



AMERICA'S ESSENTIAL HOSPITALS

December 23, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-1656-FC and IFC: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Non-Excepted Off-Campus Provider-Based Department of a Hospital; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-Excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on the above-captioned final rule and interim final rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high-quality, integrated health care across the continuum. We are concerned that Section 603 of the Bipartisan Budget Act (BBA) of 2015 (BBA) will have a disproportionately negative financial impact on essential hospitals—those that commit to serving low-income and other vulnerable patients—and runs counter to the concept of integrated, coordinated health care. In fact, CMS' finalized policies to implement the BBA, while an improvement from the proposed rule, will limit the ability of essential hospitals to expand access to the most vulnerable populations. America's Essential Hospitals urges CMS, when considering revisions to this final rule, to adopt policies that will mitigate the negative impact of the BBA on hospitals caring for complex patient populations.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Essential hospitals treat more patients who are dually eligible for Medicare and Medicaid than the average hospital. These patients often have multiple comorbidities and chronic conditions and are among the most difficult to treat. More than a third of patients at

essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital field: zero percent in aggregate compared with 8.3 percent for all hospitals nationwide.¹ Through their integrated health systems, members of America's Essential Hospitals offer primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

In particular, essential hospitals play a vital role in providing ambulatory care to their communities. The average member operates a network of more than 20 ambulatory care sites, and in 2014, saw more than three times as many non-emergency outpatient visits as other acute-care hospitals nationwide. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and pharmacy services, for example—that freestanding physician offices typically do not offer. Our members' ambulatory networks also offer behavioral health services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Given essential hospitals' expansive networks of ambulatory care in otherwise underserved communities, the BBA will have a pronounced negative effect on vulnerable patients. America's Essential Hospitals urges CMS to exercise its statutory authority to implement the BBA in a way that mitigates the negative consequences on patient access. America's Essential Hospitals appreciates that CMS moved away from some of the untenable proposals put forth in the proposed rule, which provided no reimbursement to hospitals and limited relocation and expansion of services. However, the final policies do not go far enough to protect vulnerable patients' access to care by permitting essential hospitals to expand access in a way that is consistent with the statutory text. To ensure our members have sufficient resources to continue expanding access and are not unfairly disadvantaged for serving the most vulnerable among us, CMS should adopt the following recommendations when implementing the final rule and interim final rule.

1. CMS should delay implementation of Section 603 of the BBA by at least three months to offer sufficient time for hospitals to make necessary system adjustments.

Because of the magnitude of Section 603's effect on hospitals and patient access, CMS should consider the negative consequences of its finalized policies and the difficulty providers will face adapting to its proposals on a short timeframe. **Specifically, we call on the agency to delay the implementation of Section 603 for at least three months.** CMS' final policies—which in many respects differ substantially from the proposed version of the policies—will be impractical for hospitals to fully implement on such short notice. Hospitals are provided a mere 60-day period from publication of the final rule to effective date to make cumbersome changes to their billing systems and to prepare for the impact of reimbursement policy changes. Hospitals were not on notice

¹Landry C, Ramiah K, Rangarao S, Roberson B. *2014 Essential Data, Our Hospitals, Our Patients; Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey*. America's Essential Hospitals. June 2016. <http://essentialdata.info>. Accessed December 22, 2016.

of many of these policies at the time of the proposed rule and will require time to update their systems and comply with this requirement.

For instance, CMS mandates the use of a new claims-based modifier to identify non-excepted items and services provided in off-campus provider-based departments (PBDs). The use of the modifier will allow CMS to determine which services should be paid at the lower non-excepted rate in calendar year (CY) 2017. America's Essential Hospitals is concerned that hospital billing staff will not have sufficient time to update billing systems and practices to use the modifier by January 1, 2017. CMS' approach will impose an excessive burden on hospital administrators responsible for billing practices. Until CMS' required use of the "PO" modifier in 2016, services on hospital claims were not always differentiated by whether they were provided on campus or off campus. Moreover, hospital claims do not identify individual PBDs, especially those that are considered excepted and non-excepted. Therefore, it will be difficult for billing personnel to quickly adapt their systems to distinguish between services provided in excepted and non-excepted hospital PBDs. Requiring hospitals to report a modifier will take a significant investment of time and resources. Hospital billing personnel will have to ensure the modifier is added to each line of a claim representing a service provided in a non-excepted off-campus PBD. They will do this either by building the modifier into their systems or adding the modifier to each service on an ongoing basis. Any time a hospital adds a new service to its system, it would have to repeat the process to ensure the modifier is in place. CMS' requirement that the modifier be on each line of the claim represents an additional burden, not only for coding efforts, but also for continuous review and compliance efforts. **CMS should delay implementation by at least three months to give hospitals sufficient time to prepare for the administrative requirements imposed by the final rule and to appropriately consider stakeholder feedback on provisional policies, such as the interim payment rate for CY 2017.**

2. CMS should ensure that PBDs are adequately reimbursed for the cost of providing services to patients.

As mandated by Section 603 of the BBA, CMS will discontinue paying certain off-campus PBDs under the Outpatient Prospective Payment System (OPPS) on January 1, 2017. The BBA instructs CMS to pay these new, non-excepted PBDs under another Part B "applicable payment system" instead of the OPPS. **In determining the applicable payment rate, America's Essential Hospitals urges CMS to adopt a reasonable payment methodology that accounts for the higher costs of services in hospital PBDs.**

America's Essential Hospitals is pleased that CMS has reversed its original proposal, which provided no hospital reimbursement for non-excepted services, and now will pay non-excepted PBDs a facility payment under the Medicare Physician Fee Schedule (MPFS). In the final rule and interim final rule, CMS establishes a payment rate for non-excepted items and services equal to 50 percent of the OPPS payment rate. CMS originally proposed that no facility payment would be made directly to off-campus PBDs in CY 2017. Instead, the physician performing the service would bill under the MPFS and receive the nonfacility rate, which is the higher rate that a physician receives in a freestanding office. This was an unconscionable proposal, and the lack of payment

to off-campus PBDs would have been unsustainable, particularly for essential hospitals operating on narrow (often negative) margins. While CMS' recognition that its original proposal was untenable for hospitals is a positive change, we urge the agency to ensure an adequate payment rate to cover all the costs of providing services in a hospital setting.

Excessively restrictive payment policies undoubtedly will have downstream effects, mainly on patient access. Clinics of essential hospitals incur higher costs than the average freestanding physician office for a variety of reasons, ranging from regulatory requirements to differences in case mix. The patients seeking care at off-campus PBDs of essential hospitals tend to be lower income and racial and ethnic minorities, and they are more likely to be uninsured. Clinics of essential hospitals often fill a void by providing the only source of primary and specialty care in their communities. PBDs of essential hospitals, in particular, are able to offer culturally and linguistically competent care tailored to the most vulnerable patients in their communities. Essential hospitals incur higher costs in treating their patients, whether because of the clinical complexity of their patients or the additional resources needed to provide translators and wrap-around services.

In addition to their complex patients, PBDs are required to comply with provider-based regulations, which include requirements pertaining to billing, medical records, and staffing. For example, to qualify as provider-based and receive Medicare reimbursement, an outpatient department must be clinically and financially integrated with the main provider. This includes a requirement that patients of a PBD have full access to services at the main hospital. Medical records of the PBD also must be integrated into the main provider's system. These and other requirements impose additional compliance costs on hospitals that are not borne by freestanding physician offices.

As CMS acknowledges in the preamble to the final rule, payment to hospital PBDs and freestanding clinics cannot be directly compared because payment under the OPSS accounts for the cost of packaging ancillary services to a greater extent than in the MPFS. For many services paid under the OPSS, including comprehensive ambulatory payment classifications (APCs), CMS makes a single payment for the main service and related packaged services. Under the MPFS, a separate payment is likely to be made for each service. Comparing payment under the OPSS and MPFS for services without accounting for the higher level of packaging that occurs under the OPSS understates the costs of services in hospital PBDs. The Medicare Payment Advisory Commission discussed equalizing payment across settings in its June 2013 report, where it noted that any adjustment in payment rates to hospital PBDs should account for the higher level of packaging in the hospital setting by paying the hospital department at a higher rate than the physician freestanding office.²

²Medicare Payment Advisory Commission. June 2013 Report to the Congress. Chapter 2 at 28. http://www.medpac.gov/docs/default-source/reports/jun13_entirereport.pdf?sfvrsn=0. Accessed December 22, 2016.

To adjust for the higher level of packaging in the OPSS, as well as higher costs incurred by hospital PBDs compared with freestanding offices, CMS should revise its payment rate for non-excepted items and services to 75 percent of the OPSS payment rate. In addition, CMS should ensure that the payment amount for any non-excepted item or service is no less than what would be paid under the ambulatory surgical center (ASC) rate or the MPFS rate to freestanding physician offices. For services where 75 percent of the OPSS payment (or 50 percent in the case of CMS' suggested interim payment rate) would be lower than the freestanding office or ASC rate, CMS should pay the higher of the ASC or physician office rate instead. For example, as shown in the table below, the final payment rate for a computerized tomography scan of the chest with contrast (HCPCS code 71260) would be the freestanding office payment amount of \$167.21, because the interim payment rate adjustment to the OPSS amount would fall below both the ASC payment rate and a freestanding physician office rate.

HCPCS Code and Description	CY 2016 OPSS Rate	CY 2016 MPFS Technical Component	CY 2016 ASC Payment Rate	CMS Interim Payment Rate (50% of OPSS)	AEH Recommendation
71260 – Chest CT with contrast	\$236.86	\$167.21	\$132.45	\$118.43	\$167.21 (highest of interim payment rate, ASC, or freestanding office amount)

We urge CMS to modify its payment mechanism in this way to adequately account for the higher acuity of patients treated in PBDs compared with physician offices, and the requisite resources, staff, and capabilities necessary to treat patients in a PBD. By considering the recommendations above, CMS can lessen the negative impact of Section 603 on vulnerable patients' access to care.

3. CMS should implement Section 603 of the BBA consistent with the legislative text by permitting excepted PBDs to retain their excepted status in the event of relocation, change of ownership, and expansion of services.

In drafting the BBA, Congress left many specifics of Section 603 implementation for CMS to clarify through the rulemaking process. However, in its original interpretation, the agency unnecessarily expanded the law's scope. For example, CMS proposed that PBDs that relocate, change ownership, or expand services would lose their grandfathered status, a limitation the BBA neither contemplated nor required. CMS did provide for additional flexibility in the final rule with regard to expansion of services and limited flexibility on relocation. However, with regard to relocation, CMS' interpretation of Section 603 is still unnecessarily restrictive.

Essential hospitals tend to be the only providers willing to take on the financial risk of providing comprehensive care to low-income patients, including the uninsured and beneficiaries dually eligible for Medicare and Medicaid. These clinics enable hospitals to expand access for vulnerable patients in communities with no other options for both

basic and complex health care needs. PBDs of essential hospitals often are the only clinics in low-income communities that provide the full range of primary and specialty services. Limitations on relocation or expansion of services are just another obstacle that will frustrate the ability of essential hospitals to continue to play this vital role in their communities. **We urge CMS to apply Section 603 in a way that is consistent with the legislative text and that will protect patient access by taking into account these considerations:**

- a. CMS should allow PBDs to retain their excepted status notwithstanding relocation.

CMS should allow PBDs to retain their excepted status, even if they relocate, as long as they continue to meet the provider-based requirements. In the final rule, CMS creates a limited extraordinary circumstances exception that would allow a PBD to temporarily or permanently relocate without forfeiting excepted status. CMS notes that these exceptions would be granted rarely and would apply to limited scenarios, such as natural disasters, seismic building codes, or in the case of a significant public health or public safety need. We are encouraged that CMS has realized that there are circumstances outside of a hospital's control that would necessitate relocation — however, these are only a few of the reasons a hospital would have to relocate its PBD.

There are many other external forces that could compel a hospital to relocate a clinic. For one, when a provider's lease for a PBD expires, it might find the renewal terms unsustainable, particularly for a PBD of an essential hospital with negative margins. As landlords realize that CMS policy effectively makes a PBD a captive audience, they are likely to raise the rent. While any reasonable business facing such unfavorable economic conditions would consider relocation as a response, a PBD might simply close, given the lack of a financially viable alternative under the proposed relocation policy. There are many other reasons for relocation beyond a provider's control, such as a building being closed for reconstruction or demolition, local zoning changes or ordinances, or other state and local laws. CMS' limitation on relocation is guided by the agency's belief that hospitals are motivated only by financial considerations. But as these examples show, there are many reasons a provider might have to relocate that fall outside the agency's narrow exception.

There is precedent for allowing for the relocation of provider-based facilities, such as in the context of critical access hospitals (CAHs) that were grandfathered as "necessary providers" (a designation that allows a CAH to circumvent certain geographical requirements), as well as their associated off-campus PBDs. While the Medicare Modernization Act of 2003 eliminated the necessary provider designation for CAHs, those with necessary provider designation that existed before January 1, 2006, were grandfathered. CMS has indicated in rulemaking that CAHs and their PBDs that are grandfathered may relocate without losing their grandfathered status. As CMS noted in the preamble to the CY 2008 OPPS final rule, in response to a question on relocation of PBDs of grandfathered CAHs, the agency "believe[s] it would be reasonable for a CAH to be able to move its facility." Thus, CMS would be consistent in also allowing PBDs of acute care hospitals to relocate and maintain their excepted status under Section 603.

For these reasons, CMS should allow excepted PBDs to relocate without losing their excepted status.

- b. CMS should permit non-excepted PBDs to retain their excepted status if they change ownership.

CMS finalized without modification its proposal on excepted PBDs that change ownership. Specifically, the finalized policy allows a PBD to maintain excepted status only if the main provider that owns the PBD changes ownership and the new main provider accepts the existing Medicare provider agreement. In scenarios in which the main provider does not change ownership but an individual PBD does, CMS states that the PBD would lose its excepted status. **We request that CMS extend the policy on changes of ownership to circumstances in which an individual PBD changes ownership.** It is not uncommon for provider-based facilities to change hands over time for various reasons. For example, a hospital that finds it unsustainable to continue operating an off-campus PBD for financial or other reasons might decide to sell that particular PBD. But if the loss of excepted status makes the PBD unattractive to potential buyers, the hospital might close it. In such a case, patients in the community would lose access to essential outpatient services. Because these excepted PBDs that change ownership already operated before the date of enactment and would not be newly created, they should remain excepted.

- c. CMS should continue to allow excepted off-campus PBDs to retain their excepted status, even if they expand services.

CMS notes, as required by Section 603, that off-campus PBDs that were billing for services provided before November 2, 2015, would be “excepted” from reduced reimbursement. In the proposed rule, CMS suggested that excepted PBDs would only receive OPPS payment for items and services of the type that were provided by the PBD before the BBA. If the PBD were to expand services beyond those provided pre-enactment, such services would become non-excepted and reimbursed at a rate other than the OPPS. In the final rule, CMS withdraws this proposal and allows excepted PBDs to expand services and still be paid at the OPPS rate for these new service types. We welcome CMS’ acknowledgement that PBDs have to adapt to the changing needs of their communities by adding or changing the types of services they provide to their patients.

CMS notes that it will continue to monitor service line expansion and seeks comment on either a limitation based on type of service or volume of services. While the need to monitor service line growth is understandable, CMS should apply policies that are consistent with the statutory text of Section 603. Section 603, titled “Treatment of Off-Campus Outpatient Departments of a Provider,” clearly states “the term ‘off-campus outpatient department of a provider’ shall not include a department of a provider (as so defined) that was billing” for outpatient department services furnished pre-enactment.³ In other words, a PBD that was billing for services before the date of enactment is

³Section 603 of Bipartisan Budget Act of 2015. Pub. L. 114-74, codified as Social Security Act §1833(t)(21)(B)(ii).

completely carved out of the definition of “off-campus outpatient department of a provider.” Section 603 only reduces reimbursement to applicable items and services provided at “off-campus outpatient departments of a provider,” and by carving out existing PBDs from the definition, the BBA is clear that these PBDs and the services they provide are unaffected by its provisions. Additionally, there is no language in the BBA that suggests these PBDs are excepted for only those services provided before enactment. Even the provider-based rules do not limit the scope of services that can be provided by a PBD. In fact, in rulemaking on the provider-based requirements, CMS previously noted that “the provider-based rules do not apply to specific services; rather, these rules apply to facilities as a whole.”⁴ **Therefore, we urge CMS to act consistently with the statutory text in implementing Section 603 and considering any future modifications to its policy on expansion of services.**

4. CMS should pay for the composite mental health APC at non-excepted PBDs at the per diem community mental health center rate for partial hospitalization program (PHP) services.

Under the OPSS, CMS pays for PHP services at a set per diem rate—this rate is higher if the PHP services are provided in a hospital setting as opposed to a community mental health center (CMHC). CMS assigns certain mental health services that do not qualify as PHP services to the mental health composite APC 8010. For excepted hospital PBDs, the payment rate for APC 8010 is set equal to the per diem hospital outpatient department rate for PHP services.

In the final rule, CMS notes that it will pay for PHP services provided in a non-excepted PBD at the CMHC rate. Because services falling under the mental health composite APC 8010 are not PHP services, they would be paid similar to other non-excepted services at the default interim payment rate, which is 50 percent of the OPSS rate. **CMS should instead pay for APC 8010 at the non-excepted PBD rate for PHP services—that is, the CMHC PHP rate. Doing so would be consistent with both CMS’ policy on payment to non-excepted PBDs and its existing policy to pay for the mental health composite at the per diem PHP rate.**

America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Erin O’Malley, director of policy, at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

⁴Centers for Medicare & Medicaid Services. Fiscal Year 2003 Inpatient Prospective Payment System Final Rule. 67 Fed. Reg. 49982, 50088 (August 1, 2002).