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March 29, 2018

Jim Mathews, M.S.
Executive Director
Medicare Payment Advisory Commission (MedPAC)
425 Eye St NW Suite 701
Washington, DC 20001

Dear Mr. Mathews:

At its March meeting, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed several issues of importance to the hospital and health system field 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 comments related to these topics. Our main concern is with the Commission's draft recommendation to substantially reduce payments for off-campus stand-alone emergency departments (EDs) that are within 6 miles of an on-campus hospital ED. Such a policy is unfounded and arbitrary – the Commission has presented no analysis to support its concerns or specific recommended payment cuts. Specifically, the recommendation:

- Includes no analysis of Medicare beneficiaries, Medicare costs or Medicare payments;
- Is based on data from only three states that are not representative of the nation:
 - Colorado and Texas are unique in allowing licensure of independent freestanding emergency centers (IFECs).
 - Maryland is not representative because its EDs are entirely exempt from the outpatient prospective payment system (PPS).
- Would make the already-record Medicare underpayment of outpatient departments and hospitals even worse.
 - Outpatient Medicare margins were a record low negative 14.8 percent in 2016;
 - Overall Medicare margins were a record low negative 9.6 percent in 2016;
 - Overall Medicare margins will reach a new record low of negative 11.0% in 2018; and
 - Even efficient hospitals had a negative margin in 2016, for the first time ever.

We support the Commission's recommendation to allow isolated rural hospitals to convert to stand-alone EDs and urge it to also consider expanding this recommendation to help preserve access to emergency services in vulnerable urban communities. We also make several requests related to MedPAC's post-acute care (PAC) research and long-term care hospital (LTCH) payment adequacy assessment.



USING PAYMENT TO ENSURE APPROPRIATE ACCESS TO AND USE OF HOSPITAL ED SERVICES

MedPAC commissioners are expected to vote at the April meeting on two draft recommendations related to hospital EDs. The first recommendation would allow isolated rural hospitals to convert to stand-alone EDs. The second draft recommendation is intended to disincentivize the creation of additional urban off-campus EDs that are located in close proximity to an on-campus hospital ED by reducing payment for ED evaluation and management services in these facilities. **As we explain further below, the AHA supports the first recommendation and urges the Commission consider expanding it to include vulnerable urban hospitals. We oppose the second recommendation, which is unfounded and arbitrary.**

Stand-alone EDs in Rural Communities. At its March meeting, MedPAC discussed a draft recommendation for Congress to allow isolated rural stand-alone EDs (those that are more than 35 miles from another ED) to bill standard OPSS facility fees, and receive annual payments to assist with fixed costs. **We support this recommendation and believe it would help ensure access to essential services in rural communities.**

In addition, we urge commissioners to consider that stand-alone EDs also have the potential to preserve access to emergency services in vulnerable urban communities. The AHA has recommended such a model as part of its *Task Force on Ensuring Access in Vulnerable Communities*,¹ which sets forth 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 (see attached factsheet). It 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.

Urban Stand-alone EDs. MedPAC also discussed a draft recommendation for Congress to reduce payments for off-campus stand-alone EDs that are within 6 miles of an on-campus hospital ED – either by 30 percent or by paying type B ED payment rates. **The AHA urges MedPAC not to finalize this recommendation. In the absence of any data to support the Commissioners' stated concerns and recommendations, it is unfounded and arbitrary.** Instead, we urge the Commission to pause until it is able to examine Medicare claims data specific to stand-alone off-campus EDs (OCEDs). Currently, Medicare claims do not distinguish services furnished in OCEDs from those furnished in on-campus EDs. However, we have supported MedPAC's recommendation that the Centers for Medicare & Medicaid Services (CMS) begin to track

¹ <https://www.aha.org/issue-landing-page/2016-11-16-ensuring-access-vulnerable-communities-taskforce-report-and-resources>.

OCEDs in the Medicare claims data, provided the mechanism used to do so is not overly costly or burdensome for hospitals to implement.

MedPAC bases its OCED concerns on analysis of a small number of stand-alone EDs in only three states – Colorado, Maryland and Texas. While these data provide an interesting perspective of non-Medicare patient care in emergency and urgent care facilities in these states, they are not representative of the nation and contain no Medicare data. Specifically:

- Colorado and Texas are unique in allowing licensure of IFECs, which are not recognized by Medicare as hospitals;
- the Colorado data contain information from only eight IFECs;
- Maryland EDs are entirely excluded from the Medicare OPPS; and
- None of the datasets include information on Medicare beneficiaries, costs or payments.

Therefore, the data that MedPAC alleges demonstrate that patients in hospital-based OCEDs were of lower acuity and, therefore, should be paid at a Medicare reduced rate actually contain no data on either OCEDs or Medicare patients. Instead the datasets include information on IFECs and private pay patients. Indeed, the incentives for creating IFECs are very different from those for creating OCEDs, even if the IFEC later becomes hospital-based. There is no evidence to support a conclusion that the trends in patient mix at IFECs are the same as those at OCEDs. **It follows that MedPAC's assertion that paying urban OCEDs a reduced rate "would more closely align with" Medicare beneficiaries' resource needs is entirely unfounded. Similarly, its specific recommended payment cuts are entirely arbitrary.**

In addition, the Commission's estimates of the share of facilities impacted by the 6-mile criteria are based on analyses of only five metropolitan markets; Charlotte, Cincinnati, Dallas, Denver and Jacksonville. Again, such an analysis is woefully lacking. For example, it is inappropriate to not consider the impact in, at the very least, major urban hubs like New York and San Francisco, where 6 miles could take 30-plus minutes to traverse.

Further, MedPAC's recommendation would make the already-record Medicare underpayment of outpatient departments and hospitals even worse. Outpatient Medicare margins were a record low of negative 14.8 percent in 2016. Overall Medicare margins were a record low of negative 9.6 percent in 2016, with a new record low of negative 11.0 percent projected for 2018. Of note, even efficient hospitals had a negative margin in 2016, for the first time ever. Additional cuts to hospital payments would threaten beneficiary access to these services.

Medicare Margin Data, 2011-2016

Year	Outpatient Medicare Margin (AHA calculated)	Overall Medicare Margin (MedPAC calculated)	Efficient Hospital Medicare Margin (MedPAC calculated)
2011	-10.6%	-5.8%	2.0%
2012	-11.8%	-5.4%	2.0%
2013	-13.4%	-5.0%	2.0%
2014	-11.7%	-5.7%	1.0%
2015	-13.3%	-7.1%	0.0%
2016	-14.8%	-9.6%	-1.0%

Finally, MedPAC’s analysis fails to address two important differences between hospital EDs (both on-campus and off-campus) and other providers (including IFECs). First, hospitals have a higher cost structure due, in part, to the costs of stand-by capability and capacity that hospital-based EDs bear. MedPAC’s recommendation would reimburse hospital OCEDs less for services while still expecting them to continue to provide the same level of service to their patients and communities. As we have noted previously, hospitals are the only health care provider that must maintain emergency stand-by capability 24 hours a day, 365 days a year. This stand-by role is built into the cost structure of hospitals and supported by revenue from direct patient care – a situation that does not exist for any other type of provider. MedPAC’s proposed recommendation would endanger hospitals’ ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response. Following a year in which the nation experienced record-setting natural disasters, and with the scientific community projecting an increase in the severity and frequency of extreme weather events, we must do everything we can to ensure that hospitals have the resources needed to prepare for and respond to future disasters.

Second, comparisons between Medicare payment rates for “similar patients” in different settings should explicitly account for differences in packaging of costs between the OPPTS and the Physician Fee Schedule (PFS). There is greater packaging of costs under OPPTS compared to the PFS. For instance, based on 2015 claims data, we estimate a level 3 ED visit has packaging on average of about 25 percent of the total cost. Therefore, one cannot make a direct comparison of rates for “similar services” in hospital-based EDs, urgent care centers and physician office settings without first accounting for the additional packaging included in OPPTS payments.

MEDPAC RESEARCH ON POST-ACUTE CARE SERVICES

The AHA appreciates MedPAC’s multiple research efforts to improve the accuracy of payment for PAC services, which we are closely monitoring. As such, we ask the Commission to share with the AHA and other stakeholders the following items that were addressed during recent staff presentations:

- PAC PPS Relative Weights. During its November, December and January public meetings, the Commission addressed research on an approach to “increase the equity of payments within each PAC setting.” These discussions, and the resulting recommendation, call for HHS to use a blend of MedPAC’s new PAC PPS relative weights and current setting-specific weights for the calculation of 2019 PAC payments. During the December meeting, staff indicated that the PAC PPS relative weights are “sitting on a shelf.” However, the PAC PPS relative weights have not been yet shared with the public, which counters the Commission’s commitment to transparency and prevents any external validation. **As such, we reiterate our request for the sharing of MedPAC’s, thus far, proprietary PAC PPS relative weights with stakeholders.**
- High-quality PAC Providers. During its September and March public meetings, the Commission discussed research on encouraging beneficiaries to use “higher-quality PAC providers.” This research uses a new metric developed by MedPAC – “higher-quality PAC providers” – that has not been fully explained. Rather, staff has noted that this metric is based on a compilation of variables, including mortality and readmissions data. This research and this metric are of great interest to the AHA, as it appears that any future recommendation would influence both general acute-care hospitals, as well as PAC providers. **As such, we ask the Commissions to share with the AHA and other stakeholders its specifications for this MedPAC-developed metric, “higher-quality PAC providers.”**

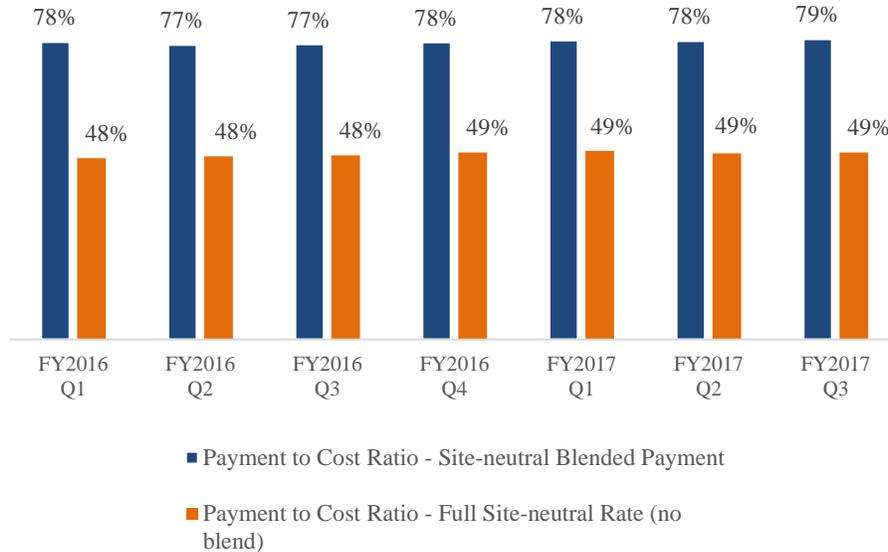
MEDPAC’S ASSESSMENT OF PAYMENT ADEQUACY FOR LONG-TERM CARE HOSPITALS

Medicare pays for LTCH services using a two-tiered system that, in general, pays higher-acuity cases a standard LTCH PPS rate and marginally-lower acuity cases an inpatient PPS-comparable amount. Our analysis of the standard analytical file shows that site-neutral LTCH cases accounted for 36 percent of all cases in the most recent period, the third quarter of FY 2017.

Given that site-neutral cases represent such a large portion of the overall LTCH case-mix, we urge MedPAC to include all LTCH cases in the Commission’s payment adequacy analysis. We are unaware of any rationale supporting the current exclusion of LTCH site-neutral cases from this assessment. Further, not only do site-neutral cases represent a substantial portion of the overall population of LTCH cases, their Medicare margins show substantial underpayment, as discussed below. As such, the latest payment adequacy assessment based only on standard rate cases was incomplete and, therefore, inaccurate.

As demonstrated by the graph below, under the fully implemented policy, average payments cover only 49 percent of the cost of care for LTCH site-neutral cases. Unfortunately, even under the 50/50 blended payments during the transition to full site-neutral payment, only an average of 79 percent of costs are covered.

**Payment to Cost Ratios for LTCH Site-neutral Cases;
 With and Without Blended Payment**



Our analyses show that these substantial underpayments are occurring because, contrary to CMS’s projections, the acuity level and cost of care for LTCH site-neutral cases far exceed those of comparable inpatient PPS cases.² However, payments are of course made at an inpatient PPS-comparable level. **While we agree with CMS that the field is still in flux as it adapts to site-neutral payment, anecdotal feedback from our LTCH members indicates that their ability to continue to lower the cost of treating site-neutral cases has plateaued.** One key driver of this underpayment is the clinical acuity of site-neutral cases. Specifically, we found that 54 percent of these cases have between one and four complications and comorbidities/major complications and comorbidities (CC/MCC), while 42 percent have five or more CC/MCCs. In contrast, of comparable inpatient PPS cases (those with fewer than three ICU days), 62 percent have one to four CCs/MCCs but only 12 percent have five or more (see table below). Consistent with their higher acuity levels, LTCH site-neutral cases also have an average length of stay of 25.1 days, which is much more similar to that of LTCH cases paid a standard rate than to the 4.0 day average length of stay for comparable inpatient PPS cases. The contrast is equally stark when comparing Medicare payment-to-cost ratios: 0.47 for LTCH site-neutral cases and 0.99 for inpatient PPS cases with fewer than three ICU days.³ Average costs per case for these cases were \$32,941 and \$11,190, respectively.⁴ **Collectively, these data show that LTCH site-neutral cases are, on average, much sicker and costlier than inpatient PPS cases with fewer than three ICU days.**

² 2016 MedPAR data.

³ Note that overall, Medicare payments to general acute-care hospitals covered only 87 cents for every dollar spent caring for Medicare patients in 2016.

⁴ FY 2016 cases with FY 2018 payment parameters.

Comparing LTCH Site-neutral Cases & Inpatient PPS Cases with Fewer than 3 ICU Days*		
	IPPS Cases with <3 ICU Days	LTCH Site-neutral Cases
Number of Cases	6,974,091	50,781
Length of Stay	4.0	25.1
% of Cases with 1-4 CC/MCCs	62%	54%
% of Cases with 5+ CC/MCCs	12%	42%
Average Cost	\$11,190	\$32,941
Average Medicare FFS Payment**	\$11,108	\$15,592
Payment to Cost Ratio	0.99	0.47

*FY 2016 cases with FY 2018 payment parameters

**Without the site-neutral blend

In summary, the AHA is concerned about MedPAC's methodology for calculating Medicare payment adequacy for LTCHs, since it excludes site-neutral cases. The clinical and cost profile of these cases continues to be misaligned with its inpatient PPS-based payments, as recognized by CMS in its FY 2018 rulemaking, and is driving systematic underpayment of these cases. **Therefore, in order to produce a complete and accurate assessment of Medicare payments to LTCHs, we call on MedPAC to modify its payment adequacy calculations for FY 2020 to incorporate all LTCH cases.**

Again, we thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org or (202) 626-2340.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: James E. Mathews, Ph.D.
MedPAC Commissioners

Attachment

Emerging Strategies to Ensure Access to Health Care Services

Emergency Medical Center



The AHA Task Force on Ensuring Access in Vulnerable Communities examined ways in which the access to and delivery of care could be improved. The emergency medical center (EMC) strategy would allow hospitals that may be struggling, for a variety of reasons, to continue to meet the needs of their community for emergency and outpatient services, without having to provide inpatient acute care services.

The AHA urges Congress and the states to allow certain qualifying hospitals to convert to an EMC. Specifically, EMCs would be required to provide the following services on an outpatient basis:

- ➔ **Emergency services**, which would be available to the public 24 hours a day, 7 days a week, 365 days a year; and
- ➔ **Transportation services**, either directly or through arrangements with transportation providers, that allow for the timely transfer of patients who require inpatient acute care services.

In addition, EMCs would be able to offer additional health care services to meet the needs of their community. These include:

- ➔ **Outpatient services**, which could include primary care services, observation care, infusion services, hemodialysis, population health and telemedicine services;
- ➔ **Post-acute care services**, including skilled-nursing facility care, home health and hospice care; or
- ➔ **Telemedicine services**, which would allow EMCs to provide or maintain access to additional health care services.

EMC vs. Other Freestanding Emergency Departments

Hospital-based freestanding EDs (FSEDs)

FSEDs are associated with an existing hospital, but provide emergency services in a facility that is structurally and geographically separate and distinct from that hospital. As provider-based facilities, they are reimbursed for emergency services at the rates paid to the existing hospital, including the facility fee.

Independent freestanding EDs (IFSEDs)

IFSEDs are recognized in a limited number of states and provide emergency services without being associated with an existing hospital. Currently, most are not Medicare providers and are not reimbursed by Medicare. Those IFSEDs that are Medicare providers are treated as outpatient clinics and reimbursed under various Medicare Part B payment systems (e.g. the physician fee schedule), but not the outpatient prospective payment system (PPS).

Emergency Medical Centers (EMCs)

The EMC would be a new designation and would need to be recognized at both the federal and state level. EMCs would only arise from a hospital conversion. As such, the number of EMCs would be limited and those hospitals selecting to convert would rescind their current hospital license and certification upon conversion. In addition, EMCs also would remain separate from any existing hospital or health system and would be reimbursed under a payment system developed specifically for EMCs.

Federal Policy Solutions to Pursue

Congress has debated the creation of similar EMC models:

Rural Emergency Acute Care Hospital Act (S. 1130). This legislation would allow certain rural hospitals to continue providing necessary emergency and observation services by converting to a “rural emergency hospital (REH).” REHs would receive enhanced reimbursement rates of 110 percent of reasonable costs for emergency, outpatient, extended care and transportation services. The AHA supports this legislation.

Save Rural Hospitals Act (H.R. 2957). This legislation also would allow certain rural hospitals to continue providing necessary emergency and observation services by converting to a “community outpatient hospital (COH).” While similar to the REH, COHs would receive reimbursement rates of only 105 percent of reasonable costs for emergency, outpatient, extended care and transportation services.

EMC Demonstration Program. In addition, the AHA urges Congress to direct Centers for Medicare & Medicaid Services to test, through its Center for Medicare & Medicaid Innovation, the feasibility of the EMC and its ability to ensure access to emergency services in all vulnerable communities. Alternatively, AHA urges CMS to adopt this demonstration program independent of Congressional action. This demonstration program should be available to current hospitals in vulnerable rural and urban communities and test at least three payment methodologies for EMC services, including:

- Medicare outpatient PPS rates plus an additional facility payment to cover standby costs;¹
- A new fee schedule for EMCs; and
- Rates of 110 percent of reasonable costs for EMC services.

The AHA has prepared a [document](#) that compares the provisions of each of these federal policy solutions.



Hospital and Health System Actions to Deploy

While there is no designation at the federal level for the EMC, hospitals and health systems should consider engaging their boards in conversations related to the services currently offered by the hospital to their community. Hospitals may utilize [AHA's Discussion Guide for Health Care Boards and Leadership](#) to assist with these conversations. These discussions may then be expanded to key community stakeholders, including patients and clinicians. AHA has developed a [Community Conversations Toolkit](#) to help hospitals as they engage in discussions related to the emergency services needed in their community.

1. The Medicare Payment Advisory (MedPAC) recommended a similar payment methodology for 24/7 rural emergency facilities in its June 2017 report. That recommendation also provided a fixed payment to cover extra costs and overhead expenses. Accessed at: http://www.medpac.gov/docs/default-source/reports/jun17_ch8.pdf?sfvrsn=0.