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December 5, 2016

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W. Suite 701
Washington, DC 20001

Dear Dr. Crosson:

At its November meeting, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed provider consolidation and its impact on site-neutral payment policy, as well as stand-alone emergency departments (EDs). Both of these issues are of critical importance to hospitals, health systems and other providers, and the Medicare beneficiaries they serve. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) asks that the Commissioners consider the following issues before making draft recommendations related to these two topics.

PROVIDER CONSOLIDATION: THE ROLE OF MEDICARE POLICY

In November, MedPAC discussed policy options that would address various types of consolidation, including horizontal consolidation, vertical financial integration and vertical integration of provider functions and insurance risk. Specifically, the Commission discussed, in the context of vertical integration, whether it should reiterate past recommendations it has made on site-neutral payments, and/or whether it should advance new recommendations on the issue. For example, previous recommendations included reducing payment for hospital evaluation and management (E/M) clinic visit services; reducing or eliminating differences in payment rates between hospital outpatient departments (HOPDs) and physician offices for 66 selected ambulatory payment classifications (APCs); and applying a site-neutral payment policy to a set of 12 surgical service APCs.

The AHA strongly opposes these site-neutral payment options. We believe it is premature and potentially disruptive to providers, patients and communities to recommend or implement additional site-neutral policies while providers are currently in the midst of implementing the site-neutral policies contained in the Bipartisan Budget Act of 2015 (BiBA).

Below we detail some of the reasons and benefits to hospital realignment and why site neutral recommendations would be premature and disruptive.



Reasons for and Benefits of Hospital Realignment

Unlike the recent insurance deals that appear motivated by top-line profits, hospital realignment is a procompetitive response to the major forces reshaping the health care system, including the need for hospitals to build a continuum of care, move toward value-based care, adhere to capital pressures and provide new health care services to patients.

Building a Continuum of Care. There has been widespread recognition of the need to replace a “siloeed” health care system with a continuum of care that improves coordination and quality and reduces costs for patients. Building this continuum demands that providers be more integrated, which can take many forms. For example, hospitals, physicians, post-acute care providers and others in the health care chain can integrate clinically or financially, horizontally or vertically, and the relationships can range from loose affiliations to complete mergers. Hospitals and patients benefit when a hospital realigns. The most common benefits are improved coordination across the care continuum, increased operational efficiencies, greater access to cash and capital for smaller or financially distressed hospitals, and support for innovation, including payment alternatives that entail financial risk. For financially struggling hospitals, finding a partner can make all the difference.

Movement Toward a Value-based Reimbursement System. Increasingly, reimbursement models are being recast to compensate providers based on outcomes achieved rather than the volume of services provided. These outcomes include keeping patients well (population health) and providing high-quality services when patients are in the hospital. The Centers for Medicare & Medicaid Services (CMS) has made substantial progress on its aggressive goals to move to alternative models of reimbursement that reward value. In that process, the agency has recognized that achieving these goals would require hospitals to make fundamental changes in their day-to-day operations to improve the quality and reduce the cost of health care.¹ As a result, many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve higher-quality care at lower costs. These reforms require further integration and include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Increased Capital Requirements. The fundamental restructuring needed to support alternative reimbursement models is challenging, and is particularly difficult for small and stand-alone hospitals. Already, the field is under serious financial pressure given hospital capital expenditures, particularly for health information technology (IT) and electronic health records (EHRs). In fact, the AHA estimates that hospitals collectively spent \$47 billion on IT, including EHRs, each and every year between 2010 and 2013. EHRs are essential to improving care and, consequently, succeeding in value-based reimbursement models. Moreover, a portion of Medicare and Medicaid reimbursement is conditioned on EHR adoption and use.

¹ CMS Healthcare Learning Action Network. Last accessed 11/23/16 at: <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>.

In addition, for many hospitals, the credit markets are already difficult to access. A Fitch Rating report recently indicated that, starting in 2011, the profitability “metrics” for the lowest-rated hospitals – smaller or stand-alone hospitals – have declined.² The debt burden for these same hospitals has continued to grow, and their operating margins are low. For these hospitals, accessing the credit markets for capital improvements, including technology, will be difficult, if at all possible. Without this access, these hospitals will continue to decline and may potentially close their doors, both of which could have devastating repercussions for the communities they serve.

New Competition for Hospital Services. Rapid changes in the health care market are providing consumers with an increased array of options for their health care. CVS, Walgreens and Wal-Mart, among others, are changing where consumers go for their health care needs. The retailers offer an array of health care services, including primary care, immunizations, blood pressure monitoring and routine blood tests, all of which were formerly available only in a doctor’s office or hospital outpatient clinic or emergency room. Many of these retailers plan to provide even more sophisticated care and services at their thousands of convenient locations in the future. These developments challenge hospitals to become more integrated with physicians and other providers so that they too can offer convenient and more affordable care that is attractive to patients.

Site-neutral Recommendations Would be Premature and Disruptive

Commissioners also discussed, in the context of vertical integration, whether MedPAC should continue to advance the site neutral policies it has proposed in the past or different policies. **The AHA strongly believes that it is premature and would be disruptive to providers, patients and communities to implement conflicting, potentially overlapping or entirely new site-neutral payment policies given CMS’s current efforts to implement on Jan. 1, 2017 the site-neutral payment policies enacted by Congress in Section 603 of BiBA.**

BiBA requires that, with the exception of dedicated ED services, services furnished in off-campus provider-based departments that began furnishing covered outpatient department services on or after Nov. 2, 2015 no longer be paid under the outpatient prospective payment system (OPPS), but instead under another applicable Part B payment system. The agency just recently issued its final rule on these policies, which will go into effect Jan. 1, 2017. Thus, we do not yet fully understand the full implications of how these policies will affect patient access to hospital-level outpatient care, making it inadvisable to layer on additional or conflicting policies.

Hospitals already suffer negative margins treating Medicare patients in HOPDs. In fact, according to MedPAC’s June 2015 data book, Medicare margins were negative 12.4 percent for outpatient services in 2013.³ The site-neutral payment policies implemented by CMS for 2017 and beyond will reduce these margins further. We are concerned that imposing further payment

² Fitch Ratings, 2015 Medium Ratios for Nonprofit Hospitals and Health Systems, Special Report, August 10, 2015.

³ This is the latest data available; Medicare margins were not published in the 2016 MedPAC databook.

reductions by implementing MedPAC's site-neutral payment recommendations would threaten beneficiary access to critical hospital-based "safety-net" services. HOPDs provide services that are not otherwise available in the community to vulnerable patient populations, such as low-income medically complex and dual-eligible patients.

In addition, the AHA continues to oppose the Commission's previous site-neutral payment recommendations. The Commission has recommended a variety of site-neutral payment policies in past years, including reducing payment for hospital E/M clinic visit services; reducing or eliminating differences in payment rates between HOPDs and physician offices for 66 selected APCs; or applying a site-neutral payment policy to a set of 12 surgical service APCs. Each year, the AHA has raised its concerns related to these recommendations. Our concerns remain and are discussed in more detail below.

- Site-neutral payment proposals 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 provider that must maintain emergency stand-by capability 24 hours a day, 365 days a year. In addition, hospitals are subject to significantly greater licensing, accreditation, regulatory and quality requirements than other providers, none of which would be reduced under the proposed site-neutral payment policies. Moreover, hospitals provide access to critical standby services, such as burn care, and remain ready to treat patients from natural and man-made disasters. This 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. Additional, site-neutral payment reductions would endanger hospital's ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response.
- Payment to hospitals for outpatient care should reflect HOPD costs, not physician or ambulatory surgery center (ASC) payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule, in particular the practice expense component, which is relevant for the site-neutral payment methodology, is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment "fixes." ASCs do not even report their costs. In this year's OPSS final rule, CMS appeared to agree stating: "We believe that...the quality of the data currently used to develop payment rates under the OPSS, including hospital claims data and cost reporting, far exceeds the quality of data currently used for [Medicare physician fee schedule] payments."⁴ In fact, the agency noted it would like to use the OPSS data in the physician fee schedule rate-setting in future years.
- The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC's site-neutral policy unstable, with any number of small technical

⁴ Federal Register, Vol. 81, No. 219, Monday, November 14, 2016, Page 79722.

and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.

- In addition, the sweeping changes that CMS has made to the OPSS since MedPAC first took on site-neutral payment policy in 2012 have had a substantial impact on the Commission's site-neutral recommendations. **The AHA urges MedPAC to review these OPSS changes and the impact they have on hospital payment before advancing its current or new site-neutral payment policies.** In particular, the calendar year 2014 OPSS final rule collapsed the 10 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, including the distinctions between new and established patient visits, are no longer recognized in the OPSS. The adoption of a single code for all hospital outpatient clinic visits means that there are no longer any E/M codes recognized in both the OPSS and the physician fee schedule that can be used to calculate the reduced HOPD payment rate for clinic visits under MedPAC's site-neutral E/M payment policy. Given this change, the AHA is uncertain how the E/M policy, as recommended by MedPAC, could be enacted by Congress.

In addition, since 2012, CMS has implemented expanded packaging policies and 62 comprehensive APCs that package together a number of related items and services contained on the same claim into a single payment for a comprehensive primary service under the OPSS. **These policies significantly increase the amount of packaging in all APCs and will likely affect the possible savings that could be achieved through MedPAC's recommended site-neutral payment policies. MedPAC should carefully evaluate and discuss the implications of these changes before advancing any site-neutral recommendations.**

STAND-ALONE EMERGENCY DEPARTMENTS

At the November meeting, MedPAC staff discussed trends in the growth, patient mix, coverage and regulation of hospital-based off-campus EDs (OCED) and independent freestanding emergency centers (IFEC). Commissioners discussed several policy options related to OCEDs and IFECs, including potentially recommending that CMS begin tracking OCEDs in Medicare claims data, examine incentives that may be encouraging providers to serve patients in the ED setting, and re-examine the ED exemption contained within BiBA, the site-neutral law. Our thoughts on each of these policy options follows.

- Tracking OCEDs in Medicare Claims Data. CMS does not separately identify claims or services provided in OCEDs. The claims are subsumed by the main provider hospital, making it difficult to fully understand the type, scope and cost of services offered in this setting. **As such, we believe it may be worthwhile for CMS to begin to track OCEDs in the Medicare claims data, provided the mechanism used to do so is not overly costly or burdensome for hospitals to implement.**

- Incentives Encouraging Providers to Serve Patients in the ED Setting. **We welcome further examination by the Commission of the incentives that may encourage hospitals to consider providing services to patients in OCEDs.** Hospitals have the best interests of patients and their communities in mind when they begin to provide ED services in new off-campus locations.
- Re-examination of the BiBA ED Exemption. **The AHA strongly opposes revocation of the ED exemption in BiBA.** As indicated above, to do so would be premature and would be disruptive to care, particularly without a comprehensive understanding of the type and level of care furnished in these EDs and in the absence of substantial evidence that OCEDs are growing in inappropriate ways. Further, layering additional site-neutral reductions on top of CMS's already complex plan to implement site-neutral payment policies in 2017 would be confusing and could have many unintended consequences for hospitals, their patients and communities.

In addition to our thoughts above, we have several general comments related to the discussion of this topic at the November meeting.

Stand-alone EDs in Non-Rural Communities. In the Commission's June 2016 Report, MedPAC recommended the creation of a freestanding ED designation as an option for preserving access to essential emergency services in rural communities. As such, during the November meeting, MedPAC staff indicated that its examination and associated policy options were limited to IFECs and OCEDs in non-rural areas. **The AHA is concerned that this distinction is shortsighted. Indeed, stand-alone EDs have the potential to preserve access to emergency services in both rural and urban communities.**

The AHA has recommended such a model as part of its [Task Force on Ensuring Access in Vulnerable Communities Report](#), which includes nine strategies that could preserve access to essential health care services (including primary care, emergency and observation, and psychiatric and substance use treatment services) in vulnerable rural and urban inner-city communities. The Emergency Medical Center (EMC) strategy would allow existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs would provide emergency services (24 hours a day, 365 days a year) and transportation services. They also could provide outpatient services and post-acute care services, depending on a community's needs. Allowing this model to serve as a solution for both rural and urban communities will allow these communities to provide care in a manner that best fits its needs and circumstances.

Differences between OCEDs and IFECs. The AHA is concerned that considering provider-based OCEDs in the same category as IFECs is misleading and inappropriate given the important differences between the two. Specifically, IFECs do not meet the same requirements as OCEDs. For example, hospital-based EDs, including OCEDs must offer a hospital-level of care, with access to specialized services, linkages to inpatient care and hospital-based physicians, and the

opportunity for continuity of care through the hospital's electronic medical record. IFECs are not required to do the same.

In addition, OCEDs, but not IFECs, must comply with Medicare's provider-based regulations that ensure that care provided is integrated into the main provider clinically, financially, administratively, in public perception and through common state licensure. Further, OCEDs must comply with the hospital conditions of participation, the physician supervision requirements and the Emergency Medical Treatment and Active Labor Act (EMTALA). Also, unlike IFECs, OCEDs play a unique and critical role in the communities they serve by providing emergency standby services such as 24/7 access to care, caring for all patients who seek emergency care regardless of the ability to pay, and disaster readiness and response capabilities.

Indeed, the Commission itself has previously noted the important distinction between hospital-based emergency care and care provided in physician offices or by other types of suppliers, such as IFECs. Most notably, we saw this in the Commission's previous site-neutral payment policy recommendations. There, the Commission appropriately excluded ED E/M services from its site-neutral payment recommendation for E/M services. In addition, the Commission excluded APCs with services that are frequently provided with an ED visit from its list of other APCs recommended for site-neutral payment. **These differences continue to exist and should be factored into any future discussions about stand-alone EDs.**

Role of OCEDs. Finally, we would like to clarify several aspects of the role of OCEDs. Specifically, they are designed to provide timely and high-quality emergency and urgent care and rapid access to hospital inpatient services, as appropriate. As such, it is unnecessary, and probably unwise, for OCEDs to operate in exactly the same way and furnish exactly the same level of care as on-campus EDs in order to be paid as provider-based departments under the OPPS. At the November meeting, the Commission staff discussed differences between on-campus EDs and OCEDs, in particular, noting that OCEDs "offered a limited set of services ... They do not provide trauma care ... they do not have operating rooms, so high-acuity cases get transferred to the affiliated hospital ... OCEDs tend to not have many patients arrive by ambulance." However, it is appropriate that these EDs offer more limited services, provide less trauma care and surgery, receive fewer patients via ambulance and send the highest acuity patients to the main campus for definitive care. That is because, unlike on-campus EDs, there is no immediate access to inpatient care in OCEDs and they are not intended or equipped to function as high-level trauma care facilities. Gravely ill or injured patients may enter the system through an OCED, but ultimately, most require inpatient care. That is why ambulances tend to bring such patients directly to the closest acute care hospital.

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Furthermore, CMS acknowledges this difference in the intensity of services between on-campus and OCEDs through its differential payment rates for Type A and Type B hospital EDs.⁵ The primary difference between these two types of EDs is that Type A EDs are required to be open 24 hours a day, 7 days a week, while Type B EDs are not required to do so. We believe that it is more likely that OCEDs identify as Type B EDs, with visits paid at a significantly lower level than Type A ED visits.

We appreciate your consideration of these issues. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Cc: Mark Miller, Ph.D.
MedPAC Commissioners

⁵“A Type A provider-based emergency department must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department and be open 24 hours a day, 7 days a week; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and be open 24 hours a day, 7 days a week. A Type B provider-based emergency department must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department, and open less than 24 hours a day, 7 days a week; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, and open less than 24 hours a day, 7 days a week; or (3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, regardless of its hours of operation.” Source: *OPPS Visit Codes Frequently Asked Questions*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/opps_qanda.pdf.