Please Reject Site-Neutral Cuts to Hospitals

New proposed cuts couldn't come at a worse time for hospitals

WHA Position

While site-neutral payment policies may sound logical on their face, in practice, they serve to increase the hidden health care tax by reducing hospital payments.

- Wisconsin hospitals receive only 73 cents on the dollar for Medicare services 67 cents for Medicaid services.
- This underpayment results in costs being shifted onto the private sector in the form of higher insurance premiums.
- Further cuts to hospitals would exacerbate this.

WHA Ask:

Please reject calls for site-neutral payment policies that will reimburse hospitals even less than they already receive under Medicare.

Instead of piecemeal cuts that create uncertainty for hospitals, CMS and Congress should work on comprehensive payment and regulatory reform that gives hospitals time to plan their budgets into the future.

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Background on Site-Neutral Payment Policy

In recent years, the Medicare Payment Advisory Commission (MEDPAC) has recommended a policy designed to equalize payments between hospitals and clinics for similar outpatient services. While this sounds logical on its face, it does not take into account the fact that the higher hospital payments that exist today were designed to offset the losses hospitals take for running 24/7 Emergency Rooms, treating higher acuity patients, and meeting higher regulatory standards.

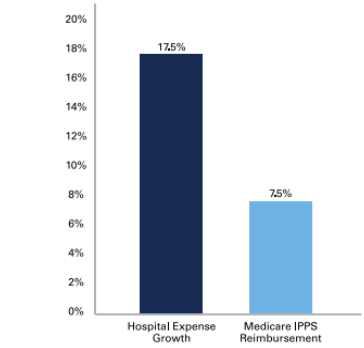
The Centers for Medicare and Medicaid Services (CMS) probably says it best when it describes the rationale for higher payments for hospital outpatient departments:

"When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively."[1]

Medicare is Already Woefully Behind Rising Costs

Hospitals are already paid well below the cost of providing care to Medicare and Medicaid patients, which on average, account for more than 60% of a hospital's payor mix. A new report by the American Hospital Association shows that Medicare's inpatient payments have greatly lagged increases in expenses hospitals have borne due to inflation, skyrocketing drug costs, and rising labor costs.

Figure 1. Cumulative Hospital Expense Growth is More Than Double the Cumulative Increases in Medicare IPPS Reimbursement, 2019-2022



Source: FY 2020-2022 IPPS Final Rule

Annual Medicare underpayments for WI hospitals grew from $1.77B in 2016 to $2.53B in 2021 – a 42% increase. This trend is only projected to increase given that Wisconsin is an aging state. In fact, as of 2018, Wisconsin was tied for 16th among states with the highest percent of their population covered by Medicare, at 20%.[2] ***Additionally, fee-for-service Medicare does not reward Wisconsin for being a low-spending Medicare state – Wisconsin ranked 16th lowest in per-beneficiary Medicare spending in 2019, yet Wisconsin hospitals receive lower payment rates from Medicare than the national average - around 73% of what it costs to provide Medicare services in Wisconsin compared to a national average of 84% of cost.*** If hospitals are unable to grow revenue from other sources, they must make cuts to service lines just like any other business to remain financially viable. But unlike other businesses, hospitals do not have the luxury of closing down the overnight shift when operating becomes unprofitable.

[1] CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.

[2] Wisconsin Department of Administration. Percent of Projected Population Ages 60 and Older. [Online] 2017. https://www.dhs.wisconsin.gov/publications/p01803.pdf

New Report Confirms Rationale for Higher Hospital Outpatient Department Payments

A new report by KNG Health commissioned by the American Hospital Association shows the valuable role hospital outpatient departments (HOPDs) play in providing care to medically underserved populations, including those who are sicker and have lower incomes.

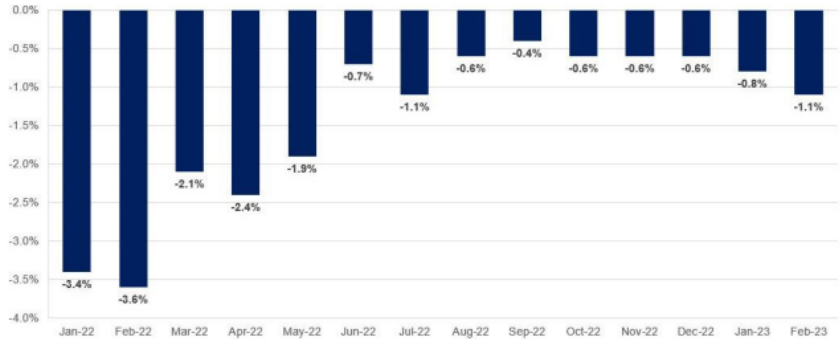
The report looked at fee-for-service Medicare data of a sample of patients seen at HOPDs, independent physician offices (IPOs) and ambulatory surgery centers (ASCs) between 2019 and 2021. It concluded patients treated in HOPDs had higher needs compared to other settings because of social determinants of health and higher clinical complexity. Among the findings of Medicare beneficiaries served were:

- HOPD patients were almost two times as likely to be dually eligible for Medicare and Medicaid, indicating both a higher rate of poverty and/or a long-term disability.
- HOPD patients were almost two times as likely to have a major complication or comorbidity as defined by the Centers for Medicare and Medicaid Services (CMS), indicating the need for more intense staffing to manage chronic conditions.
- HOPD patients were more than two times as likely to have had an emergency department or hospital inpatient stay in the last 90 days, indicating the need for more resources to care for these patients.

New Site-Neutral Payments Will Cut Medicare Reimbursements for Hospitals that are Already Operating in a Very Challenging Fiscal Environment

As the chart to the right shows, nationally, hospitals saw negative monthly operating margins throughout 2022 and persisting into 2023. Wisconsin is facing the same challenges; survey data from the Wisconsin Hospital Association shows Wisconsin's hospitals have experienced a net operating loss of -0.4% through the first six months of 2022, the most recent fiscal data available.

Figure 2. Kaufman Hall Operating Index YTD by Month



Adapted from the March 2023 Kaufman Hall National Flash Report

As mentioned previously, ***hospitals cannot simply choose to close on the nights and weekends like most businesses do when operating is unprofitable. And unlike independent clinics or ASCs, hospitals cannot choose to reject more complex patients or poor payors, such as Medicaid patients; hospitals must find a way to operate the safety-net services communities depend on while neighboring independent practices simultaneously cherry-pick more lucrative service lines.*** Unfortunately, site-neutral payment policies would exacerbate the challenges already posed by this reality.

Figure 3. Contract Labor Firms Take Advantage of Hospital Workforce Shortages (2019-2022)

Source: AHA and Syntellis Performance Solutions, "Hospital Vitals: Financial and Operational Trends, Workforce Pressures Take Their Toll in 2022."

At the same time, hospitals are being squeezed by the demands placed on them for being open 24/7/365. The historic workforce shortage has required them to rely more on expensive temporary agency staffing to fill shifts needed to keep their doors open.

Please Oppose Site-Neutral Payment Policies Being Considered by Energy and Commerce

The House Energy and Commerce Committee has announced a hearing on legislation that will consider expanding site-neutral payment policies***. It's important to remember that hospitals did not design the complex, convoluted payment structure that currently exists – but nevertheless must plan their budgets based on it. Please reject site-neutral payment cuts to hospitals. Instead, policymakers should pursue comprehensive payment reform that incentivizes the type of high quality, high value care Wisconsin is known for.***