American Hospital Association®

Fact Sheet: Changes to Site-neutral Payment Provisions in CMS's Physician Fee Schedule Proposed Rule

The Issue

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) 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 nonexcepted services at 50 percent of the OPPS rate. CMS refers to this 50 percent rate as the "PFS Relativity Adjuster."

In the CY 2018 PFS proposed rule, CMS proposes significant reductions to the site-neutral payment rates. Specifically, for CY 2018, the agency proposes to pay hospitals at 25 percent, rather than 50 percent, of the OPPS rate for non excepted services. CMS arrives at this proposed payment rate based solely on a comparison of the payment rate for a hospital outpatient clinic visit to the payment rates for similar outpatient visit services under the PFS. The agency estimates that its proposed change would save Medicare Part B $25 million in 2018. **CMS does not propose to make any other changes to its site-neutral policy in CY 2018, including to its problematic policy that the relocation of an existing (referred to as "excepted") PBD would result in it losing its excepted status and being paid at the site-neutral rate, except in extraordinary circumstances.**

AHA Position

CMS's proposal has a questionable legal and policy basis and is yet another blow to access to care for patients, including many in vulnerable communities without other sources of health care. The AHA strongly urges CMS to withdraw its proposed Relativity Adjuster of 25 percent. Making such an adjustment in CY 2018 would be arbitrary and capricious because it is unreasonable and unsupported by existing data, and therefore is in violation of the Administrative Procedure Act (APA).

Instead, the agency should retain its current methodology, which bases the Relativity Adjuster on a comparison of payment rates for the most frequently billed services in off-campus PBDs, and which resulted in the CY 2017 rate of 50 percent of the OPPS rate for non excepted services. However, the AHA also urges CMS to improve the accuracy of this methodology to account for differences in packaging across the OPPS and the PFS and to ensure that it accounts for both direct and indirect practice expense. Based on an updated AHA analysis, this improved methodology would result in a payment rate of 65 percent of the OPPS payment for non excepted services in 2018.

Further, we remain concerned that CMS's continued short-sighted policies on the relocation of excepted off-campus PBDs will prevent communities from having access to the most up-to-date services. We will 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?

- **CMS's proposed reduction would be arbitrary and capricious.** Regardless of setting, it is important for Medicare to make reasonable and adequate payment for the high-quality care that hospitals furnish to Medicare beneficiaries. Hospitals should not be penalized for providing services in locations

like off-campus PBDs that may best meet the needs of patients and communities. However, the proposed reduction to the CY 2018 PFS Relativity Adjuster from 50 percent to 25 percent of the OPPS payment rate would do just this – create an inadequate payment rate for and penalize hospitals for providing services in nonexcepted, off-campus PBDs. We strongly urge CMS to wait for more precise data before making any significant changes to its existing policy. Indeed, it would be arbitrary and capricious to make the proposed reduction to the Relativity Adjuster now for several reasons:

  - » CMS does not address serious limitations and shortcomings of its proposed methodology, which violates the APA;
  - » The agency has completely failed to provide a sufficient explanation for its proposed reduction to the Relativity Adjuster; and
  - » The agency's proposal would make an arbitrary and unjustified reduction when its CY 2017 PFS Relativity Adjuster was already unreasonably low, as the AHA explained in its comments on the CY 2017 OPPS final rule with comment period and interim final rule with comment period.

- **Hospitals already suffer negative margins treating Medicare patients in PBDs.** According to the fiscal year 2015 Medicare cost report data, Medicare margins are negative 13.5 percent for outpatient services in 2015. Additional cuts to PBDs threaten beneficiary access to these services.
- **Hospital-based clinics provide services that are not otherwise available in the community to 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.
- **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.
- **PBDs have more comprehensive licensing, accreditation and regulatory requirements than do freestanding physician offices and ASCs.**
- **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.

1. *As well as services in off-campus PBDs meeting the additional "under development" exception in the 21st Century Cures Act.*