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ONE HUNDRED FOURTEENTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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February 5, 2015

Dear Member of the Health Care Community,

On November 2, 2015, the President signed into law the Bipartisan Budget Act of 2015 (BBA, P.L. 114-74). Section 603 of this bipartisan law made changes to certain Medicare hospital reimbursements on a prospective basis. We write today to invite members of the health care community to provide feedback to the Committee related to the enactment of Section 603 of the Bipartisan Budget Act of 2015.

First, let us provide a little background on the specific policy which was enacted. The BBA policy established a site neutral payment policy for newly-acquired, provider-based, off-campus hospital outpatient departments (HOPD) after November 2, 2016 within the Medicare program. While provider-based facilities acquired before the law's enactment are able to continue to bill under the Hospital Outpatient Prospective Payment System (HOPPS), any newly acquired units after the date of enactment are prohibited from doing so for items and services furnished after of January 1, 2017. Section 603 impacts all items and services other than those furnished by a dedicated emergency department. Those facilities not operating on a hospital's main campus will be reimbursed under the most applicable of existing fee schedules, including the Medicare physician fee schedule (PFS), ambulatory surgical center prospective payment system (ASC PPS) or the clinical laboratory fee schedule (CLFS).[1]

The policy enacted into law a few months ago came after years of non-partisan economists, health policy experts, and providers expressing concern over the Medicare program's HOPPS paying more for the same services provided at HOPDs than in other settings—such as an ambulatory surgery center, physician office, or community outpatient facility. For example, Medicare pays $58 to $86 more when an evaluation and management visit is performed in an HOPD compared to a physician office, depending on the HCPCS code billed, even though these beneficiaries are no sicker than those seen in a physician's office.[2] Such parties raised concerns that this payment inequity drove the acquisition of standalone or

[1] This provision was estimated by the Congressional Budget Office (CBO) to reduce program expenditures by $9.3 billion over the next decade.

[2] GAO-16-189, "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform." Available online at http://www.gao.gov/products/GAO-16-189

independent practices and facilities by hospitals, resulted in higher costs for the Medicare system and taxpayers, and also resulted in beneficiaries needlessly facing higher cost-sharing in some settings than in others.

Some experts argued that to the extent this payment differential accelerated consolidation of providers, this would result in reduced competition among both hospitals and nonaffiliated outpatient service providers. This, in turn, could reduce large hospital systems' incentives to reduce costs, increase efficiency, or focus on patient outcomes.

At the same time, others have questioned the concerns over consolidation and have instead highlighted the beneficial efficiencies and economies of scale that can be accomplished through consolidation. For example, in testimony before the Energy and Commerce Health Subcommittee on May 21, 2014 during a hearing entitled "Keeping the Promise: Site-of-Service Medicare Payment Reforms", which examined various site-neutral prospective policy changes, Dr. Coopwood representing the American Hospital Association, argued that site neutral payment policy could not be viewed in a vacuum and instead must be viewed along with the totality of services provided, populations served and recognizing that "hospitals are subject to significant regulatory and quality requirements."[3]

Helpfully, in recent years, MedPAC has repeatedly examined whether payment policies that reimburse providers different amounts for the identical medical services provided at different types of sites encourage provider behaviors or market dynamics that ultimately increase costs to the Medicare program—without a clear benefit to the program or beneficiary. For example, MedPAC has done work dating back well over a decade on the merits of aligning payments based on the site of service. MedPAC has examined the merits of other potential payment reforms within other parts of the Medicare program such as in the post-acute care (PAC) space.

MedPAC's findings regarding the reasons and rationale for implementing Medicare site-of-service payment reforms have been well-examined and their analysis has been robust. In their June 2013 Report to Congress, MedPAC detailed several different site-neutral policy considerations including:

- "Equalizing Medicare payment rates across settings for Evaluation and Management (E&M) office visits;
- Aligning payment rates between Hospital Outpatient Departments (OPDs) and physicians' offices for other types of ambulatory services;
- Aligning payment rates between OPDs and physicians' offices for cardiac imaging services; and,
- Equalizing payment rates between OPDs and Ambulatory Surgery Centers for certain ambulatory procedures."

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[3] Written Testimony of Dr. Reginald W. Coopwood on behalf of the American Hospital Association, "Keeping the Promise: Site-of-Service Medicare Payment Reforms," Available online at http://docs.house.gov/meetings/IF/IF14/20140521/102250/HHRG-113-IF14-Wstate-CoopwoodR-20140521.pdf.

These policy analyses have not only been delivered to Congress in several MedPAC reports, but they have been presented as well in testimony before the Committee. For example, in addition to the May 21, 2014 hearing, in testimony before the Health Subcommittee on December 9, 2014, MedPAC Executive Director Mark Miller Ph.D. stated: "In principle, the Medicare program should pay the same amount for the same service, regardless of the setting in which it is provided, unless payment differentials are justifiable by differences in patient mix, provider mission (e.g., maintaining stand-by capacity for emergencies), or other justifiable factors."[4]

The Government Accountability Office (GAO) has also helpfully examined Medicare payment polices and examined the merits of various site-of-service payment reforms. In a December 2015 report to Congress, GAO found that "from 2007 through 2013, the number of vertically consolidated physicians nearly doubled, with faster growth in more recent years."[5] GAO concluded that, "regardless of what has driven hospitals and physicians to vertically consolidate, paying substantially more for the same service when performed in an HOPD rather than a physician office provides an incentive to shift services that were once performed in physician offices to HOPDs after consolidation have occurred."[6] GAO's analysis also offered interesting analysis regarding utilization of services related to sites of service:

> "Our findings suggest that providers responded to this financial incentive: E/M office visits were more frequently performed in HOPDs in counties with higher levels of vertical consolidation….. Further, our analysis of 2013 health status data suggests that beneficiaries from counties with higher levels of vertical consolidation, where we found more E/M office visits performed in HOPDs, were not sicker, on average, than beneficiaries who lived in counties with lower levels of consolidation…"[7]

As a result, GAO recommended Congress "consider directing the Secretary of HHS to equalize payment rates between settings for E/M office visits and other services that the Secretary deems appropriate and to return the associated savings to the Medicare program."[8]

With the adoption of Section 603 of the Bipartisan Budget Act of 2015, the Committee has received a large amount of feedback since enactment of law. Many parties have offered thoughts about the provision's potential impact on hospitals, beneficiaries and providers. For example, some concerns we have heard include:

- A concern with the policy generally and its impact on hospital's financial viability.
- A lack of specificity on those HOPDs that are "grandfathered" and a need for statutory clarity on issues surrounding implementation, growth, relocation, and change of purpose.

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[4] Written Testimony of Dr. Mark E. Miller on behalf of MedPAC, "Context for Medicare Payment Policy and Recommendations," Available online at http://docs.house.gov/meetings/IF/IF14/20141209/102787/HHRG-113-IF14-Wstate-MillerM-20141209.pdf.
[5] GAO-16-189, "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform."
[6] Ibid.
[7] Ibid.
[8] Ibid.

- The short period of time surrounding enactment of the provision and a concern of significant current investment of future HOPDs that range in development from architectural planning to nearly operational.
- The unique impact on Medicare PPS Excluded Free Standing Cancer Hospitals
- The unique populations served by certain safety net hospitals located in medically underserved areas and the policy's impact on their ability to continue to perform community outreach.
- A general concern that site-neutral recommendations assume that alternative payment rates, such as the Medicare PFS payment rate reflect an appropriate level of reimbursement.

While some have expressed these and other concerns to the Committee, other stakeholders and members of the health care community have suggested a range of possible Committee responses to the new provision of law. For example, some stakeholders have urged the Committee to:

- Make no modifications to statute;
- Make the current Section 603 policy retroactive including picking up currently grandfathered facilities;
- Enact further site-neutral policies across the Medicare program taking into account the numerous MedPAC recommendations noted above;
- Adopt legislation previously examined by the Subcommittee that would further payment neutrality in spaces such as post-acute care and oncology;
- Explore refinements to issues surrounding expansion, grandfathering or relocation of existing OHOPDs the Committee should do so in a holistic approach that would also evaluate similar concerns expressed by physician-owned hospitals;
- Ensure that the savings achieved by Section 603 and the Bipartisan Budget Act of 2015 should generally not be reversed and to the extent they are modified must be offset with reductions in the same provider space.

While the illustrative list of concerns and recommendations are not exhaustive, they offer a good flavor of the spectrum of feedback the committee has received related to Section 603 of the Bipartisan Budget Act of 2015. This has been an area of interest for our Members and will continue to be so in the coming year.

Given the wide breath of suggestions, ideas, concerns and proposals shared with the Committee on this issue, we are inviting all interested members of the health care community to provide formal feedback on policies the Committee should examine in the context of both the enactment of this provision of law, as well as other changes to site neutral payment policies. If changes are suggested that would represent an increase in cost to beneficiaries or the Medicare program, in the interest of serving patients, beneficiaries and taxpayers, we would hope you would also suggest additional policies or payment reforms which would ensure changes are at least budget-neutral, or which would ideally further the solvency of the Medicare Program. In providing feedback, please ensure you explain why any proposed changes are desirable from the perspective of beneficiaries, patients, and the Medicare program overall.

To inform the Committee's work in a timely manner, we request your written feedback be provided no later than February 19, 2016 to the Committee. If you have any questions about this request, please contact James "JP" Paluskiewicz, Josh Trent, or Adrianna Simonelli with the Committee.

Sincerely,

Fred Upton
Chairman

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member
The Honorable Gene Green, Ranking Member,
Subcommittee on Health