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Medicare "Site Neutral" Proposals

Background

Site neutral payment proposals have their roots in recommendations from the Medicare Payment Advisory Commission, MEDPAC, which provides Medicare analysis and policy advice to Congress. One policy proposal brought forward by MEDPAC years ago has often been referred to as "site neutral" payments, with the idea being that a service should be reimbursed the same amount regardless of the setting in which it is furnished. Since Medicare has different payment rules, MEDPAC saw that some services reimbursed under the physician fee schedule were reimbursed at a higher level under the Outpatient Prospective Payment System (OPPS) rule. While MEDPAC could have recommended bringing all payments up since it also recognizes Medicare payments do not typically cover the full costs to provide care, it instead recommended bringing hospital payments down to the level of clinics that bill under the physician fee schedule.

While equal payments for equal services sounds logical on its face, there are a variety of other factors such a policy does not take into account, such as:

- Hospitals bear much higher capacity costs, such as furnishing services 24 hours a day, 7 days a week,
- Hospitals furnish services to patients who are sicker (ie: have a higher acuity),
- Hospitals must comply with licensing, accreditation, and EMTALA requirements that are not applicable in other settings,
- Hospitals must meet Medicare conditions of participation for coverage,
- Medicare's payment systems for physicians, ASCs and hospitals are complex and fundamentally different.

The Centers for Medicare & Medicaid Services (CMS) itself acknowledged the differences in terms of payments:

> *"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]

The 2015 Bipartisan Budget Act and 2016 21st Century Cures Act

Despite these justifiable reasons for maintaining higher payments to hospital outpatient departments (HOPDs), the 2015 Bipartisan Budget Act (BiBA) reduced payments to *new* off-campus HOPDs in an effort to reduce Medicare

[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.

spending. However, recognizing that many hospitals had already built their budget projections and made community investments with the understanding of maintaining current funding, Congress grandfathered HOPDs in existence as of November 2nd, 2015. One thing Congress did not immediately take into account was the fact that there were also hospital outpatient departments in the mid-build phase that would not be grandfathered under BiBA. To correct for this omission, Congress included language in the 21st Century Cures Act signed into law in December of 2016 that grandfathered HOPDs in mid-build.

Déjà vu – 2019 OPPS Rule Proposes to Expand Site-Neutral Payments

Every year, CMS updates its payment guidelines for providers reimbursed under a variety of different payment rules. In the 2019 OPPS rule, CMS has resurrected the site-neutral discussion by proposing to extend site-neutral payment policies to clinic visits in previously grandfathered (CMS terminology is "previously excepted") provider-based departments (PBDs). According to CMS, the clinic visit is the most billed for outpatient service, and reducing reimbursements to PBDs would save the Medicare system $760 million in provider payments and beneficiary copays. Preliminary estimates suggest this will impact around 40 of Wisconsin's hospitals, reducing payments by $30 million next year alone, with a 10-year impact of around $440 million.

Reasons to Oppose the newest "Site Neutral" Payment Proposals

- Unfortunately, CMS does not seem to recognize that ***Congress specifically intended to grandfather off-campus hospital outpatient departments in two separate pieces of legislation. This new proposal clearly goes against Congressional intent.***
- Many hospitals have based their budgets and operations off of funding under the current law. ***CMS is "pulling out the rug" from under hospitals, giving them only a few months to figure out how to fill budget holes that for some will be in the millions of dollars.***

Congressional District	10 Year Impact
Paul Ryan	$72.1 million
Mark Pocan	$190.6 million
Ron Kind	$34.6 million
Gwen Moore	$57.0 million
Jim Sensenbrenner	$33.7 million
Glenn Grothman	$32.2 million
Sean Duffy	$12.4 million
Mike Gallagher	$7.9 million
Statewide	**$440.5 million**

- Studies show hospitals treat higher risk patients. Patients treated at HOPDs are often undergoing more complex procedures and have more comorbidities and complications. Hospitals also serve a higher percentage of disabled, dual-eligibles and low-income patients than physician offices or ASCs.
- HOPDs have more comprehensive licensing, accreditation and regulatory requirements than other settings.
- Wisconsin continues to rank among the leaders nationally on health care *value*—high quality, cost-efficient care, having been ranked number 1 for quality in 2017 by the Agency for Healthcare Research and Quality.

WHA Position

With Wisconsin's strong position as a national leader in delivering high quality, high value healthcare, WHA has long advocated for systemic payment reforms to Medicare's antiquated payment system. CMS should focus reform efforts on incentivizing and rewarding such high quality, high value healthcare. Unfortunately, this "site-neutral" proposal is simply another cut to hospital payments in a manner that is counter to Congress's intent to grandfather these payments in past legislation. **WHA asks Wisconsin's Congressional delegation to sign onto the attached letter asking CMS to abandon this proposal, and instead work with hospital and health system leaders in finding alternative solutions to reduce unnecessary costs for Medicare and its beneficiaries.** We believe CMS could use a similar approach to its commendable "Patients Over Paperwork" initiative that has sought input from industry leaders in identifying outdated and burdensome regulations.

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