American Hospital Association™

Advancing Health in America

Fact Sheet: Site-neutral Payment Provisions

The Issue

Section 603 of the Bipartisan Budget Act of 2015 requires that, with the exception of emergency department (ED) services,[1] services furnished in off-campus provider-based departments (PBDs) that began billing under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015 (referred to as "non-excepted services") are no longer paid under the OPPS. Instead, these services are covered and paid under "another applicable Part B payment system."

For calendar year (CY) 2017, the Centers for Medicare & Medicaid Services (CMS) finalized the physician fee schedule (PFS) as the applicable Part B payment system and set payment for most non-excepted services at 50 percent of the OPPS rate. For CY 2018, CMS further reduced the site-neutral payment rates – to 40 percent of the OPPS rate. For CY 2019, CMS proposes to maintain payment for non-excepted services at 40 percent of the OPPS amount.

In addition, for CY 2019 CMS proposes to **reduce payment for clinic visits in excepted PBDs to the "PFS-equivalent" payment rate of 40 percent of the OPPS payment amount.** Doing so would entail a cut to hospital payments of $760 million in CY 2019. CMS also proposes that, if an excepted off-campus PBD begins to furnish a new service from a clinical family for which it did not previously furnish and bill for during a baseline period (generally from Nov. 1, 2014 through Nov. 1, 2015), the new service would no longer be a covered outpatient department service. Instead, it would be a non-excepted service paid under the PFS at 40 percent of the OPPS amount.

AHA Position

With the expanded site-neutral policies proposed for CY 2019, CMS has once again shown a lack of understanding about the reality in which hospitals and health systems operate daily to serve the needs of their communities. CMS has misconstrued Congressional intent with its proposal to cut payments for hospital clinic services in "excepted" off-campus PBDs. Under Section 603, Congress clearly intended to preserve the existing outpatient payment rate for these excepted off-campus PBDs in recognition of the critical role they play in their communities. But CMS's CY 2019 proposals run counter to this and will instead impede access to care for the most vulnerable patients.

We continue to urge CMS to provide payments that are adequate to cover the costs of providing care so that hospitals and health systems can continue to serve as the access point for community care.

Why?

- **Hospitals already suffer negative margins treating Medicare patients in PBDs.** According to the fiscal year 2016 Medicare cost report data, Medicare margins for outpatient services were a record low of negative 14.8 percent in 2016.[2] Overall, Medicare margins were a record low of negative 9.6 percent in 2016, with a new record low of negative 11.0 percent projected for 2018.[3] Of note, even "efficient" hospitals had a negative margin in 2016, for the first time ever.[4] Additional cuts to PBDs threaten beneficiary access to these services.
- **Medicare payment rates for non-excepted services should explicitly account for differences in packaging of costs between the OPPS and the PFS.** There are greater packaging of costs under the OPPS compared to the PFS. Therefore, one cannot make a direct comparison of rates for similar services in PBDs and freestanding physician office settings without first accounting for the additional packaging included in OPPS payments.

- **Hospital-based clinics provide services that are not otherwise available in the community for vulnerable patient populations.** The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and underserved populations. For example, relative to patients seen in physician offices, patients seen in PBDs are:
  - 2.5 times more likely to be Medicaid, self-pay or charity patients;
  - 1.8 times more likely to be dually eligible for Medicare and Medicaid;
  - 1.8 times more likely to live in high-poverty areas;
  - 1.7 times more likely to live in low-income areas;
  - 1.7 times more likely to be Black or Hispanic; and
  - 2 times more likely to receive care from a nurse in addition to a physician.[5]

- **Patients who are too sick for physician offices or too medically complex for ambulatory surgery centers (ASCs) are treated in the PBD.** Physicians refer more complex patients to PBDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, PBDs treat patients who are suffering from more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and EDs.[6,7]

- **PBDs have more comprehensive licensing, accreditation and regulatory requirements than do freestanding physician offices and ASCs.**

- **Site-neutral payment policies endanger hospitals' ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response.** Hospitals have a higher cost structure than freestanding physician offices due, in part, to the costs of stand-by capability and capacity that they bear. CMS's site-neutral policy reimburses non-excepted PBDs 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 stand-by capability 24 hours a day, 365 days a year. This stand-by 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 a year in which the nation experienced record-setting natural disasters, and with projections for an increase in the severity and frequency of extreme weather events, we must do everything we can to ensure that hospitals have the resources needed to prepare for and respond to future disasters.

- **Payment should reflect PBDs costs, not physician or ASC payments. PBD payment rates are based on hospital cost report and claims data.** In contrast, the PFS (and specifically the practice expense component) is based on physician survey data. ASCs do not report costs.

- **Factors outside the hospitals' control contribute to growth in OPPS expenditures.** Blaming increases in OPPS expenditures on the "unnecessary" shifting of services from physician offices to PBDs ignores other factors outside of hospitals' control that are driving increases in OPPS expenditures. This includes factors such as the skyrocketing cost of prescription drugs; the impact of Medicare policies, such as the two-midnight policy, and the fact that physicians frequently refer Medicare beneficiaries to PBDs for critical services they do not provide in their offices.

Sources

1. As well as services in off-campus PBDs meeting the additional "under development" exception in the 21st Century Cures Act.
2. AHA analysis of FY 2016 Medicare cost reports.
3. MedPAC's March 2018 Report to the Congress: Medicare Payment Policy.
4. MedPAC's March 2018 Report to the Congress: Medicare Payment Policy.
5. KNG Health Consulting analysis of 2013-2014 Medicare claims data, 2008-2011 National Ambulatory Medical Care Survey and 2008-2011 National Hospital Ambulatory Medical Care Survey data.
6. Ibid.
7. KNG Health Consulting LLC analysis of 2012-2013 Medicare claims data and 2010 National Hospital Ambulatory Medical Care Survey Ambulatory Surgery Restricted Data Files.