

September XX,
2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave, S.W., Room 445-G
Washington, DC 20201

Dear Mr. Slavitt:

As you know, the Centers for Medicare & Medicaid Services (CMS) published on July 6 its calendar year 2017 outpatient prospective payment system (OPPS) proposed rule for implementing Section 603 of the Bipartisan Budget Act of 2015, "Treatment of off-campus outpatient departments of a provider." We strongly believe numerous areas need more flexibility to ensure patients have continued access to care, and we urge changes in the final rule to protect our constituents who are Medicare patients.

On May 24, a majority of both Houses of Congress (235 Members of the House and 51 Senators) signed letters to CMS stressing the importance of implementing Section 603 in a way that protects patients' access to care and provides predictability for hospitals. We are disappointed that many of those concerns were not addressed in the proposed rule, and we hope the final rule can better address these areas.

As you know, after stating that dedicated emergency departments (DEDs) are excluded, the new law establishes lower payment levels for new off-campus hospital outpatient departments (HOPDs). These "new" HOPDs are defined as those that start billing for Medicare outpatient services under the outpatient prospective payment system (OPPS) after the date of enactment, November 2, 2015. Beginning January 1, 2017, services provided in these "new" HOPDs (excluding DEDs) will no longer be covered as OPPS services. They will instead be covered under other Medicare Part B payment systems: the Medicare physician fee schedule, the clinical laboratory fee schedule, and the ambulatory surgery center payment system.

The facilities impacted by this law often serve the most vulnerable patient populations in difficult-to-serve areas, and a number of clarifications in the rule are needed to ensure they can continue serving their communities. While many hospitals have projects underway or planned for the near future, others had taken a longer view in their strategic planning and relied on regulations by expending financial resources to meet the needs of a changing population. Thus, as you plan for implementation of Section 603, we urge you to include flexibility in the following areas: additional services provided at emergency departments, relocation or rebuilding of already existing outpatient departments, change of ownership of existing sites, and interpretation of the 250-yard rule.

We appreciate that you recognized the important and varied work that emergency departments provide. Section 603 refers to the Emergency Medical Treatment and Labor Act (EMTALA) regulations in 42 CFR 489.24(b), which state that a department can be defined as a DED if it "provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis." This definition recognizes that hospital emergency departments provide a wide range of services, and that ancillary services provided by a DED are needed to diagnose and treat patients. When a facility meets the

definition of a DED, none of the services furnished in that facility should be subject to the payment reductions.

We are also concerned about the treatment of necessary and valid relocations of existing HOPDs. Existing HOPDs may need to relocate for various reasons, such as being located on an earthquake fault line or a revised flood plain, having a lease expire, becoming obsolete or damaged, or becoming too small because of population shifts and increased patient loads. The need to relocate or rebuild for these types of reasons should not trigger payment reductions under Section 603.

Similarly, a change in ownership should not cause an HOPD to lose its status as an existing HOPD. The only criteria under Section 603 for being designated as an existing HOPD rather than as a “new” HOPD is that the facility was billing under the OPSS prior to November 2, 2015. A change of ownership, such as one hospital system acquiring the existing HOPD from a second hospital, is not separately discussed in the statute. Therefore, a change in ownership should not cause an existing HOPD to be redesignated as a “new” one, and an existing site should continue to be paid under the OPSS even after a change in ownership.

Lastly, current regulations define “on-campus” as buildings within 250 yards of the main buildings of the hospital or other buildings that the CMS regional office determines, on a case-by-case basis, to be part of the hospital campus. Emphasizing the discretion of regional offices is important because a consistently strict interpretation of the 250-yard criterion would disadvantage hospitals that are adjacent to barriers that could prevent on-campus expansion. Such barriers include rivers, wetlands, highways, and those located in densely populated urban areas or those co-located on land-locked university campuses. A narrow and strict interpretation of the 250-yard rule could result in sites being designated as off-campus, and thus subject to payment reductions, despite a clear proximity and integration with the hospital’s campus. Therefore, we urge CMS to instruct its regional offices to use the rule of “reasonable proximity” when making on-campus determinations and to evaluate on-campus status within the context of the hospital and its surrounding geography.

We hope CMS will continue to ensure that patients can access care and services at the appropriate site of care in their community. We believe the clarifications in the OPSS rule discussed above will maintain quality access to care for Medicare beneficiaries, and we appreciate your consideration of these issues.

Sincerely,

Devin Nunes
Member of Congress

Joseph Crowley
Member of Congress