Oregon Association of Hospitals and Health Systems

Washington State Hospital Association

February 19, 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 161 hospitals and health systems in Oregon and Washington State, the Washington State Hospital Association (WSHA) and Oregon Association of Hospitals and Health Systems (OAHHS) thank you for the opportunity to provide feedback to the Energy and Commerce 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 February 5 letter to the health care community.

Hospitals and health systems in Washington State remain extremely concerned about proposals that would reimburse hospital outpatient departments (HOPDs) at the same payment rates as facilities with lesser clinical capabilities and significantly less stringent regulatory requirements.

WSHA and OAHHS strongly supports the American Hospital Association's position on this issue, and the association joins the AHA in urging Congress to modify Section 603 of the Bipartisan Budget Act of 2015 and to reject any further site neutral payment policies.

This joint comment letter will focus on three major areas of concern in our state:

- Opposition to future adoption of site neutral payment policies;
- Support for Congressional action to grandfather off-campus, provider-based outpatient hospital services that were already "under development" when the Bipartisan Budget Act of 2015 was signed into law; and
- Opposition to the site neutral policy for new hospital-based clinics and the geographic restrictions on future departments.

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 Medicare Payment Advisory Commission (MedPAC) proposals to cap HOPD payments for:

- Evaluation and management (E/M) clinic visit services;
- 66 outpatient ambulatory payment classifications (APCs), including certain cardiac imaging services; and
- 12 outpatient surgical procedures commonly provided at ambulatory surgery centers (ASC).

In addition, some in Congress have proposed legislation that would reduce Medicare payments for outpatient hospital oncology services to the rates paid for these services in physicians' offices.

WSHA and OAHHS remain deeply troubled by site neutral payment proposals. These would reimburse hospitals less for specific treatments while still expecting hospitals to continue to provide the same level of access to services. If these cuts were enacted, Washington State HOPDs would face an estimated $1 billion in reductions in Medicare payments over 10 years. Oregon's hospitals would face an estimated $244 million in payment reductions over the same period. Cuts of this magnitude would restrict access to care for our state's most vulnerable residents.

Hospital HOPDs are already paid less than the cost of care for Medicare patients. 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. Payment cuts to HOPDs of this magnitude would threaten beneficiary access to outpatient services.

Hospitals Care for Vulnerable Populations. Hospitals provide care to a unique population of low-income and underserved people who often cannot access care elsewhere – including in physicians' offices and ASCs. To illustrate this point, hospitals provided $42.8 billion in uncompensated care in 2014. By contrast, many physician offices and ASCs do not serve Medicare, Medicaid or charity patients.

In a recent study, the AHA found that compared 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 found that relative to patients treated in ASCs, patients 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.

A reduction in outpatient Medicare revenue that would result from adopting site neutral payment policies would threaten access to critical hospital-based services for this vulnerable population.

Hospitals Provide 24/7 Emergency Standby Services. 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 many other services that promote the health and well-being of the community.

Site-neutral payment policies would undercut the ability of hospitals to continue to provide emergency standby services that residents rely on so heavily, such as:

- Around-the-clock access to health care services, including specialized resources;
- Safety net services involving care for all patients who seek emergency medical treatment, regardless of their 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 values the safety net that hospitals provide and expects them to be open 24/7 to serve patients and their families. However, despite its importance, there is no payment for a hospital and its staff to be "at the ready" until a patient arrives with an emergency need.

Site neutral payment policies would make it more difficult for hospitals to provide these essential services our communities rely on.

HOPDs Treat Sicker Patients. Site-neutral payment cuts also would make it harder for HOPDs to continue to care for patients whose conditions are too complex for treatment in physician offices and ASCs. Community physicians refer patients who are too sick for treatment in their offices or whose conditions are too medically complex for treatment in ASCs to HOPDs because hospitals are better equipped to handle complications and emergencies.

As a result, compared to freestanding physician offices, HOPDs treat patients who suffer from more severe chronic conditions. In addition, HOPD patients have more comorbid conditions and higher prior utilization of short-term acute care hospitals and emergency departments.

Hospitals Are Subject to Higher Levels of Oversight. HOPDs must comply with much more comprehensive licensing, accreditation and regulatory requirements than freestanding physician offices and ASCs. 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 – but they also impose significant additional costs.

These requirements include compliance 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 freestanding physician offices and ASCs.

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.

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 November 2, 2015, the law's date of enactment. The law defines off-campus provider-based HOPDs as departments that are not on the main campus of a hospital and are located more than 250 yards from the main campus.

Starting January 1, 2017, items and services furnished in new off-campus HOPDs will no longer be covered as OPPS services. Instead, as of that date, payment would be based solely on 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.

WSHA and OAHHS are deeply disappointed that this law will result in substantial reductions in payments for services furnished in provider-based HOPDs.

Section 603 is problematic for a number of reasons.

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

Several health systems around the state have hospital clinics under development. These organizations made significant financial and other commitments to develop these facilities based, in large part, on assumptions about Medicare reimbursement that were changed radically in just a few days.

While Section 603 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 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 long-term care hospitals, in which Congress protected facilities under development.

As a matter of fairness, hospitals that made substantial investments – often worth 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 loans 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.

Systemic Problems of Section 603. There are a variety of additional systemic problems with Section 603 beyond its failure to account for facilities under development.

Simply stated, the concept of Section 603 is fundamentally flawed. Most notably, Section 603 prescribes an unworkable and impractical long-term plan for the development of outpatient services in the health care system.

WSHA and OAHHS are especially concerned about the consequences Section 603 will have on access to services in 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 their residence. The clinical movement of services from the inpatient setting to the outpatient setting magnifies the problem.

Section 603 will mean, as populations grow and new outpatient services are needed, there will be a significant disadvantage to off-campus outpatient facilities. 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. Thus, Section 603 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 created by Section 603.

Finally, because Section 603 was developed in such haste, there are certain unintended consequences that will result from this law. One certainly is the treatment of cancer centers that resulted from this provision, which should be addressed quickly. Others are sure to be discovered in the months and years ahead. Establishing a process to address these is essential.

Thank you in advance for your consideration of these issues. If you have any questions, please contact WHSA's Cassie Sauer at cassies@wsha.org or 206-216-2545 or Chelene Whiteaker, Policy Director at chelenew@wsha.org or 206-216-2545; or OAHHS' Andy Van Pelt at avanpelt@oahhs.org, or 503-636-2204.

Sincerely,

/s/

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/s/

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