



SITE NEUTRALITY: A Race to the Bottom for Patients with Heart Disease

On behalf of the American Society of Echocardiography (ASE), the American Society of Nuclear Cardiology (ASNC), and the Cardiology Advocacy Alliance, we thank you for the opportunity to submit this statement for the record in conjunction with the hearing “Keeping the Promise: Site of Service Medicare Payment Reforms” before the U.S. House of Representatives, Energy and Commerce Committee’s Subcommittee on Health, on Wednesday, May 21, 2014.

The concept of “site neutrality” is addressed in a number of MedPAC reports and in a number of contexts. In several of its reports, MedPAC has focused on disparities in Medicare payment among various providers of post-acute care (e.g. Skilled Nursing Facilities vs. Inpatient Rehabilitation Facilities), between hospital outpatient departments and physicians’ offices, and between hospital outpatient departments and ambulatory surgical centers. One option proposed by MedPAC would reduce Medicare payment for hospital outpatient services in 66 Ambulatory Payment Classifications (APCs) “to the levels paid in physicians’ offices or ambulatory surgical centers.”

If adopted, this approach has the potential to devastate cardiology departments and patients with heart disease in hospitals throughout the country. These cuts would adversely impacting both inpatient and outpatient cardiac care provided to critically ill hospitalized patients as well as those served by hospital outpatient clinics. In fact, almost 50% of the Medicare payment reductions that would result from this proposal would hit hospital cardiology departments, reducing payment for nuclear cardiology procedures by almost 20% and reducing payment for cardiac ultrasound procedures by over 60%. These procedures are fundamental tools in the diagnosis of a broad range of cardiac disorders, including, for example, congestive heart failure, coronary artery disease, valvular heart disease, and congenital conditions.

We strongly oppose any policy that would reduce payment to hospital outpatient departments for cardiology services to the levels paid in physicians' offices:

- As MedPAC concedes, hospital outpatient services are already operating at a negative 11 percent margin, and adopting further outpatient payment reductions would deepen that deficit.
- MedPAC's own report on this issue notes that his policy would have a disproportionate, negative impact on small rural hospitals.
- This policy would redistribute \$1.1-\$1.3 billion among hospitals, with virtually no analysis of the potential unintended consequences.
- HOPPS is designed such that some procedures within a department may be overpaid and some underpaid, but, on average, the department is reimbursed based on its costs, as determined based on audited cost reports. Hospitals have unique expenditures not experienced by physician offices, including the requirement for 24/7 provision of care, the role as a safety net for patients unable to pay for services, and the costs associated with operating large scale integrated systems. These expenditures are not taken into account in

the Physician Fee Schedule methodology, which bases allowances on the resources required to provide services to the “typical” patient in a physician’s office.

- The patient populations served by hospital cardiology departments and physicians’ offices may be very different. For example, approximately 66% of cardiac ultrasounds performed by hospitals are provided to hospital inpatients, who are often critically ill, and more than 20% of these studies are provided in emergency rooms. The MedPAC proposal makes no adjustment to account for these differences in patient populations served by hospital cardiology departments and physicians’ offices.
- Because the Hospital Outpatient Prospective Payment (HOPPS) methodology differs in critical respects from the Physician Fee Schedule methodology, adopting the “site blind” policy proposed by MedPAC will result in illogical and unsupportable payment anomalies. For example, some physician services only have “global” rates, which also include subsequent follow-up care following a procedure. As a result, the physician rates pay for a different bundle of services than the hospital APC, which results in an apples-to-oranges comparison between rates for the two settings.
- Services reimbursed under the HOPPS are placed in APCs on the basis of clinical and cost similarity, and all services within an APC have the same payment rate. On the other hand, physician services are paid on the basis of weights for the work, practice expense, and malpractice associated with an individual procedure. MedPAC proposes to reduce Medicare payment for *all procedures* in selected APCs based on physicians’ office rates based on whether *some of them* are paid less in physicians’ office settings. Thus, under MedPAC’s suggested policy, procedures in APCs could have their payments reduced even though those procedures are not, or not commonly, provided in the physician’s office.
- The proposed policy would result in unanticipated incentives for hospitals and physicians to substitute more costly “and potentially more invasive” procedures for those subject the “site blind” reductions.

Perhaps most importantly, the proposed policy has the potential to substantially reduce the quality of and impede patient access to critical cardiac services in our Nation's hospitals. Physician Fee Schedule allowances paid for the targeted cardiology procedures have been slashed to financially unsustainable levels, and reducing payment to hospital cardiology departments to these levels will inevitably impact patient care for those with heart disease.

The private practice of cardiology has been decimated by Medicare payment reductions that have been implemented under the Physician Fee Schedule over the past several years. For example, Medicare payment for the primary cardiac ultrasound service has been reduced by almost 50% since 2007 based in part on flawed data gathered from only 55 cardiologists throughout the country. As a result of these payment reductions and a leveling off in utilization, Medicare spending for cardiac ultrasound services under the Physician Fee Schedule was lower in 2011 than it was in 2001. These reductions have placed many cardiology practices under substantial financial constraints and threatened the independent practice of cardiology. Because of these reductions, there has been a drop in the number of physicians providing cardiac ultrasound services in their offices and an increase in hospital employment of cardiologists. It simply makes no sense to reduce payment for critical cardiac services provided by hospitals to levels that have already been determined to be insufficient. Quite simply, two wrongs don't make a right.

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ASE is an organization of over 16,000 professionals committed to excellence in cardiovascular ultrasound and its application to patient care. ASE members include not only physicians but also cardiac sonographers who acquire cardiac ultrasound images for physician interpretation in both hospital and non-hospital settings.

ASNC is a greater than 4,500 member professional medical society, which provides a variety of continuing medical education programs related to nuclear cardiology , develops standards and guidelines for training and practice, promotes accreditation and certification within the nuclear cardiology field, and is a major advocate for furthering research and excellence in nuclear cardiology.

The Cardiology Advocacy Alliance (CAA) is a nonprofit organization that represents the interests of more than 5,000 cardiologists in the United States. CAA educates the professional cardiovascular community about regulatory and legislative issues that affect their ability to provide rapid access, high-quality patient care; represents the common interests of the cardiovascular patient and professional on such issues; and encourages its members to advocate for their patients and their practices.