

## The Issue

**Section 603 of the Bipartisan Budget Act of 2015 requires that, with the exception of emergency department (ED) services,<sup>1</sup> 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-grandfathered” services) are no longer paid under the OPPS.** Instead, these services are covered and paid under “another applicable Part B payment system.” Since calendar year (CY) 2018, the Centers for Medicare and Medicaid Services (CMS) has maintained payment for non-grandfathered services at 40% of the OPPS amount. This same site-neutral rate is proposed for non-grandfathered services in CY 2020.

In addition, in CY 2019, citing “unnecessary” increases in the volume of clinic visits in hospital PBDs allegedly due to payment differentials driving the site-of-service decision, CMS finalized its policy to pay for visits furnished in grandfathered off-campus PBDs at the same rate they are paid in non-grandfathered off-campus PBDs. Specifically, CMS pays for clinic visit services in grandfathered PBDs at 40% of the OPPS payment amount. However, the agency phased in over two years the application of this policy. Thus, in CY 2019, grandfathered off-campus PBDs were paid 70% of the OPPS rate for clinic visit services. **In CY 2020, CMS proposes to complete the phase-in and pay grandfathered off-campus PBDs 40% of the OPPS rate for clinic visit services.** The agency again proposes to implement the clinic visit policy in a non-budget neutral manner, estimating that it would cut hospital payments by \$810 million in CY 2020.

**Further, there are other proposals being considered by the Administration and Congress to expand so-called site-neutral cuts.** The President’s FY 2020 budget proposes to apply site-neutral payment to clinic visits and certain other services furnished in on-campus outpatient departments as well as to all services furnished in grandfathered off-campus PBDs. The Senate Committee on Finance’s “The Prescription Drug Pricing Reduction Act of 2019” includes a provision that would pay site-neutral rates for drug administration services furnished in grandfathered off-campus PBDs.

## AHA Position

By continuing payment cuts for hospital outpatient clinic visits, CMS has not only undermined clear congressional intent, but has threatened to impede access to care, especially in rural and other vulnerable communities. These cuts clearly exceed the Administration’s legal authority, which is why the AHA has been working to overturn this rule through legal action and by working with the Congress.

Further, we are concerned that the other site-neutral proposals being considered by the Administration and Congress could endanger hospitals’ ability to continue to provide critical services. These short-sighted policies demonstrate a lack of understanding about the reality in which hospitals and health systems operate daily to serve the needs of their communities and fail to reflect the significant differences between hospitals, independent physician offices and other sites of care.

## Why?

- **Hospitals already suffer negative margins treating Medicare patients in PBDs.** According to the fiscal year (FY) 2017 Medicare cost report data, Medicare margins for outpatient services were negative 14.2% in 2017. Overall, Medicare margins were a record low of negative 9.9% in 2017, with a negative 11% projected for 2019.<sup>2</sup> Of note, even “efficient” hospitals had a margin of negative 2% in 2017.<sup>3</sup> Additional cuts to PBDs threaten beneficiary access to these services.
- **Factors outside the hospitals’ control contribute to growth in OPSS expenditures.** Blaming increases in OPSS expenditures on the “unnecessary” shifting of services from physician offices to PBDs ignores other factors outside of hospitals’ control that are driving increases in OPSS 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.
- **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 Medicare beneficiaries seen in physician offices, beneficiaries seen in PBDs are:
  - 1.6 times more likely to be under 65 and, therefore, eligible for Medicare based on disability, end-stage renal disease or amyotrophic lateral sclerosis;
  - 1.8 times more likely to be dually eligible for Medicare and Medicaid;
  - 1.5 times more likely to be Black or Hispanic;
  - 33% higher severity, as measured by the Charlson Comorbidity Index, a measure computed by assigning higher weights to more severe conditions in terms of their effect on mortality; and
  - 1.3 times more likely to have at least one complication/comorbidity and 1.8 times more likely to have at least one major complication/comorbidity.<sup>4</sup>
- **Site-neutral policies are based on flawed assumptions.** CMS’s site-neutral policies are based on the flawed assumption that Medicare physician fee schedule (PFS) payment rates are sustainable rates for physicians. However, the truth is much different. When hospitals acquire independent physician practices, it occurs because the physicians have reached a tipping point – their practices are failing due to poor payer mix, increasing Medicare and Medicaid regulatory burden, and declines in Medicare and Medicaid reimbursement. Instead of allowing these physician services to be lost to the community, or in communities where there are already health care deserts, hospitals acquire the practices in order to ensure continued access to these services.
- **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 and ASCs, PBDs treat Medicare beneficiaries who are suffering from more severe chronic conditions and have higher prior utilization of hospitals and EDs.<sup>5,6</sup>

- **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 standby capacity for disaster response.** Hospitals have a higher cost structure than freestanding physician offices due, in part, to the costs of standby capability and capacity that they bear. CMS's site-neutral policies reimburse excepted off-campus 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 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 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 audited hospital cost report data and claims data. In contrast, the PFS (and specifically the practice expense component) is based on estimates of the costs of resources physicians use in furnishing services, determined by a combination of CMS analysis of inputs from physician consensus panels and physician survey data. ASCs do not report costs.

## Sources

---

1. Services in off-campus PBDs meeting the additional "under development" exception in the 21st Century Cures Act are also excepted from Section 603 of the BBA.
2. MedPAC's March 2019 Report to the Congress: Medicare Payment Policy.
3. Ibid.
4. KNG Health Consulting, LLC analysis of 2010-2016 Medicare Inpatient, Outpatient, and Carrier Standard Analytical Files and Denominator files.
5. Ibid.
6. KNG Health Consulting, LLC analysis of 2016-2017 Medicare Inpatient, Outpatient, and Carrier Standard Analytical Files, and Denominator files.