FACTSHEET

Additional Hospital Outpatient Services at Risk for Site-Neutral Cuts

THE ISSUE

Congress is considering a proposal to cap total payment for certain hospital outpatient department (HOPD) services at the physician rate. The Medicare Payment Advisory Commission (MedPAC) estimates that this would cut hospital outpatient payments by 2.7 percent, or $1.44 billion, in one year. The services in these 66 ambulatory payment classifications (APCs) are outpatient services that are integral to hospitals' service mission. However, MedPAC identified them as candidates for site-neutral cuts because a MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices, being infrequently provided with an emergency department visit and having minimal patient severity differences across settings.

Under the policy being considered, a hospital would be paid a residual amount calculated as the difference between the payment rate the physician would receive under the Medicare physician fee schedule (PFS) for a service furnished in his or her private office and the PFS rate paid for the service furnished in an HOPD. The policy would result in steep cuts. For instance, using data reflecting 2014 APC packaging policies, the hospital's payment for a level II echocardiogram without contrast (APC 0269) 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.

At its January 2014 meeting, despite the AHA's urging, MedPAC voted to formally recommend this policy without considering the several sweeping changes made in the calendar year (CY) 2014 hospital OPPS final rule. These changes, and subsequent changes finalized by the Centers for Medicare & Medicaid Services (CMS) for CY 2015, will have a substantial impact on MedPAC's site-neutral payment policy and its associated savings estimate. In particular, these OPPS rules include new policies that significantly increase the amount of packaging in all APCs and will likely affect the impact of the estimates for the 66 APCs site-neutral payment recommendation.

In general, as CMS carries out its intentions 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, implementing site-neutral payment policies will result in increasingly unfair and inaccurate payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources. Site-neutral payment policies will hamper this innovation.

Additionally, MedPAC and Congress are considering an alternate site-neutral proposal that would base payments for certain HOPD services on the rates Medicare pays for services in ambulatory surgery centers (ASCs). The impact of this alternate approach also would be significant; currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. MedPAC is considering a policy that would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient payment by $590 million per year, or 1.7 percent.

AHA POSITION

The AHA strongly opposes legislative proposals to reduce Medicare payment rates for 66 APCs to a residual amount of the PFS payment rate or for 12 additional APCs to the rate paid in ASCs.

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Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering many 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 physicians and ASCs do not serve Medicaid and charity care patients. In addition, hospitals provide emergency standby services such as:

- **24/7 Access to Care:** Providing health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year.
- **The Safety Net:** Caring for all patients who seek emergency care regardless of ability to pay.
- **Disaster Readiness and Response:** Ensuring 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. **It is critical that Congress consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services.**

For example, despite its importance, hospitals' standby 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, the standby 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.

WHY?

- **Hospitals already suffer negative margins treating Medicare patients in HOPDs.** According to MedPAC's June 2015 data book, Medicare margins were negative 12.4 percent for outpatient services in 2013. Additional cuts to HOPDs threaten beneficiary access to these services.
- **Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations.** The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and underserved populations. For example, 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
  - 1.7 times more likely to be Black or Hispanic
- **Patients who are too sick for physician offices or too medically complex for ASCs are treated in the HOPD. 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 suffering from more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and emergency departments.
- **HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs.**
- **Payment should reflect HOPD costs, not physician or ASC payments.** HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule (and specifically the practice expense component) is based on physician survey data. ASCs do not even report costs.
- **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 MedPAC's site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.