September 1, 2016

Mr. James Maguire
AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

RE: Notice of Supplemental Proposed Rulemaking on Standards for Payment: Reimbursement of Freestanding Emergency Departments

Dear Mr. Maguire:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) thank you for the opportunity to comment on the AHCCCS Administration's proposed rule to establish a new payment methodology for hospital-based freestanding emergency departments (FSEDs). AzHHA is a statewide association of more than 70 hospitals, affiliated healthcare systems, and other healthcare organizations across Arizona. Our members are committed to working collectively to achieve the Triple Aim – improving the quality of healthcare and the health of all Arizonans, while reducing the growth in per capita healthcare costs.

We have supported and continue to support many of the Administration's recent efforts to develop payment methodologies that reward efficiency and focus on value. We also share the Administration's concern that greater emphasis should be placed on the appropriate utilization of services by AHCCCS members, including unnecessary use of emergency services for conditions that could be treated in a primary care or urgent care setting. Many of our members are partnering with AHCCCS health plans to reform the delivery system to advance these goals.

Having said this, we have serious concern that—while well-intentioned—the proposed rule will harm access to emergency care in medically underserved areas of the state while doing little to address the underlying causes of inappropriate use of emergency department (ED) services by AHCCCS members. As of this writing, two AzHHA members operate FSEDs in Arizona. Both serve populations outside urban cores; one is located in Vail and the other in Sedona. In each of these communities, the hospital-based FSED is the sole source of emergency services available. Based on the service areas of these communities, some patients would need to travel an hour or more to the next closest ED.

We also dispute a number of assumptions the Administration makes about hospital-based FSEDs in the Preamble, including statements about the capabilities of these facilities, their role

within the larger delivery system, and how they hold themselves out to their respective communities. While some of these statements may be true for certain FSEDs in the metro Phoenix area—where the garnering of market share and/or marketing objectives may be a motivating factor—they should not be generalized to all hospital-based FSEDs, particularly those located in rural and medically underserved areas. The following are our specific comments.

Hospital-Based FSED Capabilities

The Preamble asserts the outpatient prospective fee schedule (A.A.C. R9-22-712.10 through R9-22-712.50) has been used to reimburse services provided by a hospital-based FSED

> *"even though the hospital-based FSED does not have the same capabilities as a hospital emergency department. They often do not have the same equipment or access to on-call specialists and do not have the ability to immediately admit persons requiring inpatient care."*

Under Medicare Conditions of Participation, hospital-based FSEDs are subject to all the requirements of their main campus's ED, including 24 hour a day operation and EMTALA obligation. Moreover, the Centers for Medicare & Medicaid Services (CMS) instructs state surveyors that the ***capabilities and capacity of the hospital's main campus*** (not just the off campus ED) be used when determining whether there has been a violation of EMTALA. (CMS S&C Letter 08-08, page 4; emphasis added.) CMS further requires:

- The organization and direction of emergency services at a hospital-based FSED to be by a qualified member of the hospital's medical staff.
- Medical and nursing staff to be integrated into the hospital's single organization medical and nursing staffs respectively.
- Nursing services and infection control to comply with Medicare's hospital Conditions of Participation (CoPs).
- Quality assessment/performance improvement programs and medical records to be integrated with the hospital's main campus program and systems, and comply with hospital CoPs.
- Laboratory services to be available at the FSED in accordance with hospital CoPs (CMS S&C Letter 08-08).

CMS clearly intends hospital-based FSEDs, which it designates as hospital outpatient departments (HOPDs), to meet patient needs under the same regulatory framework as the hospital's main campus. Physician specialists, if not on-site, must be available by phone consult—which can also occur on a hospital's main campus. Hospital-based FSEDs must also have full laboratory and imaging services. In discussions with our members who operate FSEDs, the only significant difference we found in capabilities compared to the main campus is the absence of emergency MRI services. (As one would expect, such decisions are based on a

calculation of equipment and operational costs relative to expected utilization and patient outcomes.) Other imaging services, such as CT scan, ultrasound, and X-ray services are available on-site.

Hospital-based FSEDs are also staffed by board certified emergency medicine physicians and registered nurses. If a patient needs inpatient services, qualified hospital staff accompanies the patient to the main campus as required under federal law. (See the section below for additional information on this requirement.)

It is important to note that hospital-based FSEDs are regulated differently than independent FSEDs, which often do lack the same capabilities as hospital EDs. Independent FSEDs are licensed by the Arizona Department of Health Services as outpatient treatment centers, subject to the requirements of R9-10-1019. However, they are NOT required to follow the rigorous Medicare hospital CoPs because they are not affiliated with a hospital. As such, independent FSEDs are not held to the same standards as hospital-based EDs—whether located on the main campus or freestanding.

Transportation & Access to Care

The Preamble goes on to state:

> *"By the very nature of being a FSED, transportation services are required when a patient requires inpatient care."*

It is not clear under what context the Administration is making this observation. While it's true that a patient who needs to be admitted would be transported to the hospital's main campus or to another facility (depending on the patient's medical needs and preference), the alternative of NOT having access to emergency services is much worse for patients living in rural or medically underserved areas.

For example, patients living on the opposite side of Sedona from Cottonwood would need to travel an hour to reach emergency services if the Sedona Campus of Verde Valley Medical Center (VVMC) did not offer ED services. The community's population swells during certain times of year, which further exacerbates travel times due to limited roadways and travel routes to VVMC's main campus. Without Northwest Emergency Center (NEC) at Vail, patients would need to travel to Benson Hospital or Carondelet St. Joseph's Hospital in Tucson for the nearest emergency services.

While policymakers may perceive FSEDs as unnecessary and duplicative of emergency services in urban areas like Maricopa County—where medical care is readily accessible, this is simply not the case in rural communities and medically underserved areas. Our members have described several instances of lives being saved, including children's lives, as a result of the emergency care their physicians and nurses provide at their FSEDs. While patients needing a higher level of care—including inpatient services—will be transported to another facility, the

stabilization and emergency treatment received at the FSED is indispensable to the well-being of these patients.

The only alternative for addressing the lack of emergency medical care in rural or medically underserved areas is for a "full-service" acute care hospital to locate in the community. This is a tremendously expensive enterprise. It is also an inefficient use of limited resources when patient volume is not sufficient to justify the construction and operation of inpatient beds. In this regard, our members strive to be good financial stewards by assessing local community needs and providing only those services that can be supported.

The Sedona Campus of VVMC is an example of this stewardship. Twenty years ago, Verde Valley Medical Center in Cottonwood and Flagstaff Medical Center each recognized that Sedona was a medically underserved community. But rather than establishing separate medical campuses there, which could have duplicated services, the organizations merged to become Northern Arizona Healthcare (NAH). This shared vision and collaboration created the Sedona Campus of VVMC, which was established as part of the new NAH system. The campus today offers a variety of locally-driven medical services, including emergency services.

It is also important to note that transportation between a hospital-based FSED and the hospital's main campus is considered an intra-hospital transport, which must be consistent with 42 CFR 482.13(c)(2) relating to the patient's right to receive care in a safe setting. The hospital is accountable for the patient's safety and care during such transportation. Moreover, while there is a cost associated with this transportation, it is typically not passed onto the patient/payer. And, as noted above, such transportation is considerably more cost-effective than building inpatient beds on a medical campus with insufficient volume to support them.

Promotional Materials and Primary Care Alternative

The Preamble states:

> *"Media coverage and promotional materials published by hospitals present these facilities as an appropriate alternative to treatment by a primary care practitioner in an office setting."*

We have not seen the materials the Administration references, so we cannot respond to the actual documents or claims they make. However, we have queried our members as to whether they have held out their FSED services as an appropriate alternative to primary care. They have responded with a resounding "no."

We have also looked at the websites of VVMC Sedona Campus and NEC to see how they characterize their services. Both websites clearly portray their FSED services as emergency services, not as an alternative to primary care. We do not believe our members are "marketing" their FSED services as primary care alternatives, and we urge the Administration not to

assume the entire industry is doing so based on promotional materials Administration staff have seen from one or two health systems.

In this vein, we urge the Administration to use their considerable leverage with these health systems to encourage them to withdraw such promotional materials rather than promulgating statewide payment rules that could harm access to care in rural and medically underserved areas.

FSEDs and the Delivery System

The Preamble states:

> *"Treatment of non-emergency conditions by healthcare providers other than the patient's primary care practitioner restricts the ability of the primary care practitioner to coordinate care for the patient, potentially leading to sub-optimal outcomes. As such the AHCCCS Administration is concerned about the use of the FSED as a substitute for services that are more appropriately and cost-effectively rendered in a clinic or physician's office."*

AzHHA wholeheartedly agrees with the Administration that non-emergency conditions are best treated in a clinic or physician office. (However, as stated previously, we do not believe our member hospitals are promoting their FSED services as a primary care alternative.) Patients use FSEDs for non-emergent conditions for many of the same reasons they "inappropriately" use the hospital's main campus ED:

- Their symptoms mimic an emergency.
- They are injured or in acute pain, and their physician is unavailable to see them (e.g., at night and on weekends).
- Their physician directs them to an ED because he or she cannot see them in a timely manner.
- They are uninsured and/or lack a primary care provider.

A number of strategies can be employed to reduce non-emergency use of EDs—at FSEDs and those located on a hospital's main campus. These include public education campaigns, more robust physician networks and timely access to physician services. Our members also tell us that improved Medicaid physician payments, especially in rural areas, would help to shore up the networks there and alleviate unnecessary ED visits.

When patients are seen at a hospital-based FSED, it is important to note their treatment is not "siloed" at the FSED. The FSED is an extension of the hospital. Services are clinically integrated with the hospital's main campus. FSED clinicians and other providers coordinate care and follow up treatment with community and hospital-based physicians in accordance

with the same policies and procedures utilized by the main campus. Patients benefit from having their care delivered locally, with follow-up care coordinated closer to home.

AzHHA strongly believes hospital-based FSEDs are an asset to rural and medically underserved areas. They are a cost-effective alternative to building full-scale acute care hospitals in medically underserved areas that do not have sufficient population to support inpatient beds, but which have a demonstrated need for emergency services. If the Administration moves forward with the proposed rule, we urge the Administration to consider the role FSEDs play in these communities when finalizing the rule by exempting them from the proposed payment changes.

Rule Provisions & Recommendations

The proposed rule would reimburse level 4 and 5 hospital-based FSED visits at 100 percent of the hospital outpatient fee schedule; level 3 visits at 90 percent; level 2 visits at 80 percent; and level 1 visits at 60 percent. We appreciate the Administration proposing the use of a "sliding fee" or scalable schedule, which recognizes the higher cost of treating high acuity patients, and which will mitigate the financial impact of the proposal. However, we are concerned the proposed payment reductions do not adequately address the fixed costs of all services provided at the FSED, especially those located in rural areas. Moreover, the Preamble does not identify any data or studies used by the Administration to justify the proposed payment changes, including development of the proposed methodology, which makes it impossible to evaluate the reasonableness of this proposal.

We urge the Administration to explain how it determined the appropriateness of this particular fee schedule, which will allow the public and other stakeholders, including policymakers, to more effectively evaluate the proposal.

Under the proposed rule, a hospital-based FSED outside of Pima and Maricopa counties will be eligible to receive a peer group modifier "where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015." The Preamble explains this adjustment is for FSEDs that "replace the services of a hospital that has closed in a *rural area where appropriate local care might not otherwise be available*." (Emphasis added.)

AzHHA appreciates the Administration acknowledging the importance of local access to care in rural areas. However, we do not believe the proposal goes far enough in protecting access to emergency services for Medicaid beneficiaries. First, as a matter of policy a rural hospital should not have to close for a hospital-based FSED to receive enhanced payment relative to the current proposal. The State Legislature has long recognized the need to protect access to healthcare in rural areas by adopting a number of special Medicaid payment provisions, including supplemental payments to Critical Access Hospitals and the Rural Hospital Inpatient

Fund. We strongly believe access to emergency services in rural areas needs similar robust protection, more than is provided by the peer group modifier proposal.

If the Administration moves forward with the proposed payment methodology for hospital-based FSEDs, we strongly recommend it take a more comprehensive approach to ensuring access to emergency services in rural areas. We recommend that hospital-based FSEDs located in counties with less than 500,000 residents be exempt from the new methodology under R9-22-712.90 and continue to receive the full hospital outpatient fee schedule for ED visit levels 1 through 5.

Medically underserved areas can also be found in pockets of more urbanized counties, such as Maricopa and Pima counties, and we urge the Administration to take this into account when finalizing the rule. **Should the Administration move forward with the rule, we urge hospital-based FSEDs located in counties with more than 500,000 residents be exempt from the new payment methodology, if there are no other emergency services within ten miles of the FSED. These facilities would thus continue to receive the full hospital outpatient fee schedule for ED visit levels 1 through 5.**

In reading the proposed rule, we have also found two technical issues that should be clarified in the final rule, should the Administration proceed. First, based on our discussion with Administration staff, the purpose of Subsection E is to clarify FSEDs not affiliated with a hospital will be paid the capped non-hospital fee schedule—although this is not at all clear from the proposed language. Administration staff has indicated a drafting error occurred in the proposed rule, and the internal reference to "subsection B" will be changed to "subsection A" in the final rule, which they believe will clarify the intent. While we appreciate this change, we do not believe it is sufficient. Under the change recommended by Administration staff, any outpatient treatment center that is not a hospital-based FSED will be reimbursed based on the non-hospital fee schedule. This would include those HOPDs that are licensed as OTCs, but are not FSEDs, as well as all independent OTCs (including FSEDs not affiliated with a hospital). As such, we recommend replacing the term "outpatient treatment center" with "free standing emergency department." Alternatively, Subsection E could be stricken from R9-22-712.90, and the title rewritten as "Reimbursement of Hospital-based Freestanding Emergency Department." This perhaps makes the most sense since the focus of the rulemaking is on hospital-based FSEDs.

Also, subsection C should clarify whether the proposed schedule for hospital-based FSEDs applies to all CPT codes, including ancillary service codes. We recommend excluding the latter codes and retaining their current reimbursement rate.

In conclusion, we agree with the Administration that FSEDs should not promote their services as an alternative to primary care. These facilities should exist for the central purpose of providing emergency medical care, although under federal law, they are required to screen for an emergency medical condition anyone who presents to the ED. Having said this, we also

believe that much more can be done to reduce inappropriate utilization of EDs (including at hospital-based FSEDs) by Medicaid beneficiaries and others. The creation of more robust physician networks; public education campaigns around appropriate ED utilization; and better care coordination and clinically integrated care can make a difference. (As stated previously, hospital-based FSEDs are on good footing to advance such care coordination closer to home due to their clinical integration with the hospital main campus and local footprint.)

Regrettably, we do not believe the proposed rule will do much to advance appropriate utilization of the ED, including hospital-based FSEDs, as it does not address the underlying causes. Moreover, we do not believe the rulemaking makes a strong enough case to warrant a change in payment methodology, particularly given the current status of AHCCCS payments, which cover about 70 percent of the cost of hospital services in the aggregate. Additional information and data is necessary to fully evaluate the proposed methodology. And, we are very concerned that many of the assumptions about hospital-based FSEDs included in the Preamble are incorrect and/or generalizations.

Finally, we strongly believe that the proposed rule will harm access to emergency services in rural and other medically underserved areas. Only a few FSEDs currently exist outside of the metro-Phoenix area. However, these facilities are a more cost-effective strategy for bringing emergency care to underserved areas than building full-service acute care hospitals. As such, we believe more hospitals (especially in rural areas) will want to explore this option in the future as the delivery system continues to shift away from inpatient services. We urge the Administration to support this transformation in the delivery system rather than penalizing hospitals that are trying to innovate by bringing more cost-effective emergency care to their communities.

Thank you for the opportunity to submit comments on the AHCCCS Administration's proposal. Please feel free to contact me if you have any questions.

Sincerely,

Greg Vigdor,
President and Chief Executive Officer