GNYHA POSITION PAPER

555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

MEDICARE "SITE-NEUTRAL" CUTS FOR HOSPITAL OUTPATIENT SERVICES

Congress is considering several so-called Medicare "site-neutral" proposals that would cut hospital reimbursement for outpatient services to make it equal to the lower rate paid to physician offices. ***GNYHA strongly opposes these misguided, harmful measures, which reflect a fundamental misunderstanding of how hospitals deliver care.***

Hospitals and the health care workforce are emerging from the COVID-19 crisis under enormous strain. Site-neutral cuts to payments for ambulatory care will worsen their existing financial challenges and disrupt access to care.

Hospital Outpatient Departments vs. Freestanding Physician Offices

Hospital-based outpatient departments (HOPDs), or hospital-based outpatient clinics, are operated by the hospital and located either on the hospital's main campus or offsite. Regardless of the location, HOPD patients are considered hospital patients and have full access to its support services. By contrast, freestanding physician offices are unaffiliated with hospitals and their patients often require a referral to a hospital for further care.

Unlike freestanding physician offices, hospitals deliver care 24/7 and accept any patient who walks through their doors, regardless of their ability to pay. They are built to withstand and respond to major disasters, and they are subject to intensive regulatory requirements to ensure they can fulfill these responsibilities. The higher reimbursement rates for HOPDs have long and appropriately reflected the high costs of such compliance.

Hospitals provide an additional layer of patient safety protections and wraparound services that freestanding physician offices do not. Patients who might benefit from treatment in a hospital-based site instead of a freestanding physician office might include:

- A cancer patient who has an allergic reaction to their chemotherapy medication can be treated by an on-site allergist during drug administration
- A low-income patient, who is more likely to encounter systemic barriers to medication adherence, can meet with a social worker to establish a medication adherence regimen and follow-up appointments to reduce future emergency room visits and hospitalizations
- A child with cerebral palsy who needs input from interdisciplinary groups can visit GI, pulmonary, pediatrics, nutrition, and surgery to address all of their issues

Hospitals are a critical safety net for underserved communities and ensure that the sickest, most vulnerable patients can access care where it may not otherwise exist. HOPD patients, compared to patients in freestanding physician offices, are more likely to be Medicare or Medicaid beneficiaries, or dual-eligibles; low-income; patients of color; chronically ill, with an increased chance of multiple comorbidities; and recently or frequently seen in a hospital setting.[1]

1 L. Koenig, Sheriff, J., Nevo, O., Sari, M., "Comparison of Medicare Beneficiary Characteristics Between Hospital Outpatient Departments and Other Ambulatory Care Settings," March 2023. https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf (accessed June 28, 2023)

Previously Enacted Site-Neutral Cuts

There is an inaccurate and often misleading narrative fueling the Congressional site-neutral debate that hospitals are buying up physician practices, "flipping the sign," and billing Medicare at a hospital rate to make a profit. These claims are simply untrue.

Newly Medicare-enrolled off-campus HOPDs have already incurred significant site-neutral cuts, diminishing any perceived incentive for a hospital to convert a physician practice into a HOPD. In 2015, Congress enacted a major Medicare cut to "new," off-campus HOPDs. Subsequent policies "excepted" sites if they billed Medicare under the outpatient prospective payment system (OPPS) before November 2015, or if they were under construction ("mid-build") when the law was enacted.

Since 2017, the Centers for Medicare & Medicaid Services (CMS) have required non-excepted off-campus HOPDs to bill at the lower physician fee schedule rate—60% lower than the OPPS rate—for virtually all services. In 2019, CMS extended site-neutral cuts to *all* off-campus HOPDs, including sites that Congress intended to be excepted or "grandfathered" from the cuts, for evaluation and management (E&M) services. Payments for E&M services were cut from $121 to $48 per visit, resulting in a $800 million annual cut to hospitals.

Hospitals have struggled to keep their outpatient departments afloat since site-neutral cuts took effect. Medicare already reimburses hospitals below cost for their outpatient services (at 79 cents per dollar in New York State). Additional site-neutral cuts will further erode hospitals' thin margins, ultimately threatening patient access to care.

Site-Neutral Cuts Ignore the Challenges Facing Physician Practices

Medicare payments do not cover the cost of care. According to the American Medical Association, Medicare physician pay has declined by 26% over the last two decades after accounting for inflation. Instead of site-neutral cuts, Congress should increase Medicare payments for both hospital-based outpatient services and physician practices to cover the costs of care.

Employment trends are shifting and physicians increasingly prefer working in the hospital to private practice. Most physicians find it financially and administratively challenging to run their own practice, and 90% of graduating medical students feel unprepared to manage the business responsibilities associated with private practice. These challenges include the increased regulatory burdens such as demonstrating meaningful use of electronic health records as required by the Affordable Care Act and participation in value-based payment programs such as the Merit-Based Incentive Payment System established under the Medicare Access and CHIP Reauthorization Act of 2015. Practicing medicine in the hospital setting allows physicians to focus on providing high-quality care without managing administrative burdens that contribute to clinician burnout.

Providers need relief from abusive health insurer practices that drive up costs and diminish health care access. 84% of employed physicians reported that the administrative burden from commercial health insurers and government insurance programs impacted their employment decision. Hugely profitable commercial health insurers must be held accountable so that hospitals can continue to provide timely, essential care to their communities.[2]

Additional Site-Neutral Cuts Under Consideration

Congress is considering several proposals that would extend HOPD cuts and further undermine hospitals' ability to care for patients.

- Site-neutral cuts for **drug administration**: Starting in 2025, and phased in over four years, Medicare would pay for drug administration services furnished in grandfathered off-campus HOPDs at a lower site-neutral rate.
- Site-neutral cuts to **all hospital off-campus services**: Starting in 2025, *all services* furnished in grandfathered off-campus HOPDs would be subject to site-neutral payment (extending the site-neutral policy far beyond

2 American Hospital Association, "Examining the real factors driving physician practice acquisition," June 2023. https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf (accessed June 28, 2023)

E&M services already subject to the regulatory cut described above).

- Site-neutral cuts that align rates across hospitals, ambulatory surgical centers, and physician offices: directs the Health and Human Swervices Secretary to specify which ambulatory payment classifications (APCs) should be furnished only in a hospital HOPD, and for all other APCs, to compare the volume of services delivered over the preceding four years for each ambulatory setting. CMS must pay for items and services under the PPS tied to the setting in which the respective items and services were delivered at the highest volume over the preceding four years.[3] This proposal does not take patient acuity into consideration and would cut payment rates for both on- and off-campus HOPD Services.

Summary Impacts (10 Years)

	Off-Campus Drug Administration	All Off-Campus Services	All HOPDs
Total US	$3B	$31.2B	$180.3B
New York	$282.4M	$2.8B	$9.7B
New York % of total cut	9.4%	9%	5.4%

Note: numbers cannot be combined due to overlapping policies in models.

GNYHA Position: GNYHA strongly opposes cutting Medicare payments for HOPD services. Such cuts do not account for the legitimately higher costs of providing services in a hospital setting. Hospital-based outpatient services are a lifeline for communities with scarce health care options. And with hospitals experiencing enormous staffing and financial challenges that threaten patient care, now is not the time to dramatically cut Medicare reimbursement rates.

3 A similar recent MedPAC proposal would cut payment rates to HOPDs for 66 of 169 APCs furnished in both on- and off-campus sites, cutting Medicare reimbursement to hospitals nationally by $7.5 billion per year. Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf