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Modeling the Impact of Potential Cuts in Hospital Surgery Payments

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IF IMPLEMENTED, MEDPAC'S RECOMMENDATION TO EQUALIZE PAYMENTS TO ASCS AND HOSPITAL OUTPATIENT DEPARTMENTS FOR 12 SELECT SURGICAL PROCEDURES WOULD REDUCE HOSPITAL OUTPATIENT DEPARTMENT REVENUE BY 1.7 PERCENT.

In a June 2013 report, the Medicare Payment Advisory Commission (MedPAC) identified $590 million in possible Medicare savings for non-emergency hospital outpatient surgeries and $40 million to $220 million in out-of-pocket savings for Medicare beneficiaries via reductions in coinsurance payments. These potential savings stem from the cost savings that would be realized if Medicare paid hospitals the same rates paid to ambulatory surgery centers (ASCs) for specific surgeries rarely performed in emergency situations.

The MedPAC analysis has many implications that would significantly affect the economics of the ASC and hospital industries if implemented.

OPPS Reimbursement Changes by Specialty

Currently, Medicare reimburses hospital outpatient departments 76 percent more for the same outpatient surgery procedures performed at ASCs. According to MedPAC, there are two main reasons for paying hospitals more than ASCs.

First, hospitals incur substantial costs to maintain access to standby emergency surgery services. Hospitals are subject to the Emergency Medical Treatment & Active Labor Act of 1986 (EMTALA), which requires them to screen and stabilize (or transfer) patients who are experiencing a medical emergency, regardless of their ability to pay. ASCs are not subject to EMTALA and they do not maintain emergency departments (EDs) or provide emergency surgery services. As part of its analysis, MedPAC identified surgical procedures rarely performed in a hospital outpatient department in conjunction with an ED visit. The cost of these surgeries is not directly associated with the costs of operating an ED.

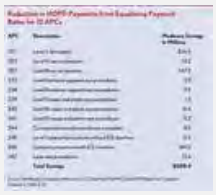
Second, hospital outpatient departments may be predisposed to treat patients with more comorbidities. Whereas an arthroscopic knee procedure will result in a discharge for most patients, the most complex cases and high-risk patients might be kept overnight or admitted for reasons related to their risk factors.

ASCs frequently screen out higher-risk patients because ASCs do not maintain the same level of emergency backup to support these patients as hospitals. Furthermore, ASCs are not permitted to keep patients for planned stays longer than 23 hours and 59 minutes under the Medicare program.

Therefore, hospital surgery patients may inherently be more medically complex and require more resources. To account for these differences, MedPAC identified surgeries for which there was no difference in patient severity between hospital outpatient departments and ASCs by focusing on procedures for which the length of stay and services used by hospital outpatient departments were similar to ASCs.

After making these adjustments, MedPAC identified 12 ambulatory payment classification (APCs) groups that include surgeries for which hospital outpatient department payments could be reduced to ASC rates. These include nine eye procedure groups, two nerve injection groups, and a skin repair group.

Within these groups, Medicare would realize more than half of the total $590 million in savings from cataract surgeries and more than a quarter of the savings from nerve injections (see the exhibit below). This change would reduce the overall Medicare revenue that hospitals receive by 0.4 percent and hospital outpatient department revenue by 1.7 percent, according to the MedPAC analysis.



M&A Considerations

If these changes are implemented, the economics of ASC acquisitions will dramatically change for hospital buyers. Hospitals' ability to realize substantial reimbursement increases after buying ASCs—solely because of a shift to a separate fee schedule—will materially decrease.

With limited capital to fund acquisitions, hospital and health systems frequently submit acquisition proposals to capital and finance committees where contemplated ASC acquisitions often compete with other internal projects for capital. Although the fair market value for ASCs may remain the same, the ROI for hospital buyers would be comparatively worse for ASC acquisitions if CMS adopted MedPAC's proposal.

A Diagnostic Imaging Comparison

Under the Deficit Reduction Act (DRA) of 2005, Medicare reimbursements for non-hospital imaging centers were set to the "lower of" the Medicare physician fee schedule or the hospital outpatient prospective payment system (OPPS). As a result, non-hospital-owned imaging centers saw Medicare reimbursement decrease by as much as 35 percent for MRIs and CT scans, according to an analysis published by *MMP Radiology* in 2011. Providers indicated that Aetna and various regional Blue Cross plans adjusted their reimbursement to mirror the reductions enacted by Medicare very quickly, while other payers implemented the changes by the end of 2007.

While commercial payers often follow Medicare's lead with respect to payment policy, it is difficult to predict the degree to which such a change would be adopted for outpatient surgery. The DRA reduction was targeted at non-hospital-owned services, and a study released by the Center for Studying Health System Change in 2010 indicates that hospitals exert more market power on commercial insurers than other non-hospital-owned providers. That study found that commercial payer reimbursement for outpatient hospital services ranged from 193 percent of Medicare to 368 percent of Medicare, while physician practice reimbursement was 82 percent to 176 percent of Medicare.

Three Potential Paths

From a business perspective, there are three likely responses to these reimbursement reductions if implemented.

First, some operators may elect to divest their service line or get out of the business altogether. As an example, during and immediately prior to the implementation of DRA in 2007, several medical imaging companies divested and/or consolidated. During 2006 and 2007, HealthSouth sold its imaging division to The Gores Group, a private equity firm, and Radiologix merged with RadNet.

Similarly, when home health reimbursement was reduced via the interim payment system in 1998 and subsequent prospective payment system in 2000, the number of Medicare-certified home health agencies decreased from approximately 10,400 in 1997 to 6,900 in 2000. Thus, it is likely that a quarter million dollar reinvestment in cataract surgery equipment may become unpalatable for a hospital outpatient surgery department if only a few eye surgeons use it for their high-risk patients.

Second, hospitals will likely focus more on increasing utilization by joint venturing with physicians. Currently, a major impediment to hospital joint ventures with ASCs is the revenue loss that hospitals would incur. It is difficult to support a joint venture business plan in a capital planning committee when it will result in direct revenue losses to hospital surgery departments that are not superseded by increases in utilization.

Finally, hospitals may need to scale up their operations to realize economies of scale. Hospitals and health systems that have the capital to fund acquisitions could respond to reimbursement reductions by buying more surgery centers to augment surgical volumes. This is the more aggressive of the three responses and probably applies only to a small segment of the affected organizations.

The Affect on Physician-Owned Specialty and Surgical Hospitals

According to MedPAC, 61 specialty and surgical hospitals that operate primarily as outpatient surgical hospitals would be among those most adversely affected by reductions in reduced Medicare payments. All physician-owned surgical hospitals received their Medicare certification prior to December 31, 2010, and achieved grandfather status under Section 6001 of the Affordable Care Act. Those developed and constructed immediately prior to the ban are likely still paying down their financing for building construction, equipment, and working capital. A fundamental change in eye surgery and pain reimbursement may affect these surgical hospitals' ability to service their debt and could lead to transactions in which larger, health systems purchase surgical hospitals that are experiencing financial distress.

Just the Beginning?

MedPAC has submitted multiple reports to Congress identifying the cost savings of neutralizing site-of-service payment differences between hospital outpatient departments, ASCs, and physician offices for various types of services.

Ambulatory surgery accounts for $590 million of the $1.5 billion per year in savings that MedPAC identified by neutralizing the site-of-service differential for various services provided in hospital outpatient departments. If Congress adopts MedPAC's proposals, there is the potential that other surgical procedures outside of those initially identified could be added to achieve savings even greater than the suggested $590 million per year that MedPAC has identified.

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Discussion Starters

What do you think? Please share your thoughts in the comments section below. Alternatively, use the "inshare" button at the top of this web page to share this article and your comments on the Payment & Reimbursement Forum's LinkedIn board.

- How do you think MedPAC's recommendation to equalize payments to ASCs and hospital outpatient departments would affect the economics of ASCs and hospitals?
- Do you think Congress will adopt MedPAC's recommendations for equalizing these payments?

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