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December 1, 2017

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Crosson:

At its November meeting, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed improving incentives in the emergency department (ED) payment systems, increasing the equity of payments within each post-acute care (PAC) setting and refining an alternative to the Merit-based Incentive Payment System (MIPS). Each of these issues is of critical importance to hospitals, health systems, other care providers, and the Medicare beneficiaries they serve. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks that the Commissioners consider the following before making draft recommendations related to these topics.

We are primarily concerned about MedPAC’s potential recommendations regarding site-neutral payments to hospital-based off-campus EDs (OCEDs) in urban areas, and payments to PAC providers. The proposals set forth in both of these areas are premature and have not been completely thought through or analyzed. We are specifically concerned that the site-neutral recommendations would be disruptive to providers, patients and communities alike and that the PAC payment recommendations are not feasible to implement.

IMPROVING INCENTIVES IN THE ED PAYMENT SYSTEMS

At the November meeting, MedPAC staff once again reviewed trends in the growth, patient mix, coverage and regulation of OCEDs in urban areas. Commissioners discussed two possible policy options related to these OCEDs. The first is what they described as a “technical fix” to the site-neutral policy included in Section 603 of the Bipartisan Budget Act of 2015 (BiBA) and would establish site-neutral rates for “physician offices” co-located with OCEDs. The second would



establish a policy to pay urban OCEDs located within 20 minutes of an on-campus ED at the lower Type B ED rates.¹

The AHA opposes these site-neutral payment options. We believe it is premature and potentially disruptive to providers, patients and communities to recommend additional site-neutral policies in the absence of any data to support the Commissioners' stated concerns. Instead, we urge the Commission to delay making any recommendations on this topic until it is able to examine Medicare claims data specific to stand-alone OCEDs. As we indicated in our Dec. 5, 2016 [letter](#) to MedPAC, the AHA believes it may be worthwhile for the Centers for Medicare & Medicaid Services (CMS) to begin to track OCEDs in the Medicare claims data, provided the mechanism used to do so is not overly costly or burdensome for hospitals to implement.

Site-neutral Rates for Physician Offices Co-located with OCEDs (Section 603 Fix). At the November meeting, Commission staff discussed a possible “technical fix” to the site-neutral policy in Sec. 603, which currently exempts all items and services furnished in a dedicated ED from site-neutral payment. Commission staff argued that the exemption allows OCEDs to bill outpatient prospective payment system (OPPS) facility fees for scheduled visits to “physician offices” that are co-located with the OCED and, therefore, undermines the principles of site-neutral payment. **Describing this recommendation as a “technical fix” is misleading. Indeed, it would be a significant change in policy that is contrary to Congressional intent.** In addition, the AHA is confused by the staff’s continued reference to paying site-neutral rates to “physician offices.” If it is truly describing physician offices, then they are already being paid physician rates – site-neutral rates would not actually make sense. **While we believe that the staff are actually describing non-grandfathered off-campus hospital outpatient departments (HOPDs), which are the entities subject to Sec. 603, the confusing nomenclature is emblematic of the prematurity of MedPAC’s proposed options.**

Also underscoring the prematurity of MedPAC’s proposals is the absence of evidence that hospitals are actually co-locating “physician offices” with OCEDs – even MedPAC staff stated that they do not know whether this is occurring. Specifically, in response to a question from a Commissioner about how prevalent co-location of “physician offices” is, staff responded, “So we don’t have a good read on that, actually... We haven’t seen a lot of examples of this, but

¹ A Type B provider-based emergency department must meet 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, and open less than 24 hours a day, 7 days a week; or (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, and open less than 24 hours a day, 7 days a week; or (3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 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, regardless of its hours of operation.” Source: *OPPS Visit Codes Frequently Asked Questions*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/opps_qanda.pdf.

we don't have a great idea of how common it is.”² In fact, in its March 2017 report, the Commission said, “CMS is currently unable to track growth in stand-alone ED claims because the claims are not distinguished from hospitals’ on-campus ED claims.”³ Indeed, this is why the March report recommended that the Secretary “should require hospitals to add a modifier on claims for all services provided at off-campus standalone emergency department facilities.”⁴ To pursue the fix discussed in November when it is not clear that such co-locations are occurring, and when there is no way to separately identify which and what type of services are being furnished in the hospital’s OCED, is attempting to solve a problem that may not exist. It also would add unnecessary complexity to the agency’s already burdensome site-neutral policy.

In addition, MedPAC staff cited concerns that OCEDs can receive higher hospital rates for both emergency and non-emergency services, which could include services like imaging, as well as scheduled visits that are not related to emergency care. However, such services are often an integral part of emergency services. Indeed, the Emergency Medical Treatment and Labor Act (EMTALA) regulations explicitly allow for scheduled visits in EDs. Specifically, under the definition of a dedicated ED, which Congress explicitly referenced in Sec. 603, the department must:

- (1) be licensed by its state as an ED;
- (2) hold itself out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) *be a location where CMS makes a determination under EMTALA that at least one-third of patient visits are for the treatment of an emergency medical condition without requiring a previously scheduled appointment* [emphasis added].

We believe that Congress’ use of this definition in Sec. 603 was deliberate and intended to recognize that ED encounters can appropriately take many different forms beyond just unscheduled visits or arrivals via ambulance. Scheduled visits may occur, for example, when a patient is directed to the OCED after hours to be evaluated by a specific specialist or by their own physician for alarming symptoms, such as chest pain, an acute exacerbation of a chronic condition, or unanticipated side effects of a medication. In addition, it is appropriate for an individual experiencing alarming signs or symptoms to seek care in an OCED, even if the final diagnosis is less serious or “low acuity.” Determining the patient’s final diagnosis is appropriately the job of the physicians and other staff in the ED. This line of reasoning is incorporated into EMTALA through the “prudent layperson” definition of an emergency medical condition,⁵ which focuses on the patient’s presenting symptoms, rather than the final diagnosis,

² See page 104 of the Nov. 2 MedPAC meeting transcript at <http://www.medpac.gov/docs/default-source/default-document-library/november-2017-transcripts/1b311adfa9c665e80adff00009edf9c.pdf?sfvrsn=0>.

³ See page xiv of the March 2017 MedPAC Report to Congress at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch3.pdf?sfvrsn=0.

⁴ Ibid.

⁵ The “prudent layperson” definition, which has been enacted into EMTALA and state law, defines an emergency medical condition to mean, “(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (i) Placing the health of the individual (or,

when determining whether a visit to an ED is appropriate. This definition is part of what triggers the hospital's EMTALA obligation.

In addition, we are concerned that, if the Commission were to further pursue this policy, it risks misidentifying any service that is *not* an ED evaluation and management (E&M) service as instead being furnished in a co-located "physician office." As noted above, all EDs, including OCEDs, appropriately provide services other than ED E&M services, including a wide variety of ancillary and supportive services that are necessary for emergency care, such as imaging, laboratory tests, drug infusions and minor procedures. Just because a service is also commonly furnished in nonemergency circumstances does not mean that it is inappropriately provided in an OCED or that it is being provided by a co-located "physician office." Further, as noted above, just because a patient's final diagnosis may rule out an emergency medical condition does not imply that the visit was furnished by a co-located "physician office" or is otherwise an inappropriate OCED encounter.

Type B Rates for Urban OCEDs within 20 Minutes of an On-campus ED. The second policy option discussed at the Nov. 2 meeting was to pay the lower Type B ED visit rates for urban OCEDs that are located within 20 minutes of an on-campus ED. The rationale posed by Commission staff was that this policy would better reflect these OCEDs' resource needs and services due to assumptions that they tend to get fewer patients arriving via ambulance and more walk-in patients. Staff further note that this policy would be a disincentive to build additional OCEDs near on-campus EDs, when community needs could instead be met with urgent care centers.

The AHA opposes this policy and believes that it is premature and potentially disruptive to care. MedPAC has not presented any Medicare claims data that allow it to accurately identify and evaluate the volume and type of services furnished to Medicare beneficiaries in urban OCEDs. Yet, it still assumes that urban OCEDs are not seeing "the most difficult cases⁶" and that paying at the Type B rates "would more closely align with patient resource needs."

In addition, we believe that urban OCEDs, even those that are close to a hospital's on-campus ED, play an important role in improving access to emergency care for beneficiaries who would otherwise experience long wait times if they sought care in the hospital's on-campus ED. As noted during the November discussion by a MedPAC Commissioner, "We also have to understand that there's a lot of our EDs, especially in urban areas, that have, you know,

with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part; or (2) With respect to a pregnant woman who is having contractions, (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child." at https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=060daea35afcfbf6b1c6a8bf685d6f87;rgn=div5;view=text;node=42:5.0.1.1.7;idno=42;cc=ecfr#se42.5.489_124

^{6 6} See page 80 of the Nov. 2 MedPAC meeting transcript at <http://www.medpac.gov/docs/default-source/default-document-library/november-2017-transcripts/f1b311adfa9c665e80adff00009edf9c.pdf?sfvrsn=0>.

10-, 12-, 14-hour waits, frankly, which isn't great either....there is a level of care that is not appropriate for an urgent care but probably doesn't need to be in a trauma center, and there's something in the middle.”

Finally, we believe that determining which OCEDs are 20 minutes away from an on-campus ED in urban areas will entail arbitrary analyses and will lead to variable results, which could lead to inequities between OCEDs and result in legal disputes. Factors such as time of the day, season, construction, population density, etc., considered in these analyses would result in vastly different conclusions about which OCEDs would be subject to this policy. Imposing such an arbitrary policy would be unfair to those hospitals that are seeking to provide improved access to emergency care to Medicare beneficiaries.

Stand-alone EDs in Rural Communities. In the Commission's June 2016 Report, MedPAC recommended the creation of a freestanding ED designation as an option for preserving access to essential emergency services in rural communities. MedPAC staff further elaborated on this recommendation at the November meeting. Specifically, they continued to indicate that this option would be limited to stand-alone EDs in rural communities. In addition, they recommended that these rural outpatient facilities with an ED receive Type A prospective payment system (PPS) rates for ED services in addition to an annual payment amount to help cover the facility's fixed costs. Then, to ensure the community supports the facility, the local government or hospital district also may be required to contribute a matching grant to support the facility.

While the AHA supports consideration of stand-alone EDs as a way to ensure access to emergency services in these vulnerable rural communities, we are concerned that this distinction is shortsighted. Consistent with the comments made by Commissioner Wang at the November meeting, the AHA believes that these stand-alone EDs have the potential to preserve access to emergency services in both vulnerable rural and urban communities.⁷ In addition, while we believe the payment methodology recommended by MedPAC is one potential option, we believe further exploration is necessary to determine the most appropriate payment methodology to sustain the financial viability and ongoing operations of these facilities.

To that end, we urge the Commission to consider the work of AHA's Task Force on Ensuring Access in Vulnerable Communities, which explored a similar Emergency Medical Center (EMC) model. The task force's [report](#), included nine strategies that could preserve access to essential health care services (including primary care, emergency and observation, and psychiatric and substance use treatment services) in vulnerable rural *and* urban inner-city communities. The Task Force's EMC strategy would allow existing hospitals to eliminate their inpatient acute care services, while retaining emergency and outpatient services along with transportation and PAC services, depending on their community's need.

⁷ See page 121 of the Nov. 2 MedPAC meeting transcript at <http://www.medpac.gov/docs/default-source/default-document-library/november-2017-transcripts/f1b311adfa9c665e80adff00009edf9c.pdf?sfvrsn=0>.

To further the task force's recommendation, the AHA has urged Congress and the Administration to consider the development of a demonstration program to test the feasibility of the EMC model and its ability to ensure access to emergency services. Through this demonstration, CMS could test various payment methodologies for services provided, including:

- Medicare OPPS rates, plus an additional facility payment to cover standby costs;
- a new fee schedule for EMCs; and
- rates of 110 percent of reasonable costs for EMC services.

We urge MedPAC to consider a similar demonstration program to test other payment options as part of its recommendation.

INCREASING THE EQUITY OF PAYMENTS WITHIN EACH PAC SETTING

During the November meeting, Commission staff presented new work on "increasing the equity of payments within each post-acute care setting." This session is related to MedPAC's broader effort to increase the accuracy of PAC payment, a goal strongly supported by the AHA, as well as the statutorily mandated development of a PAC PPS prototype, a model that raised substantial concerns as described in AHA's report titled "[*A Critique of MedPAC's Post-Acute Care Prospective Payment System Prototype*](#)." The November presentation included a discussion of a preliminary policy recommendation to use a blend of MedPAC's new PAC PPS weights and current setting-specific weights for the calculation of 2019 and 2020 PAC payments under the current payment systems.

The November presentation and discussion lacked detail explaining how this policy concept could actually be implemented. Given the incongruent design of the PAC PPS relative to the four existing PAC PPSs, and the limited information shared thus far, such feasibility is far from a given. For example, the PAC PPS's 100-variable regression model creates a unique payment amount for each patient. However, the current home health, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital PPSs each have a distinct number of pre-set payment categories, case-weight schemes, episode lengths, and other unique design elements. Compounding these concerns, the PAC PPS relative weights have not been shared with the public, which counters the Commission's commitment to transparency and prevents any external validation.

Given these incongruities, we are concerned about the feasibility of implementing this recommendation, which would require CMS to, in some way, cross-walk the current diverse elements of the four PPSs with the new unified PAC PPS relative weights. We urge the Commission not to proceed with this recommendation absent further exploration of its feasibility and increased transparency with the public.

REFINING AN ALTERNATIVE TO THE MIPS

The AHA continues to appreciate the Commission's interest in identifying ways to improve the implementation of the new physician quality payment program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The new MIPS and Advanced Alternative Payment Model (APM) tracks established under the law are major public policy changes and, as such, merit ongoing evaluation.

At the same time, we continue to urge that the Commission use data and experience from the field before advocating for major changes to the MIPS. The first performance period for the MIPS and APMs began on Jan. 1, 2017. As a result, clinicians and the hospitals with whom they partner are at the very beginning of putting the MACRA's policy requirements into action. As a result, the significant policy changes that the Commission has discussed since early 2017 do not yet have the benefit of data and experience. Furthermore, CMS has appropriately taken steps to provide a gradual ramp-up of MIPS requirements in the first two years of the program to allow clinicians time to make the transition. Changing course on the MIPS so soon after program implementation could lead to confusion in the field, and prompt clinicians to spend time deciphering the requirements of a new program rather than on improving care.

At its November meeting, the Commission discussed a revised approach to the MIPS in which the current policy would be repealed in favor of a voluntary value program (VVP). The VVP would withhold at least 2 percent of clinician payment unless clinicians either joined an advanced APM, or agreed to be measured as part of a voluntarily elected group on measures of "population-based outcome measures," patient experience and cost. The measures would need to be specified, but in its June 2017 *Report to Congress*, the Commission recommended using measures drawn from Medicare claims data and patient surveys.

The AHA appreciates that the Commission appears to be turning away from an approach in which it assigns clinicians to groups in their communities, rather than letting clinicians choose their own groups. The AHA has always supported the notion of clinicians coming together voluntarily to participate in the MIPS as a group practice, as it provides a way to share resources and improvement strategies. Allowing clinicians to form their own groups is appropriate given the considerable variation in market composition and the ability of clinicians to collaborate on improving performance.

However, the AHA continues to urge that any pay-for-performance program not rely so heavily on claims-based measures. We appreciate that MedPAC recognizes the significant resources required to collect and submit quality data. Without question, using Medicare claims entails less data collection effort on the part of clinicians. However, claims data cannot and do not fully reflect the details of a patient's history, course of care and clinical risk factors. Such information is crucial to performing the risk adjustment that most outcome measures require to fairly compare provider performance. As a result, many claims-derived outcome measures do not accurately reflect provider performance. Basing clinician performance on unreliable data would be highly problematic.

Francis J. Crosson, M.D.

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Again, we thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org or (202) 626-2340.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: James E. Mathews, Ph.D.
MedPAC Commissioners