

# America's Hospitals and Health Systems

September 12, 2012

Dear Member of Congress:

On behalf of the undersigned organizations, we are writing to bring to your attention a proposed Medicare cut to hospitals that would, if enacted, result in reduced access to care for your constituents. We ask that you oppose the inclusion of this proposed cut in any legislation coming before the Congress.

Some in Congress are considering a policy that originated with the Medicare Payment Advisory Commission (MedPAC) that would cap "total" payment for non-emergency department evaluation and management (E/M) services at the rate paid to physicians for providing the services in their offices. Therefore, when the visit occurs in a hospital outpatient department (HOPD), the physician would receive the standard amount for the service in a hospital setting and the hospital would receive the difference between the physician payment in the office minus the physician payment in the hospital. This would reduce the hospital payment by at least 71 percent for 10 of the most common outpatient hospital services.

America's hospitals have greater responsibilities and requirements than physician offices: requirements to treat all comers (regardless of ability to pay), 24/7 staffing requirements, and seemingly endless regulations from nearly a dozen different federal, not to mention state, agencies. To pay a hospital – with our Emergency Department, surgical, nursing, emergency transportation, and myriad other costs – the same as a physician office does not make sense.

We are concerned that the proposed policy would reduce patient access to outpatient care that is not otherwise available in the community and would undermine the ability of hospitals to adequately fund their emergency stand-by capacity. Further, we believe that moving forward with this policy is premature given that its impacts have not been adequately analyzed and confirmed. We believe that rushing to put this untested policy into place is not justified when one considers that HOPDs account for only 7.3 percent of all E/M visits and this share has only increased by about 2 percent in the past six years. Indeed, while such a moderate trend may deserve further analysis over time, it certainly does not justify an immediate and extreme payment reduction that would be applied to all HOPD E/M clinic services.

Hospitals already are underpaid for these services (according to the June 2012 *MedPAC Databook*, Medicare margins are negative 9.6 percent for outpatient services); making additional reductions of this magnitude is excessive and harmful. Implementing this policy would result in an additional 3 percent cut to hospital outpatient payments, thereby reducing Medicare outpatient payments to 87 percent of cost, or a margin of about *negative* 13 percent. According to Congress' own advisors, HOPD rates are 9.6 percent below cost; to cut them even further is unfair and unsustainable.

This will harm hospitals' ability to continue to maintain emergency stand-by capacity and capability, which is not a situation that can be resolved or justified through cost-shifting when the inpatient, outpatient and overall Medicare margins are all negative.

Further, the proposed recommendation interferes with health system reform efforts to achieve better clinical integration through improving the coordination of care between hospitals and physicians. This policy would hamper integration efforts by creating even greater shortfalls in Medicare funding. In fact, those hospitals participating in the Pioneer Accountable Care Organization (ACO) demonstration program would see an average 5.2 percent reduction in their Medicare outpatient prospective payment system (PPS) payments under the proposed recommendation. This short-sighted proposal would disproportionately harm the very type of accountable care models that we are striving to foster.

These cuts to outpatient Medicare payments would particularly threaten access to critical hospital-based services provided by safety net health systems and teaching hospitals. These hospitals and systems provide integrated care to low-income, vulnerable, and chronically ill patients, many of whom are medically complex and have multiple co-morbid conditions. Often, there are no other providers in these communities that can provide these services and manage the care of extremely complex patients. These safety net health systems provide primary and specialty care in broad networks of outpatient clinics, often purposely locating clinics directly in the neighborhoods of hard-to-reach patient populations. Hospital-based outpatient clinics provide these vulnerable patients with integrated, culturally competent services that are not commonly available from free-standing physician practices. These proposed Medicare payment cuts would be devastating to these hospitals and the vulnerable patients they serve.

Other hospital-based clinics serve patients with complex illnesses or multiple co-morbidities in clinics such as diabetes clinics, pain clinics and cancer clinics. The costs in all these hospital-based clinics are higher due to more severely ill patient populations requiring greater use of resources, greater regulatory requirements, stand-by capacity costs related to offering emergency department and other services 24/7, 365 days a year, and the costs of unreimbursed "wrap-around" services needed to support these vulnerable patient populations, such as transportation, case management and translation services.

While the overall impact of MedPAC's recommendation on rural hospitals – a 2.6 percent reduction in total outpatient PPS payment (or about \$138 million in 2012) – is close to the national average reduction of 2.8 percent, this is exacerbated by rural hospitals' high Medicare share, high outpatient share and their limited cash flow. Therefore, this recommendation would have a significant impact on rural access to care.

An analysis of Medicare data demonstrates that average patient severity for E/M clinic visits is nearly 24 percent higher in HOPDs than in physician offices, as measured using hierarchical condition categories (HCC) scores weighted by numbers of E/M visits.

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Free-standing physician practices often refer more complex patients to hospital-based clinics for safety reasons, as hospitals are better equipped to handle complications and emergencies because these services are not available in their offices. Such services cannot be supported by payments set at a residual of the physician fee schedule amount, as proposed by MedPAC. Cuts of the magnitude described by MedPAC's recommended policy would make it difficult for hospitals to continue to support existing clinics and provide a disincentive to create new clinics to support the growing needs of these populations.

Simply put, it is significantly damaging to beneficiaries and the providers on which they rely to enact legislation that will result in such large cuts. We urge you to oppose inclusion of these cuts in any legislation, and appreciate your continued support of our hospital and its patients.

Sincerely,

American Hospital Association  
Association of American Medical Colleges  
Catholic Health Association of the United States  
Federation of American Hospitals  
National Association of Public Hospitals and Health Systems