'Site-Neutral' Payment Reduction Proposals

Background

Congress and the Centers for Medicare & Medicaid Services (CMS) have proposed cost-reduction strategies that seek to reduce Medicare payment for services provided by hospital outpatient departments (HOPDs). The proposals would "equalize" payments made for services provided in the HOPD, reducing them to a "residual rate" consisting of a combination of payment rates under the Physician Fee Schedule (PFS), the existing HOPD rate and Ambulatory Surgical Center (ASC) rate. This methodology means significant reductions to hospital outpatient payments and does not take into consideration differences in costs incurred, nor how costs are grouped in the HOPD versus a physician office or ASC.

IHA POSITION

IHA strongly opposes these proposals and any resulting legislation or regulation that would reduce Medicare rates paid to HOPDs. Existing Medicare outpatient payment rates do not cover the full cost of care provided and reductions to those already-low rates would be financially damaging to Iowa hospitals. Medicare payment rates to providers should reflect costs incurred.

Explaining Differences in Costs of Care Settings

Hospitals provide a robust set of services including: 24/7/365 emergency care; charity care services to patients regardless of their ability to pay, investments in health and wellness through innovative public health initiatives and disaster planning and preparedness. In addition to serving as hubs of acute and diagnostic care delivery, these additional services are all part of a community hospital's mission. Unlike physician offices and ASCs these services are unique to hospitals and require a commitment of resources and personnel as well as a financial investment.

Further, research by the American Hospital Association shows that there are differences in the types of patients treated in hospitals. For instance, patients treated in hospital outpatient departments are more likely to be uninsured or covered by Medicaid, tend to come from communities with low income, higher poverty rates, and lower educational attainment, tend to have more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and emergency departments. In addition, patients of higher medical complexity may require a greater level of care than patients of lower complexity, who can be treated in the other settings, where available.

Hospitals are bound by a host of regulatory requirements that do not apply to physician offices or ASCs. An example of this, are the requirements under EMTALA that require hospitals to treat all patients who present to the ED in regardless of their ability to pay for those services. Physician offices and ASCs are not subject to EMTALA.

Another example is the fact that hospitals are required to have emergency preparedness plans that requires a significant investment of resources. CMS has recently required more stringent requirements for hospitals in this area and even acknowledges that physician offices and ambulatory surgical centers would close in the event of an emergency, but that hospitals would be called upon during the time.

Budgets for these services are built in to the overall cost and charge structure of a hospital. These services are not provided by physician offices or ASCs, recognized by payers through lower payments for care delivered in those settings. To reduce hospital payments to the PFS or ASC levels would substantially jeopardize hospitals' ability to provide these critical services and in turn, compromise investments being made in the health and well-being of patients and communities served by hospitals.

Resources:

- Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients
- Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices

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