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Advancing Health in America

Fact Sheet: Medicare Hospital Outpatient Site-Neutral Payment Policies

AHA Take

The AHA strongly opposes site-neutral payment cuts, which would reduce access to critical health care services, especially in rural and other underserved communities.

Hospital outpatient departments (HOPDs) — such as hospital-owned clinics that provide complex cancer, pediatric and mental health services — should not be paid the same Medicare rate as a stand-alone physician office. These outpatient departments treat more patients from medically underserved populations who tend to be sicker and more complex to care for than Medicare patients treated in independent physician offices and ambulatory surgical centers. They also are held to more rigorous licensing, accreditation and regulatory requirements. Implementing site-neutral payment policies could force hundreds of outpatient clinics to close or cut back on critical services, resulting in reduced patient access and job losses.

The cost of care delivered in hospitals and health systems, including HOPDs, is fundamentally different than other sites of care and thus needs to take into account the unique benefits that only they provide to their communities. This includes maintaining standby capacity for natural- and man-made disasters, public health emergencies, other unexpected traumatic events, and the delivery of 24/7 emergency care to all who come through their doors, regardless of ability to pay or insurance status. Since the hospital safety-net and emergency standby roles are funded through the provision of all outpatient services, expanding site-neutral cuts to additional HOPDs and the outpatient services they provide would endanger the critical role that they play in their communities, including access to care for patients, especially the most medically complex.

Why

Site-neutral payment policies endanger hospitals' ability to continue to provide 24/7 access to emergency care and standby capability and capacity for disaster response. Hospitals have a higher cost structure than independent physician offices and ambulatory surgery centers (ASCs) due in part to the costs of standby capability and capacity. Existing site-neutral policies reimburse certain off-campus HOPDs less for services while still expecting them to continue to provide the same level of service to their patients and communities. Hospitals are the only health care provider that must maintain emergency standby capability 24 hours a day, 365 days a year. This standby role is built into the cost structure of hospitals and supported by revenue from direct patient care — a situation that does not exist for any other type of provider. Following several years in which the nation experienced a pandemic and a record-setting number of natural disasters, we must do everything we can to ensure that hospitals have the resources needed to prepare for, and respond to, future disasters.

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HOPDs provide services that are not otherwise available in the community for vulnerable patient populations. Continuing site-neutral payment cuts would greatly endanger the critical role that HOPDs play in their communities, including providing convenient access to care for the most vulnerable and medically complex beneficiaries. HOPDs are more likely to treat Medicare beneficiaries who have both more chronic conditions and more severe chronic conditions; are more likely to have a prior hospitalization and higher prior emergency department (ED) use; and are more likely to live in communities with lower incomes. For example, relative to Medicare beneficiaries seen in physician offices, beneficiaries seen in HOPDs are:

- 73% more likely to be dually eligible for Medicare and Medicaid;
- 52% more likely to be enrolled in Medicare through disability or end-stage renal disease (ESRD);
- 31% more likely to be non-white;
- 62% more likely to be under age 65 and, therefore, eligible for Medicare based on disability, ESRD or amyotrophic lateral sclerosis (ALS); and
- 11% more likely to be over 85 years old.[1]

Moreover, among Medicare beneficiaries with cancer, the differences in the types of patients seen in HOPDs compared to those seen in physician offices is even starker. For example, relative to cancer patients seen in physician offices, cancer patients seen in HOPDs are not only more likely to have more chronic conditions and more severe chronic conditions, higher prior utilization of hospitals and EDs, and a higher likelihood of residing in low-income areas, but also are:

- 123% more likely to be dually eligible for Medicare and Medicaid;
- 84% more likely to be enrolled in Medicare through disability or ESRD;
- 81% more likely to be non-white; and
- 137% more likely to be under age 65 and, therefore, eligible for Medicare based on disability, ESRD or ALS.[2]

HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do independent physician offices and ASCs. Hospitals' safety net roles means that they also are subject to more comprehensive licensing, accreditation and regulatory requirements than other settings. This includes the Emergency Medical Treatment and Labor Act (EMTALA), stricter requirements for disaster preparedness and response, stringent ventilation and infection control codes, quality assurance, accreditation, and fire and life safety codes. Site-neutral payment policies fail to account for these fundamental differences between hospitals and other sites of ambulatory care.

Medicare already pays substantially less than the cost of caring for its beneficiaries. AHA survey data finds that the federal government only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries.

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Additionally, a report from Kaufman Hall reports that average hospital operating margins were consistently negative throughout 2022, and that over half of hospitals lost money caring for patients in 2022. Moreover, at least three dozen hospitals entered bankruptcy or closed in 2020, according to data compiled by Bloomberg. Specifically, between 2010 and 2021, 136 rural hospitals have closed, and 19 of these closures occurred in 2020, the most of any year in the past decade[3]. Site-neutral cuts contribute to the tenuous financial situation of hospitals.

The AHA strongly opposes further site-neutral payment cuts, which threaten access to care. Treating services as the same regardless of the site of care ignores the fact that only certain providers are capable of caring for the most acute and vulnerable — and therefore resource-intensive — patients. In addition, these same providers are the sole source of a wide range of high-acuity essential services, such as emergency and trauma care, the costs for which must be shared across all services.

[1] Based on an Analysis of the Limited Data Sample of 2021 Medicare Claims Data conducted by KNG Health Consulting, LLC, 2023.

[2] Comparison of Care in Hospital Outpatient Departments and Independent Physician among Cancer Patients, KNG Health Consulting LLC, April 2021.

[3] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

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