NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

September 6, 2016

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Attention: CMS-1656-P

Subject: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program

To Whom It May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our concern about the proposed Medicare outpatient prospective payment system rule for calendar year 2017, which was published on July 14, 2016 in the *Federal Register* (Vol. 81, No. 135, pp. 45604-45788).

NAUH is concerned about several aspects of the proposed rule governing future site-neutral payments for Medicare-covered outpatient services:

1. How the proposed rule addresses the relocation of existing hospital-based outpatient departments
2. How the proposed rule addresses the expansion of services at existing hospital-based outpatient departments
3. How the proposed rule addresses the sale of existing hospital-based outpatient departments
4. How the proposed rule could affect current hospital-based outpatient departments' future participation in the section 340B prescription drug discount program

Together, we believe these and other provisions in the proposed rule would have a disproportionately harmful effect on private, non-profit urban safety-net hospitals and the low-income residents of the urban communities such hospitals serve.

At the heart of our concerns is our belief that Medicare and hospitals share two major objectives: ensuring access to care for Medicare beneficiaries – and from NAUH's perspective, beneficiaries in the generally low-income communities private urban safety-net hospitals serve; and ensuring that these services are provided in more efficient, less costly outpatient settings whenever possible and practical. Without access to these services in their communities, many low-income individuals might have to make the difficult choice between paying for transportation out of their communities to find an outpatient provider who will accept their government (Medicare and/or Medicaid) insurance or obtaining more

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readily available care through a hospital emergency department – the last place, we all agree, that anyone should seek routine, non-emergency medical care.

With this understanding, we address our concerns individually below.

Limiting the Relocation of Existing Hospital-Based Outpatient Departments

Under the proposed rule, hospital-based outpatient departments that move from their location at the time the Bipartisan Budget Act of 2015 passed, whether by rebuilding or simply relocating, would no longer receive Medicare hospital-based outpatient rates. NAUH disagrees with this proposal.

There are a number of legitimate reasons hospitals would choose to relocate existing outpatient departments: the space they currently occupy may no longer have the infrastructure needed to accommodate the growing technological demands associated with the practice of medicine; they may be too old or too difficult to upgrade; they may be too small, which could reflect growing demand for their services; a building may be sold and its new owners may have other uses in mind for it – or for the land on which it stands; older buildings may no longer meet local building codes – or in the case of buildings in places like California or Florida, no longer meet local requirements for buildings to withstand forces of nature that plague such areas; a community needs assessment, required under the Affordable Care Act, might reveal that the community would be better served by relocating services; or the prudent financial step at some point may be to shift from renting to owning or from owning to renting such facilities. Urban safety-net hospitals already are concerned about how their landlords in rented facilities may react when they realize their tenants cannot move without suffering severe financial penalties.

The Bipartisan Budget Act of 2015 that constitutes the basis for this proposed regulation does not prescribe this specific requirement; in fact, it is silent on this subject. Thus, this requirement comes entirely at CMS's discretion, and NAUH urges CMS to reconsider this proposal. We believe it would be damaging to existing hospital-based outpatient departments and damaging to the communities those departments serve, especially in low-income urban communities. Instead, we believe CMS can make a major contribution toward continuing the movement toward greater use of providing Medicare-covered services on an outpatient basis by not taking steps that would, in NAUH's view, discourage hospitals from participating in that movement in at least some circumstances. At the very least, CMS could develop criteria for what would constitute acceptable reasons for relocating existing hospital-based outpatient departments without incurring the loss of that important status.

Limiting the Expansion of Services Provided by Existing Hospital-Based Outpatient Departments

Under the proposed rule, existing hospital-based outpatient departments would not be permitted to expand the scope of services they provide at those facilities and receive hospital-based reimbursement for those new services. NAUH disagrees with this proposal as well.

Again we come back to what we believe to be one of Medicare's and hospitals' shared objectives: providing more Medicare-covered services on an outpatient basis. Another shared objective is providing more integrated and holistic care. Sometimes that can be achieved, for example, by adding oncology services as the number of patients a facility serves grows and more need to be referred for cancer care. Sometimes it may mean adding nephrology services when the on-site patient volume of a urology practice suggests additional expertise is needed to serve those patients more effectively. And sometimes it means adding medical imaging and laboratory services because of the sheer volume of patients who need to be referred to outside providers for such services and the challenges those patients encounter finding providers willing to serve them. Such developments are natural, an evolutionary part of enhancing the

integration of care and should be viewed as signs that providers are succeeding in serving more Medicare patients on an outpatient basis and doing a better job of integrating care and helping to achieve one of Medicare's policy objectives. The proposal to limit such service expansions would jeopardize what should clearly be viewed as progress and NAUH therefore urges CMS to reconsider these provisions in the proposed rule and not limit the expansion of outpatient facilities' services as it has proposed.

In fact, CMS should be encouraging the expansion of services provided by these outpatient departments rather than discouraging them. The Affordable Care Act, for example, requires hospitals to perform periodic community needs assessments. What is the point of performing such assessments if hospitals are to be so severely limited in their ability to respond to the needs those assessments identify? If a hospital's needs assessment, for example, finds that a predominantly white or Hispanic community has a growing African-American population, hospitals should be encouraged to consider adding services for medical challenges that research shows disproportionately affect African-American patients, such as diabetes and hypertension. It should not, in NAUH's view, become new public policy to discourage providers from responding to the emerging needs of their communities and to penalize them financially for doing so.

This is another area in which Congress did not prescribe specific policies through the Bipartisan Budget Act of 2015; this approach is of CMS's choosing. NAUH urges CMS to reconsider this proposal and instead enable existing hospital-based outpatient departments to offer additional services for which they would be paid Medicare hospital-based outpatient rates. Hospital outpatient departments, like hospitals, need to be able to expand the services they offer to meet the emerging needs of their communities and be free to do so without suffering significant financial penalties in return for their efforts.

Limiting the Sale of Hospital-Based Outpatient Departments

Under the proposed rule, existing hospital-based outpatient departments sold by their current owners would lose their ability to receive hospital outpatient department rates. NAUH opposes this proposal as well.

At times, hospitals that are closing their doors may choose to sell their outpatient departments to help satisfy financial obligations and to ensure continuity of care for the many patients they have served over the years. The inability of a potential purchasing entity to receive hospital-based outpatient rates would reduce the appeal of acquiring such facilities and could, in turn, jeopardize access to care for the low-income Medicare beneficiaries who have long been served by such outpatient departments. Adopting a policy that could result in the closure of such facilities would detract from Medicare's efforts to increase the use of outpatient services in the delivery of care to the Medicare population and reduce access to care in the low-income communities urban safety-net hospitals serve. NAUH believes that if a new owner of an existing hospital outpatient department is willing to accept that facility's obligations and take on its challenges it should be permitted to retain its grandfathered status under new ownership. For these reasons, NAUH urges CMS to reconsider this proposal and instead authorize hospital-based outpatient departments to retain their hospital-based outpatient payments even if they are sold.

Jeopardizing Access to the 340B Prescription Drug Discount Program

The proposed rule does not appear to contemplate the potential impact of new site-neutral outpatient payment policies on hospital outpatient departments' participation in the Health Resources and Services Administration's section 340B prescription drug discount program. This program is incredibly important to urban safety-net hospitals, ensuring their access to prescription medicines that in many situations their low-income patients could not possibly afford. Along with Medicare's long-time recognition of the greater costs and greater benefits that come with the delivery of outpatient care in a fully integrated

hospital outpatient department, the 340B program recognizes the special challenges hospitals face in providing access to these services in communities that are disproportionately low-income.

In the absence of any specific mention of the 340B program in the proposed rule, NAUH is concerned about a possible unintended consequence of the proposed rule: the loss of hospital-based outpatient department status resulting in the loss of such operations' 340B eligibility. If an outpatient facility were to lose its hospital-based status, would it lose its 340B eligibility as well? Has CMS considered this problem? Has it sought to address this issue with the Health Resources and Services Administration, which operates the 340B program?

If a decision has been made about this issue, NAUH urges CMS to amend the proposed rule, state what has been decided, and give stakeholders an appropriate opportunity to comment. If the agencies involved have not addressed this issue and made a decision, NAUH urges them first, to address the issue, make a decision, and provide for an appropriate period of stakeholder comment, and second, to ensure that outpatient departments that lose their hospital-based status, no matter what the reason, retain their eligibility for the 340B program. The continuing care of too many Medicare beneficiaries depends on this.

Additional Technical Concerns

NAUH has a number of additional technical concerns about the implementation of site-neutral outpatient policies. Among them:

- We disagree with the proposal that the submission date of Medicare claims should be used to determine whether a new hospital outpatient department shall be considered hospital-based and urge CMS to consider another, more appropriate measure.
- The proposed regulation does not address how CMS intends to reimburse off-campus outpatient departments for services that are not included on the current physician fee schedule, such as infusion services.
- We believe hospital cost reports should continue to include costs associated with off-campus outpatient departments even if they are not paid under the outpatient prospective payment system. Otherwise, hospital overhead will not be properly allocated and hospitals' overall costs and payments will not be accurately reflected.
- Under the proposed regulation, hospitals would have to manually attempt to identify the facility components of payments to physicians under the physician fee schedule and attempt to collect that portion from physicians. This will present administrative and possibly legal challenges.
- For some teaching hospitals, the physicians practicing in their outpatient departments may be employed by the university rather than the hospital. In such instances, the universities, under the proposed regulation, would receive the facility payments meant to cover the costs of providing hospital services. This, in NAUH's view, needs to be addressed.
- Currently hospital use the UB-04 form to submit claims to Medicare. Through this form, hospitals also provide additional data that goes above and beyond what ordinary physician offices provide, including services unique to the hospital-based outpatient department setting. Changing this form would necessitate major system-wide changes for hospitals. Consistent use of this form also would ensure that hospitals continue to be able to identify and attribute their costs and payments for cost-reporting purposes. NAUH urges CMS to preserve the current billing process and form for hospital-based outpatient departments, but if it chooses not to, it should delay implementation to give providers time to make appropriate adjustments and investments in the changes needed.

Conclusion

The primary objective of mission-driven, non-profit urban safety-net hospitals is to meet the medical needs of their low-income, historically underserved communities. Increasingly, they are doing this by going out into those communities and establishing outpatient facilities that serve people where they live. It is left to safety-net hospitals to do this because no one else will: no independent physician practice or entrepreneur is going to spend money to offer health care services in communities where most of the residents are insured by Medicare or are low-income and therefore insured by Medicaid or not at all. The market speaks, we are constantly told, and the market left many of these communities behind years ago.

The outpatient facilities hospitals establish in these communities are not, moreover, the same as most ordinary physician offices. Most ordinary physician offices do not offer radiology, laboratory services, and pharmacy services; they do not offer behavioral health services, interpreters, patient advocates, and social and support services; they do not manage their patients' care through electronic health records that are integrated with the hospital or hospitals that will serve those patients should they ever require hospitalization. Most ordinary physician offices offer none of this; hospital-based outpatient departments do.

All of these measures that go above and beyond the cost of one doctor seeing one patient come at a cost. NAUH is not asking CMS to permit hospitals to establish new hospital-based outpatient departments: all we are asking is that those that are currently in operation be permitted to continue operating and to expand their services if their communities need additional services; to relocate and expand if relocation and expansion enable them to better meet the needs of their communities; and to enable ownership of those operations to change hands without jeopardizing the new owner's ability to ensure continued access to outpatient care in low-income urban communities. Anything less will jeopardize access to care in those communities and jeopardize the health and well-being of the people who have come to depend on these outpatient departments for high-quality, accessible, affordable health care.

For these reasons, NAUH urges CMS to reconsider its proposal to limit the ability of hospital-based outpatient departments to relocate without losing their hospital-based status; to reconsider its proposal to limit the ability of hospital-based outpatient departments to expand the services they provide without losing their hospital-based outpatient department status; and to reconsider its proposal to limit the ability of the owners of hospital-based outpatient departments to sell those departments to another willing provider without jeopardizing those departments' hospital-based status. None of these aspects of the proposed rule to which NAUH objects are required under the Bipartisan Budget Act of 2015 and all of them can be changed at CMS's discretion. NAUH urges CMS to exercise that discretion now.

Finally, in light of the many questions about the proposed regulation that remain unanswered – how CMS will identify grandfathered facilities and pay them, how the 340B status of facilities would be affected, how certain services would be paid, and many other such considerations – NAUH urges CMS to delay implementing its regulation governing Medicare site-neutral outpatient payments for another year until it can address these issues and answer the many questions that today are unanswered and, in some cases, unanswerable.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory

entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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NAUH appreciates the opportunity to present these comments to CMS and invites any questions you may have about the concerns we have raised.

Sincerely,

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Executive Director