
0364 Level I Audiometry	$	3,084,830	Yes	Yes	Yes	Yes	**Yes**
0365 Level II Audiometry	$	7,463,534	Yes	Yes	Yes	Yes	**Yes**
0366 Level III Audiometry	$	1,016,155	Yes	Yes	Yes	Yes	**Yes**
0368 Level II Pulmonary Tests	$	16,363,652	Yes	Yes	Yes	Yes	**Yes**
0369 Level III Pulmonary Tests	$	3,934,203	Yes	Yes	Yes	Yes	**Yes**
0370 Allergy Tests	$	25,872	Yes	Yes	Yes	Yes	**Yes**
0373 Level I Neuropsychological Testing	$	83,064	Yes	Yes	Yes	Yes	**Yes**
0377 Level II Cardiac Imaging	$	418,633,847	Yes	Yes	No	No	**No**
0381 Single Allergy Tests	$	3,271,718	Yes	Yes	Yes	No	**No**
0382 Level II Neuropsychological Testing	$	2,182,886	Yes	Yes	Yes	No	**No**
0383 Cardiac Computed Tomographic Imaging	$	4,761,350	Yes	Yes	Yes	No	**No**
0398 Level I Cardiac Imaging	$	8,404,185	Yes	Yes	Yes	Yes	**Yes**
0412 IMRT Treatment Delivery	$	547,284,398	Yes	Yes	Yes	Yes	**Yes**
0426 Level II Strapping and Cast Application	$	5,261,461	Yes	Yes	Yes	Yes	**Yes**
0428 Level III Sigmoidoscopy and Anoscopy	$	1,043,745	Yes	No	Yes	No	**No**
0440 Level V Drug Administration	$	211,281,904	Yes	Yes	Yes	Yes	**Yes**
0660 Level II Otorhinolaryngologic Function Tests	$	6,711,161	Yes	Yes	Yes	No	**No**
0678 External Counterpulsation	$	1,747,548	Yes	Yes	Yes	Yes	**Yes**
0689 Level II Electronic Analysis of Devices	$	12,259,945	Yes	Yes	Yes	No	**No**
0690 Level I Electronic Analysis of Devices	$	5,897,619	Yes	Yes	Yes	No	**No**
0692 Level III Electronic Analysis of Devices	$	4,320,634	Yes	Yes	Yes	No	**No**
0697 Level I Echocardiogram Without Contrast	$	20,176,709	Yes	Yes	No	Yes	**No**
0698 Level II Eye Tests & Treatments	$	12,055,041	Yes	Yes	Yes	Yes	**Yes**
0699 Level IV Eye Tests & Treatments	$	1,885,711	Yes	Yes	Yes	No	**No**