American Hospital Association

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Glenn M. Hackbarth, J.D.
64275 Hunnell Road
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Dear Mr. Hackbarth:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) remains extremely concerned that the Medicare Payment Advisory Commission (MedPAC) is considering broadening the application of its "site neutral" payment policy for hospital outpatient department (HOPD) services to an additional 71 payment categories beyond its March 2012 recommendation to cut payment for 10 evaluation and management (E/M) services. **After meeting with MedPAC staff, the AHA has serious questions about the policy rationale and methodology underlying the option being considered. We believe that greater transparency and understanding of the impact on hospitals is needed before the commission considers a recommendation to reduce payments for an additional 71 HOPD categories. Therefore, MedPAC should refrain from proposing these cuts to Congress until a thorough, public analysis has been provided.**

Commissioners and those affected by the proposed policy do not know which services would have payments cut, and consequently cannot fully understand the impact such a reduction would have on access to services. Of the 71 Ambulatory Payment Classifications (APCs) under consideration only six have been named publicly. Of those six APCs, MedPAC staff have shared the extent of cuts in payments for only two. In the only example provided at the November meeting — APC 698 (Level II eye tests and treatments) — the hospital would experience a 42 percent payment cut. In October, MedPAC indicated a cut of 49 percent for APC 697 (Level I Echocardiogram).

Overall, the impact of these cuts is very significant. MedPAC analysis shows that the cuts to these services would decrease Medicare outpatient payments by 2.8 percent, or $1 billion per year. When combined with the E/M cuts already recommended by the commission, the site neutral payment policies would impose deep cuts of $2 billion per year on routine outpatient services that are integral to the service mission of hospitals. Together, they would reduce Medicare outpatient payments by 5.5 percent, and reduce hospitals' Medicare outpatient margins from a *negative* 9.6 percent in 2010 to a *negative* 16 percent, all else being equal.

## MEDPAC'S ANALYSIS OVERESTIMATES THE NUMBER OF HOPD SERVICES THAT MEET ITS CRITERIA

According to the presentation at the November meeting, MedPAC is considering expanding its site-neutral payment policy to 71 APCs beyond the E/M codes using specific criteria for their selection, such as how often these services are furnished in a physician office. Each APC contains multiple services. In a meeting with AHA and other national hospital associations, MedPAC staff provided some details regarding its methodology for selecting APCs for its site-neutral payment policy but did not provide the list of APCs included. Based on this discussion, the AHA is concerned that MedPAC's analysis is flawed and results in too many APCs being included in the site-neutral payment policy.

First, MedPAC staff overestimated the proportion of services performed in physician offices, increasing the number of APCs to which the site-neutral policy would apply. The commission put forward a criterion to include only services provided more than half the time in physician offices, assuming that at this level the services can be safely performed and appropriately provided in physician offices. However, MedPAC's analysis does not count occasions on which the service was performed in other non-HOPD facility settings, such as ambulatory surgical centers (ASCs). While not as sophisticated a setting as the HOPD, ASCs are capable of providing more complex procedures to a broader range of beneficiaries than physician offices. By excluding services furnished in ASCs from the denominator in its calculation of the percentage of services performed in a physician office, MedPAC staff overestimated the number of services that meet this criterion. As this criterion is supposed to rule out risky services, such an overestimate could put patient safety at risk.

Second, MedPAC staff likely underestimated the proportion of procedures that are performed in conjunction with an ED visit, which is important because the commission set a criterion that only services provided with an ED visit less than 10 percent of the time would be included in the policy. From the technical discussion, it appears that MedPAC staff calculated whether or not an ED visit occurred based on the presence of certain ED procedure codes billed either on the same day or the same claim. In a separate AHA analysis, we also looked at the presence of an ED revenue center code on the claim. This method most effectively captures whether or not resources from the ED were used. MedPAC's focus solely on procedure codes likely underestimated the percentage of services associated with the provision of ED care and inappropriately increased the number of APCs included in the analysis.

## HOPD PAYMENTS ARE THE RELEVANT COMPARISON

We note that most of the impact data presented at the November meeting masked the extent of the cut to outpatient payments by presenting impact data based on overall Medicare payments – including inpatient and post-acute services – and not separately for outpatient payments. This presentation of impact runs counter to MedPAC's stated preference against cross-subsidies in payment, which would require looking at each payment system separately. **The AHA believes that outpatient payments are the relevant base to consider when proposing outpatient cuts.**

In looking at the impact across groups of hospitals, the November presentation showed the combined impact of these two proposals would be higher for rural hospitals than other hospitals because of their greater dependence on outpatient revenue. However, this analysis was an *underestimate* because MedPAC assumed the continuation of the current rural outpatient hold-harmless payments that, by law, expire this year. Further, the focus on overall Medicare payments, not outpatient payments, likely masks the impact across hospital groups, as some hospital groups, including rural hospitals, generally provide a greater share of outpatient services.

As noted above, according to MedPAC, HOPDs margins were *negative* 9.6 percent in 2010. Imposing a site-neutral payment policy would result in an additional 5.5 percent cut to hospital outpatient department payments, leading to a *negative* 16 percent margin. That is, Medicare would only pay 84 cents on the dollar for care provided in all hospital outpatient departments, including the emergency department. Further, the AHA's annual replication of the Medicare margin analysis indicates that the situation is getting worse. We estimate that hospital outpatient Medicare margins were even lower in 2011, at negative 11.3 percent. Additional cuts to outpatient payments could endanger Medicare and Medicaid beneficiary access to these services.

## THE MAJORITY OF PHYSICIANS ARE NOT EMPLOYED BY HOSPITALS

In its discussions regarding expansion of the site-neutral payment policy to additional APCs, the Commission considered whether the impact on hospitals would be lessened because hospitals employ many physicians practicing in HOPDs and, therefore collect both the physician fee and the hospital facility fee. Supported by comments from MedPAC staff, some concluded that the hospital would not receive just the residual amount provided under MedPAC's site-neutral payment policy, but instead would be paid at least as much as a physician would receive under the Medicare physician fee schedule (PFS) if the same service had been furnished in a physician's office.

The AHA disagrees. First, hospitals incur the costs of providing services whether or not the physician is employed. When the physician is employed, the hospital must also pay the physician for his or her services. Second, only a minority of physicians are employed by hospitals. According to 2010 data from the American Medical Association and AHA, only 18 percent of physicians (excluding interns and residents) are employed by community hospitals. While the number of employed physicians is increasing for the reasons MedPAC cited in its March 2012 report, the increase is modest, only 4 percent between 2009 and 2010. Thus, in most circumstances, HOPD services are often furnished to beneficiaries by physicians who are not employed by the hospital. In these cases, if MedPAC's policy were implemented, the hospital's payment in full would be the residual amount provided under MedPAC's site-neutral payment policy. In the example provided at the November meeting of APC 698 (Level II eye tests and treatments), the hospital would experience a 42 percent payment cut. In October, MedPAC indicated a cut of 49 percent for APC 697 (Level I Echocardiogram).

We also disagree with an assertion made by some commissioners and staff at the October meeting that it is common practice for hospitals to charge non-employed physicians for the use of hospital facilities while also billing Medicare directly for the hospital's facility fee. In the

discussion, it was stated that hospitals had an opportunity to mitigate the decline in Medicare revenue from the commission's site-neutral payment policy by negotiating with the non-employed physician to "split the total Medicare revenue from this."

Our understanding based on practices in the field and regulatory requirements is that in the case of non-employed physicians furnishing services in a HOPD, the physician bills for his or her professional services under the PFS, the hospital bills the facility fee under the hospital outpatient prospective payment system (OPPS) and there is no "splitting" of the physician's Medicare payment with the hospital. Splitting Medicare money as suggested would, at a minimum, be viewed as inappropriately double billing the facility fee. Additionally, law enforcement would view the exchange as creating a high risk of abuse and lead to scrutiny under the Stark law and anti-kickback statute.

## HOSPITALS' EMERGENCY RESPONSE CAPACITY WOULD BE ENDANGERED

Hospitals are not physician offices and play a very different role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs and offering myriad other services to promote the health and well-being of the community. While many of these services also are offered by other health care providers, three are unique to hospitals:

- The provision of health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year;
- Caring for all patients who seek emergency care, regardless of ability to pay; and
- Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent an essential component of our nation's health and public safety infrastructure. Medicare beneficiaries and the public consistently express concern that cuts to hospital payments could mean fewer nurses and longer waits in emergency departments. The public also values the safety net that hospitals provide and expects them to be open 24/7 to serve patients and their families.

Despite its importance, the standby role is not explicitly funded. Until a patient arrives with an emergency need, there is no payment for the staff and facility to be at the ready. The attached report, *Prepared to Care*, outlines the many elements of stand-by capacity that allow hospitals to respond to emergencies ranging from multi-vehicle car crashes to hurricanes and terrorist attacks. Recent events like Hurricane Sandy serve as a reminder that we, as a society, need this response capacity. Direct funding for this capacity is limited, and federal funding for the Hospital Preparedness Program declined by nearly 30 percent between fiscal year (FY) 2003 and 2012. While these funds are very much appreciated by hospitals, they do not come close to meeting the costs of maintaining stand-by capacity and responding to disasters.

**The commission must realize that, without adequate, explicit funding, the stand-by 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 or any other type of provider.**

## HOPDs Treat Higher-Severity Patients, Face Greater Regulatory Burdens

MedPAC staff proposed a principle stating that patients should have access to settings that provide the most appropriate level of care. We agree. Hospitals want patients to receive care in the appropriate setting and note that community physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. We fear that with a significant reduction in payment, this may no longer be an option or fallback for community physicians.

In addition, hospitals face significantly higher regulatory requirements than physician offices. While many of these requirements help to ensure a higher level of quality and patient safety, they all impose additional costs. The attached infographic highlights these regulatory differences, which include complying with the Emergency Medical Treatment and Active Labor Act (EMTALA), state hospital licensure requirements, the voluminous Medicare conditions of participation, and Medicare cost reporting requirements, among others. **The higher costs associated with these regulations are legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to free-standing physician offices.**

## Payment Amounts Should be Set Appropriately

MedPAC's proposal assumes that the Medicare physician fee schedule payment rate somehow reflects the "correct" rate to pay for outpatient services, when, in fact, it is difficult to determine how well Medicare payment rates (especially PFS payment rates) reflect the actual costs of specific services. It is fair to say that the differences in the payment rates for similar services across ambulatory settings are largely artifacts of the very different and complex methodologies that Congress enacted and that the Centers for Medicare & Medicaid Services (CMS) implemented under the OPPS and the PFS. But at least OPPS payments are generally based directly on hospital data – audited cost reports and claims data – and have been found by MedPAC to be significantly below cost. In contrast, physicians are not required to report their costs to Medicare; therefore, their costs cannot be compared to payment. While the commission's discussion centered on whether, as a prudent purchaser, Medicare should refrain from paying more for a service in the HOPD setting than in the physician office setting, it is equally correct to question whether payment is adequate in the setting paying the lower amount.

We appreciate your consideration of these concerns and would urge the commission not to propose any recommendations to Congress on such a dramatic reduction in payments to hospitals until a complete, transparent analysis and debate has occurred. Ensuring adequate payment for outpatient services will allow hospitals to continue to ensure access to care, including provision of standby capacity and emergency response, for all patients. If you have any questions, please feel free to contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners