**Healthcare issues 2016**

**Urge Congress to Protect Access to Care and Expand the Hospital “Grandfather Provision” of the Bipartisan Budget Act of 2015.**

**ISSUE:** On November 2, President Obama signed the Bipartisan Budget Act of 2015 (BBA). The legislation provides a budget for the next two years, extends the debt ceiling to March 2017 and raises discretionary spending caps by $80 billion, split evenly between defense and non-defense spending. The law also avoids increasing the cost of Medicare Part B premiums for some seniors. The cost of the BBA is offset, in part, by implementing payment changes for **new** off campus provider-based hospital outpatient departments and a one-year extension of the 2 percent Medicare sequester.

**Action:** Inland Action urges Congress to take action to reject any further expansion of site-neutral payment policies in the acute or post-acute setting. In addition, we ask for assistant in revising Section 603 of the BBA to restore appropriate hospital outpatient prospective payment system payments to off-campus provider-based outpatient departments

**Background:** Medicare beneficiaries require and deserve continued access to all levels of medically necessary care, including hospital-level and post-acute care. One of the key drivers in access is adequate provider payment. Notably, the Medicare Payment Advisory Commission (MedPAC) has stated that for fiscal year 2016, the average hospital will have an overall Medicare margin of negative 9 percent (a decrease from negative 5.8 percent in 2014), and even relatively efficient providers will experience *negative* Medicare margins. MedPAC notes that hospital outpatient margins are at negative 12.4 percent. In January of this year, MedPAC recognized the inappropriate payment levels to hospitals and recommended a 1.75 percent increase in the annual payment update for both inpatient and outpatient services. Hospitals in California continue to lose money on their Medicare and Medicaid beneficiaries and are forced to shift costs to commercial payers. **Current hospital payment is already inadequate to sustain even the slightest positive margin, let alone the impacts of reducing that payment to a level far below current rates.**

The American Hospital Association estimated that implementing site-neutral proposals for evaluation and management services alone would decrease hospital outpatient department margins to negative 14 percent. If fully implemented, margins would fall to negative 20 percent. Hospitals cannot continue to provide needed services at financial losses. Adopting such polices jeopardizes access to medically necessary care for all, including Medicare beneficiaries.

In addition, hospital-based providers have higher costs than non-hospital providers for a number of reasons. For example, as compared to other outpatient settings, HOPDs treat higher severity patients, operate with higher cost structures due to 24/7 emergency stand-by capacity, and incur higher costs associated with the many regulatory requirements, as compared to the physician office setting or the ambulatory surgery center (ASC) setting (e.g. licensing and accreditation). **To the extent that a payment system does not recognize and accommodate these very real, very costly differences, the result will be further destabilization and erosion of access to care.**

While such a policy is intended to accurately match patient characteristics with resource needs and ensure reimbursement is sufficient to support the delivery of all medically necessary care, the metrics to adequately assess resource needs are woefully inadequate. For example, we are just beginning data collection through the implementation of the IMPACT Act to measure and reflect differences in areas such as functional and cognitive function status of patients. Recognition of these differences in patients speaks directly to the resources (e.g. staffing, specialty care) needed to successfully manage the care of the patient. While the Committee has highlighted recent work by MedPAC and GAO in this area, more exploration is needed — more specifically, a greater emphasis should be applied to the clinical makeup of patients derived through patient assessment tools and quality metrics. The limitations of administrative data in accurately predicting the needs of patients across settings are well documented and should be evaluated as such.

Finally, Medicare providers are currently subject to myriad regulations, many of which are unique to a specific level of care or payment system (i.e., a three-day inpatient stay needed to qualify for skilled-nursing facility care). While these regulations were originally developed to support appropriate resource use and access to care, any significant redesign of the reimbursement system must include relief from regulations that have become obsolete and interfere with, rather than support, clinical integration.

This is particularly true when considering the differences in requirements of all providers for the Medicare Conditions of Participation (CoPs). This will become even more acute with the upcoming release of updated hospital CoPs related to disaster preparedness. When this federal regulation is combined with state licensing and building code requirements, the cost and regulatory requirements for hospital-based providers are far more significant than those for any other provider. For example, the building code requirements for a hospital outpatient department far exceed the requirements for a physician office setting. **Until Congress also evaluates the regulatory framework in which services are provided, there will be significant inequities creating new and different incentives.**

**Section 603 of the Balanced Budget Act of 2015**

As noted above, in light of California’s severe shortage of primary care and specialty physicians, as well as behavioral health providers — and even fewer who will accept Medi-Cal, California’s Medicaid program, patients — hospitals and health systems across the state are undertaking a variety of innovative approaches for ensuring access to care in underserved communities. This includes partnerships with physician groups, including the development of new hospital-based outpatient clinics and satellite facilities. These off-campus facilities, often located in communities with otherwise limited access to care, are bringing needed health care services to all patients — in particular, our Medi-Cal beneficiaries and those who are uninsured.

This has been critical to preserving access to care in California rural communities, where partnership is one of the only ways to recruit and retain physicians who can no longer afford to remain in private practice. In California, employment of physicians is prohibited — the only way to keep struggling physicians in a community is to provide an infrastructure within which they can provide critical health care services to the community.

**Separate from the realities of the changing dynamics with our physician colleagues, California’s hospitals are in the midst of significant campus changes and rethinking how to provide services in their communities.** Until 1973, California hospitals, like most U.S. hospitals, were built to the national Uniform Building Code. A huge building boom from 1968-1972 helped to meet the demands of services that would be provided to Medicare and Medicaid beneficiaries, but the San Fernando Valley’s 1971 Sylmar Earthquake resulted in 50 hospital-related deaths. As a result, the state enacted the Hospital Facilities Seismic Safety Act (HFSSA) in 1973, which required that all new and structurally retrofitted hospital buildings in California be able to remain standing after a major earthquake. However, since the building boom preceded the enactment of state legislation, many hospitals did not have the resources to make necessary changes.

Subsequent earthquakes in 1989, and the famous 1994 Northridge Earthquake — which resulted in over $3 billion in structural and non-structural damages to hospitals — raised significant concerns with the Federal Emergency Management Agency**. In response to those concerns, California amended the HFSSA in 1994 to require all hospitals, by 2030, to remain both standing and operational following major seismic activity. This mandate is estimated to cost California hospitals $110 billion, excluding financing costs. The requirements of this standard are complex; it is far less costly for California hospitals to move on-campus outpatient services to off-campus buildings with less stringent building code requirements than the inpatient setting, but still higher than a typical physician office setting. Because facilities on campus must comply with the highest and most costly inpatient standards, hospitals are incentivized to provide off-campus services when possible.**

Meeting the 2030 seismic deadlines takes years of planning. Most of our hospitals are in every stage of development, from drawings to securing financing to breaking ground. In preparation for these changes, hospitals have to make financial assumptions about reimbursement. Moreover, the current building codes incentivize off-campus services over the more costly on-campus – but still at far greater building costs than our colleagues in other states who do not have seismic requirements that result in a $110 billion unfunded mandate.

Unfortunately, Section 603 of the BBA requires “site-neutral” payment reductions for all *new* hospital outpatient departments located more than 250 yards from the main hospital campus. This provision means that any outpatient service provided by a hospital in a facility off of the main hospital campus, not billing for the service as of November 2, 2015, will be reimbursed a lower amount paid to other part B providers including physicians or ambulatory surgery centers beginning January 1, 2017.

**Hospitals will see their payments cut dramatically. This disproportionately disadvantages California rural and urban hospitals that are providing health care services to people in underserved communities throughout California. Moreover, this undermines the current strategic planning and financing strategies of many hospitals and health systems in California that are in the middle of very detailed planning for meeting seismic standards.**

Further, the legislation is particularly problematic for dozens of hospitals across the state that had followed existing federal rules, in place since January 2001, and that undertook new partnerships and facilities to take patient care services out of the hospital and into the community. Under the new requirements of the BBA, only outpatient facilities that were operational and billing Medicare before November 2, 2015, will be “grandfathered” under the old rules and will continue to be paid at the existing hospital reimbursement rate.

This limited grandfather provision means that hospitals that are in definitive stages of project development of outpatient programs, but have not yet completed them, will now be subject to reduced payment rates. These hospitals followed the rules, but the rules were changed without warning in only a matter of days.

Inland Action urges Congress to expand the grandfather provision of the BBA to incorporate hospital outpatient facilities that are currently in definitive stages of development. This limited amendment will help ensure that Medi-Cal patients and the uninsured continue to have access to lifesaving care. **In addition, while we believe the secretary has discretion to allow for relocation of existing services under the grandfather provision, providing additional legislative clarity would be most helpful. To disallow relocation of existing off-campus entities in a state like California is dangerous for patients. Our buildings must be updated, retrofitted and, in some instances, torn down and rebuilt in a more suitable location. Asking hospitals to unravel an existing and already complex relationship to reform a different relationship, because of a change in address, is a waste of health care dollars.**