American Hospital Association

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

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) wishes to share our recommendations regarding the Centers for Medicare & Medicaid Services' (CMS) upcoming rulemaking for Section 603 of the Bipartisan Budget Act of 2015, which enacted 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 covered as OPPS services. Instead, as of that date, payment would be made under other Medicare Part B payment systems, such as the Medicare physician fee schedule, the ambulatory surgery center 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 HOPDs. While we will continue to work with Congress to make changes to the provision to address the serious concerns of the field, we remain concerned that, as it stands, Sec. 603 will restrict patients' care options. **Therefore, we strongly believe that flexibility is needed when CMS implements this provision to protect patients' access to care.**

DEDICATED EMERGENCY DEPARTMENTS (DEDS)

As noted above, the law excludes from these site-neutral payment reductions items and services that are furnished by a DED. **In this context, the AHA believes that CMS should explicitly recognize that DEDs provide a wide variety of services to Medicare beneficiaries, for both emergency and nonemergency medical conditions – consequently, such items and services that are provided in the same facility as the DED fall under the exception from site-neutral payment.**

In defining a DED, Sec. 603 refers to the Emergency Medical Treatment and Labor Act (EMTALA) regulations at 42 CFR 489.24(b). Therefore, a DED is "any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets 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;

(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; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section 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" (italics added).

The "one-third test" definition of a DED recognizes that hospital emergency departments provide a wide variety of services to Medicare beneficiaries, for both emergent and non-emergent conditions, as well as for unscheduled and scheduled care. Ancillary services are provided by DEDs to diagnose and treat patients, including radiology, laboratory testing, medication administration and infusions, and other diagnostic and therapeutic services. For instance, beneficiaries often come to DEDs requesting nonemergency services, such as prescription refills, immunizations, blood pressure checks or treatment for minor illnesses or injuries. Some hospitals have a fast-track as part of their DED to provide this kind of nonemergency care. Also, physicians or other caregivers may schedule appointments with beneficiaries and arrange to meet them in a DED. In addition, in some communities, off-campus DEDs serve as essential access points for beneficiaries to receive treatment for their chronic conditions, such as chemotherapy or radiation therapy for cancer.

The AHA believes that CMS should continue its policy that considers all items and services that are provided in the same facility as a DED to be part of the DED, as long as the facility continues to meet the definition of a DED. Therefore, none of the items and services furnished in the same facility as a DED should be subject to the site-neutral payment reductions. In fact, the history of Sec. 603 demonstrates that Congress clearly intended to include an expansive scope of items and services for the purposes of this DED exception. That is,

while the initial draft of Sec. 603 made an exception only for the emergency department evaluation and management services, Congress caught the error and fixed it prior to the law's passage so as to include all items and services furnished in a DED.

RELOCATION AND REBUILDING

Sec. 603 applies payment reductions to new off-campus HOPDs, but does not specifically address relocation and rebuilding of existing (grandfathered) HOPDs. However, the sole criterion for being a grandfathered HOPD is that a facility was billing the OPPS prior to Nov. 2, 2015. **The AHA strongly believes that, as long as a facility meets this criterion, Congress did not intend it to trigger the payment reductions in Sec. 603, regardless of whether it relocates or is rebuilt at any future point.** Indeed, there is already a robust precedent, found with regard to the critical access hospital program, for allowing relocation and rebuilding of grandfathered facilities under Medicare, when a previous legislative moratorium did not specifically address relocation or rebuilding.

There are many reasons an existing HOPD may need to relocate or rebuild. For instance, the HOPD may:

- be located on an earthquake fault line or in a revised flood plain and have little choice but to relocate or rebuild at a different off-campus location;
- have a lease that has expired and a different location may offer better terms;
- be obsolete or damaged and need to be rebuilt at the same location or elsewhere, as is often the case with regard to seismic requirements;
- be too small or otherwise limited to care for its patient population and a larger space may be necessary; or
- be subject to other circumstances that would require relocation or rebuilding.

In such cases, the HOPD is merely moving from one space into another, with its Medicare provider number and billing history unchanged. The only change is a new address or new structure. **Therefore, such cases of relocation or rebuilding should not trigger site-neutral payment reductions. To do otherwise would mean that hospitals' outpatient services would essentially be frozen in place, with no ability to respond to environmental, financial or population pressures or demands – this is clearly unrealistic and impractical and not what the Congress intended.**

EXPANSION OF SERVICES AND PERSONNEL

The AHA also believes that Congress did not intend to preclude grandfathered off-campus HOPDs from changing or expanding the types of outpatient services they furnish to beneficiaries while still receiving Medicare payment at the OPPS rate. Again, the sole criterion for being a grandfathered HOPD is that a facility was billing the OPPS prior to Nov. 2, 2015. As long as a facility meets this criterion, it should not trigger payment reductions under Sec. 603, regardless of whether or when it changes or expands the types of services it furnishes or the personnel it employs.

Health care is constantly evolving, and hospitals must not be precluded from providing beneficiaries with the most innovative therapeutic services and advanced diagnostic tests. Advances in medical science, such as precision medicine, are leading to powerful new treatments that are tailored to specific characteristics of individuals, such as a person's genetic makeup, and improve survival and quality of life. It is critical that hospital outpatient care be able to keep up with these developments without risking financial penalties.

CHANGE OF OWNERSHIP

Sec. 603 also does not specifically address changes in ownership for grandfathered HOPDs. Again, the sole criterion for being a grandfathered HOPD is that the facility was billing the OPPS prior to Nov. 2, 2015. **The AHA strongly believes that, as long as a facility meets this criterion, Congress did not intend it to trigger payment reductions under Sec. 603, even if it is purchased or acquired by a different hospital.** In a change of ownership, the HOPD continues to provide services at the same address with the same billing history, simply under a different provider number. In today's changing health care landscape, hospitals and health care systems often undergo ownership changes in order to better serve their community.

SITE-NEUTRAL PAYMENT RATE

Under 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 covered as OPPS services. Instead, as of that date, payment would be made under other Medicare Part B payment systems, such as the Medicare physician fee schedule, the ambulatory surgery center (ASC) payment system or the clinical laboratory fee schedule, as long as the requirements for such payment are otherwise met.

While the language in this provision raises many questions, one thing is clear: Congress still considers off-campus HOPDs to be provider-based departments of the hospital with defined payment rates. **As such, we believe that Congress intended that Medicare payment for services furnished in these HOPDs still include both a facility fee and a professional fee.**

In addition, we believe that CMS should implement this provision with the least amount of disruption possible to billing and payment for all providers and payment systems involved, including hospitals, physician offices, ASCs and laboratories. We believe that hospitals should be able to continue to bill using the UB-04 hospital claim, and not be required to bill for new off-campus HOPD services using the CMS-1500 professional claim form. Further, because only the payment rate for these services has changed, and services furnished are still HOPD services, we also believe that hospitals costs and revenues should continue to be reported using the hospital cost report.

Thank you for your consideration of our comments. If you have any questions, please contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President