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February 17, 2016

The Honorable Fred Upton
Chairman
Energy & Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joseph Pitts
Chairman, Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Health Subcommittee Chairman Pitts:

On behalf of our nation's teaching hospitals and their hospital outpatient departments (HOPD), clinical physician faculty, and medical schools, I write to express our appreciation for your willingness to consider health care stakeholder concerns with the site-neutral payment provisions included in the (Section 603) of the Bipartisan Budget Act of 2015 (H.R. 1314). The academic medicine community has longstanding concerns with the impact this policy will have on our patients and the communities we serve. This provision is counter-productive and could lead to the closure of some teaching hospital HOPDs and the reduction of services in others, greatly affecting vulnerable populations—especially those with complex medical problems--that receive care there, and limiting the ability to train the next generation of health professionals in these outpatient settings. While we recognize the challenges associated with revisiting the provision, the AAMC strongly urges you to enact a technical correction that would expand the current grandfather to include HOPDs that were "under development" at the time of the legislation's enactment, direct CMS to work with the hospital community to answer the many regulatory questions related to implementation of Section 603, and consider an exemption for growth beyond the hospital campus when there is not choice due to the unavailability of contiguous land and the need to serve certain patient populations.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 145 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

HOPDs Differ From Physician Offices in Important Ways

Medicare recognizes that physician offices and HOPDs are both essential care settings in the health care landscape *and* that they differ from each other in key ways that warrant different

payment methods and rates. This payment differential appropriately accounts for the differences in the patients treated, services provided, and regulatory burden at HOPDs.

- HOPDs are frequently the sole sources of care for low-income and otherwise underserved populations of Medicare beneficiaries, accepting those who otherwise face difficulty being seen in physician offices;
- HOPDs need to meet the myriad regulatory requirements of their association with a hospital, including compliance with hospital conditions of participation and providing stand-by care not provided in a physician's office;
- HOPDs are comprehensive and coordinated care settings for patients with chronic or complex conditions. Many centers of excellence are based in hospital settings and provide outstanding team-based, patient-centered care; and
- HOPDs provide wraparound services, such as translators and other social services.

Proposed "Equalizations" Disproportionately Target America's Teaching Hospitals

As noted in your request for feedback, the Medicare Payment Advisory Commission (MedPAC) has made several proposals related to site-neutral payment. In fact, in 2012 MedPAC recommended an equalization of Evaluation and Management (E/M) codes that would have disproportionately impacted major teaching hospitals. While MedPAC raised important concerns about the HOPD payment system, they also urged caution recommending this HOPD change be phased in over a three-year transition and a suggested a stop loss should be included that exempts a limited number of hospitals from the policy. MedPAC also recommended the Secretary monitor the impact of the change and issue a report on its findings. The AAMC strongly believes the HOPD payment changes should be studied before they are implemented.

As you know, major teaching hospitals provide complex, coordinated care to Medicare's most vulnerable patients. Representing just 5 percent of all U.S. hospitals, major teaching institutions would receive nearly half of the cuts. Additionally, major teaching hospitals provide a disproportionate amount of health care services to challenging patient populations including dual eligibles, disabled, and the underserved compared to other hospitals and physician offices. The site-neutral provisions included in Section 603 are likely to jeopardize beneficiaries' access to care and have a negative impact on the future physician workforce, which must be trained to deliver care in an integrated, largely outpatient setting.

Limiting the Number of Teaching Hospital HOPDs Will Mean Less Primary Care Training for Residents

Medical schools and teaching hospitals know that trainees are best served through experience in multiple settings such as the operating room and outpatient clinics. Locating those clinics in areas that are closest to the patient populations served is an important adjunct to making care available, as well as exposing learners to a wide variety of patients, many with complex multiple conditions. Cuts to HOPDs will mean cutbacks in services and closures – limiting the key setting for outpatient training and the availability of care to patients. In fact, in nearly half of the academic faculty group practices, more than 50 percent of Medicare visits are provided in HOPDs and resident training takes place in a majority of these HOPDs.

Congress Should Expand the Grandfather Clause to Include "Under Development" HOPDs

The AAMC recognizes that much concern has been voiced about the growth of HOPDs, but not all HOPDs are equivalent. As we have stated above, and in prior communications, HOPDs owned by teaching hospitals often serve populations that would not otherwise have access to health care. These patient populations also benefit from the many additional services available at teaching hospital HOPDs that cannot be found at physician offices. Of institutions that responded to a recent AAMC survey, a full 85% indicated they will be adversely impacted by the site-neutral provision. In fact, many teaching hospitals are now reconsidering growth and expansion plans aimed at providing additional care in their communities or filling gaps where other hospitals have closed or some providers refuse to treat challenging patient populations.

Teaching hospitals that were in the midst of planning for or building new HOPDs were caught unprepared when section 603 was passed. Among the most frequently cited situations of these hospitals are the following:

- Construction is already in progress, almost ready to open, or plans have been drawn up but ground has not been broken;
- Approved HOPDs are in the process of relocation;
- Hospital is acquiring an existing facility; and
- Hospital is considering expanding services at an existing HOPD.

To alleviate concerns related to patient access, Congress should expand the current grandfather clause to include HOPDs that were "under development," as described above, at the time of enactment.

Issues of Regulatory Concern

We ask that Congress direct the Centers for Medicare & Medicaid Services (CMS) to work with hospital stakeholders to ensure access to care for all patients as it implements Section 603. Specifically, CMS must clarify the following issues via the rule-making process:

- The definition of "items and services furnished by a dedicated emergency department" for purposes of this legislation;
- All ancillary departments within the same off-site building are eligible for provider-based status due to the proximity of an emergency department;
- Clinics that are grandfathered, but have plans to move their physical location in the future, will retain grandfather status;
- Grandfathered HOPDs that are acquired remain eligible for provider-based status; and
- New ancillary services added at grandfathered HOPDs are eligible for provider-based status.

Addressing the Hospital Campus Definition

Many of our urban members are "land-locked" institutions, lacking the ability to expand their campuses to contiguous spaces. To better serve their patients they strategically locate their HOPDs to "off campus" locations in the communities with challenging, underserved patient populations. While we appreciate that the site-neutral grandfather provision allows existing off-campus HOPDs to continue billing under the Outpatient Prospective Payment System (OPPS), the inability to expand services and access for challenging patient populations will negatively impact their communities. The AAMC strongly encourages you to consider an exemption for growth beyond the hospital campus when there is not choice due to the unavailability of contiguous land and the need to serve certain patient populations.

Again, thank you for your willingness to engage the health care community on this important issue. The AAMC strongly urges you to pursue a legislative technical correction that would define "under-development" HOPDs, expand the grandfather provision to include those sites, and direct CMS to work with the hospital community to answer the many regulatory questions related to implementation of Section 603. If you would like to discuss any of these comments in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at lmarquez@aamc.org or 202-862-6281.

Sincerely,

Atul Grover, MD, PhD
Chief Public Policy Officer