American Hospital Association®

Oppose Reductions to Payments for Hospital Outpatient Services

AHA View

The AHA strongly opposes so-called "site-neutral" policy proposals that would reduce Medicare payment rates for services furnished in hospital outpatient departments (HOPDs) to a residual amount of the physician fee schedule (PFS) payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).

Background

Congress is considering several proposals, including three originally raised by the Medicare Payment Advisory Commission (MedPAC), which would cap total payment for certain HOPD services at the physician rate or at the rate paid in ASCs. One proposal, recommended by MedPAC in 2012, would cap payment for non-emergency department evaluation and management services (clinic visits) in HOPDs at the rate paid to physicians for providing the services in their private offices. Specifically, a hospital would be paid an amount calculated as the difference between the payment rate the physician would receive under the Medicare PFS for a service furnished in his or her private office and the PFS rate paid for the service furnished in an HOPD. MedPAC estimated that this policy would cut hospital outpatient payments by 2.8 percent, or $900 million per year. However, given changes made by Medicare in 2014 that collapsed the coding structure for hospital outpatient clinic visits, it is unclear how Congress could enact this ill-advised recommendation.

MedPAC subsequently expanded its site-neutral payment recommendations to include the services in 66 selected ambulatory payment classifications (APCs). These outpatient services are integral to hospitals' service mission. MedPAC estimates that this recommendation would cut hospital outpatient payments by 2.7 percent, or $1.44 billion, in one year. As an example of these steep cuts, a hospital's payment for a level II echocardiogram without contrast would drop from $427.27, the average amount paid in 2014 under the outpatient prospective payment system (OPPS), to $163.57 – a 62 percent reduction.

A third MedPAC proposal would base HOPD payment for an additional 12 APCs on the rates Medicare pays for these services in ASCs. This alternate proposal would reduce hospital outpatient payment by 1.7 percent, or $590 million per year.

In addition, President Obama's fiscal year (FY) 2016 budget proposal recommends lowering payment for services provided in off-campus HOPDs to either the physician or ASC rate, resulting in $29.5 billion in federal savings over 10 years.

Key Facts

Implementing site-neutral payment policies would further erode Medicare payments to HOPDs and threaten patient access to care.

- **Medicare Already Covers Less than the Cost of Care.** According to data presented at MedPAC's December 2014 meeting, hospitals' Medicare margins were negative 12.4 percent for outpatient services in 2013. Additional cuts to HOPD payments threaten beneficiary access.

- **Hospitals Care for Vulnerable Populations.** Site-neutral payment policies put critical hospital-based services at risk, such as care for low-income patients and underserved populations. Unlike physician offices and ASCs, hospitals play a unique and critical role in their communities by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering other services that promote the health and well-being of the community. For example, hospitals provided $46.4 billion of uncompensated care in 2013. By contrast, many physician offices and ASCs do not serve Medicaid or charity care patients. Relative to patients seen in physician offices, patients seen in HOPDs are:

  - 2.5 times more likely to be Medicaid, self-pay or charity patients;
  - 1.8 times more likely to be dually eligible for Medicare and Medicaid;
  - 1.8 times more likely to live in high-poverty areas;
  - 1.7 times more likely to live in low-income areas; and
  - 1.7 times more likely to be Black or Hispanic.

- **Hospitals Provide 24/7 Emergency Standby Services.** Site-neutral payment policies also undercut the ability of hospitals to continue to provide emergency standby services that Americans rely upon so heavily, such as: (1) around-the-clock access to health care services, including specialized resources; (2) safety-net services involving caring for all patients who seek emergency care, regardless of ability to pay; and (3) disaster readiness and response capabilities that ensure that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions. These critical services, while often taken for granted, represent essential components of our nation's health and public safety infrastructure.

  However, this role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, this role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider. Hospitals today face challenges in maintaining this role, such as staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

- **Hospitals Treat Sicker Patients.** Site-neutral payment cuts also would make it harder for HOPDs to continue to care for patients who are too complex for physician offices and ASCs. For example, physicians refer more complex patients to HOPDs for safety reasons, as hospitals are

better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients who are burdened with more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and emergency departments.

- **Hospitals Are Subject to a Higher Level of Oversight.** HOPDs must comply with a much more comprehensive scope of licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs, resulting in a higher cost structure than these other providers. These requirements are important and reflect the broad mission of hospitals to protect and care for their community, patients, staff and visitors at all times.

- **Hospital Payments Should Reflect HOPD Costs, Not Physician or ASC Payments.** HOPD payment rates are based on hospitals' audited cost reports and claims data. In contrast, the physician payment schedule (and specifically the practice expense component) is based on physician survey data and has been held flat for years due to the cost of various physician payment "fixes." ASC payment rates are based on HOPD rates because ASCs do not report their costs to Medicare.

The chart below outlines some of the key differences in regulatory requirements HOPDs face versus ASCs and physician offices.

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✔		
Back up for Complications Occurring in Other Settings	✔		
Disaster Preparedness and Response	✔		
EMTALA Requirements	✔		
Uncompensated Care/Safety Net	✔		
Teaching/Graduate Medical Education	✔		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✔		
Required Government Cost Reports	✔		
Equipment Redundancy Requirements	✔		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✔		
Infection Control Program	✔	✔	
Quality Assurance Program	✔	✔	
Joint Commission Accreditation	✔	✔	
Life and Fire Safety Codes	✔	✔	✔
Malpractice Insurance	✔	✔	✔
Admin Staff/Billing	✔	✔	✔
Medical Supplies	✔	✔	✔
Nurses	✔	✔	✔
Space and Utilities	✔	✔	✔

- **Applying Site-neutral Policies to Evolving OPPS Will Result in Unfair and Inaccurate Payments.** In making its recommendations, MedPAC did not consider the sweeping changes Medicare has undertaken in recent years in its HOPD payment policies. In particular, recent OPPS regulations include new policies that significantly increase the amount of packaging in all APCs. In general, as the Centers for Medicare & Medicaid Services carries out its intentions, year after year, to shift the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles, the package of services paid under the OPPS will become less comparable to those paid under the PFS. As a result, the implementation of site-neutral payment policies is more likely to result in increasingly unfair and inaccurate hospital payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources – site-neutral payment policies will hamper this innovation.

The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of a site-neutral policy unstable. Any small technical or methodological change to one of the payments systems could result in a significant change to the other payment systems.