Site-Neutral Issue Brief

Site-Neutral Cuts Will Jeopardize Access for Tennesseans

Summary

Site-neutral payment has gained significant interest in Congress this year. Numerous proposals have been introduced to make provider payments equal regardless of whether the service is performed in a hospital, ambulatory surgical center (ASC), or independent physician office (IPO). *These proposals would equate to devastating reimbursement cuts to Tennessee hospitals already facing unsustainable financial and workforce challenges.*

These hospital cuts are viewed by some as an attractive "pay for" to offset the cost of other healthcare priorities Congress is considering. However, these proposals are shortsighted and ignore fundamental differences between hospitals and other physician offices, which justify the payment differences. The proposals also fail to consider the devastating impact on Tennessee hospitals' ability to care for the patients and communities they serve.

Tennessee hospital outpatient departments (HOPDs) are:

- Ready To Serve Every Patient – Tennessee HOPDs care for sicker and more complex patients than other outpatient settings and are twice as likely to provide care to patients dually eligible for Medicare and Medicaid.
- Subject to Far More Regulations – Hospitals must meet more stringent federal and state requirements on licensure, certification, conditions of participation, life safety codes, electrical systems, etc.
- Ready to Respond 24/7 to National, State, and Local Emergencies – Tennessee hospitals are ready to respond to natural disasters, pandemics, and acts of violence.

Site-neutral proposals do not "level the playing field;" rather, they retrospectively change the rules for reimbursement but not for accreditation. Hospitals will still have to meet significantly higher state and federal requirements than ASCs and IPOs, despite drastic reimbursement cuts.

Finally, these cuts will only disincentivize making investments in our communities to provide greater access to care. Many Tennessee hospitals will be left with no choice but to bring services back to the main hospital and either close or curtail services in convenient locations depended on by sick and elderly patients, especially in rural communities.

The issue brief below goes into greater detail on how hospitals differ and how the three site-neutral proposals that have been considered in the House Energy & Commerce Committee **would negatively impact Tennessee Hospitals by up to $203 million in the first year and as much as $3.2 billion over 10 years.**

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Site-Neutral Background

The *Bipartisan Budget Act (BBA) of 2015* first introduced the concept of site-neutral payments. Site-neutrality is the policy of having Medicare Part B pay the same amount for the same outpatient services regardless of whether the service is performed in a hospital, ambulatory surgical center, or physician's office.

Grandfathering Provision

In BBA, and subsequent Centers for Medicare & Medicaid Services (CMS) rules, hospitals could no longer receive hospital-based reimbursement for outpatient services if they were performed at sites opened or converted after Nov. 2015 and more than 250 yards from the hospital's main campus. Sites where hospitals were billing for services prior to Nov. 2015 were excluded or "grandfathered" from these rules and have been allowed to continue receiving hospital outpatient reimbursements for the last eight years.

Site-Neutral Payment Policies Ignore Fundamental and Cost Structure Differences Between Hospitals and Other Physician Offices

Tennessee Hospitals are Ready to Serve Every Patient

It's not about the "service," but about the "patient" who receives the care. HOPD payments for certain services differ from physician practices and ASCs because the patients and treatments are different even though some of the services provided may seem the same.

Sicker and more complex patients often are referred to HOPDs for care due to their need for more specialized clinical personnel and broader facility capabilities.

- HOPDs are more prepared to treat a variety of patient needs and conditions, including patients that are allergic to contrast, patients that are morbidly obese, patients that experience extreme anxiety, patients that have multiple co-morbidities, etc.
- Many chronically or terminally ill patients are referred to HOPD clinics for services they might otherwise receive in physician offices or ASCs due to HOPDs having more highly trained personnel capable of providing more complex care.

Medicare, Medicaid, underinsured, or uninsured patients often are referred to HOPDs for care.

- As an example, skilled nursing facilities usually take their patients to HOPDs for needed screening and diagnostic services because freestanding physician offices are not prepared to fully meet the needs of these older, more complex patients who are nearly all on Medicare or Medicaid.
- More importantly, ASCs and freestanding physician offices can, and do, decline to care for many of these patients.

Medicare Already Underpays Tennessee Hospitals

Hospital revenue primarily comes from third-party payers, including commercial insurers, Medicare, and Medicaid. Unlike other industries where an increase in costs is simply passed on to consumers through increased prices, hospitals have little ability to negotiate government rates, which typically do not cover the cost of care.

In fact, the federal government significantly underpays hospitals for outpatient services, resulting in consistent negative Medicare margins – a negative 17.5 percent in 2021. Between 2019 and 2022, Medicare payment rates for hospital outpatient care rose 7.2 percent, while total hospital costs increased more than double, 17.5 percent. In fact, combined underpayments to hospitals from Medicare and Medicaid totaled $100.4 billion in 2020 alone.[1]

Tennessee Hospitals Face Significantly More Regulations

Before 2015, Congress and CMS fully recognized the increased cost of being prepared to provide services to all patients and rightfully allocated higher reimbursements to all outpatient services provided by a hospital.

Tennessee HOPDs are subject to far more regulations than provider clinics, ASCs, freestanding imaging centers, etc. Because HOPDs are extensions of the main hospital, they are held to higher standards than other outpatient settings. Hospitals, unlike ASCs and IPOs, provide and maintain vital services to protect their communities, including:

- 24/7 standby capacity for emergencies, disasters, traumatic events, etc.;
- Special service capabilities such as burn, neonatal, psychiatric services, etc.;
- Uncompensated care and service as safety-net providers; and
- Adherence to Emergency Medical Treatment and Labor Act (EMTALA) standards.

Tennessee HOPDs must comply with more stringent life safety codes, essential electrical systems, and Joint Commission standards. Federal and state regulators place **additional licensure, certification, conditions of participation, and other regulatory requirements** on hospital outpatient facilities because of their specialty staffing and capabilities to provide more complex care. These rules apply to hospital departments whether they are on campus or located away from the main hospital campus, and these regulations increase the cost of operating these locations.

Tennessee Hospitals are Ready to Respond to National, State, and Local Emergencies

Hospitals are ready to respond to natural disasters, pandemics, and unfortunately, acts of violence. Tennessee hospitals and HOPDs put significant resources – financial, workforce, and technology – toward ensuring they are always prepared and ready to provide care.

[1] https://www.aha.org/system/files/media/file/2023/06/Proposals-to-Reduce-Medicare-Payments-Would-Jeopardize-Access-to-Essential-Care-and-Services-for-Patients.pdf

Legislative Proposals

Site-neutral payment policies have been a major theme in this Congress, with numerous proposals being introduced and debated in both the House and Senate. Below focuses on the three site-neutral proposals that were considered as part of the April 26 legislative hearing in the House Committee on Energy & Commerce (E&C) Subcommittee on Health. On May 17, the full House E&C Committee held a markup where one site-neutral proposal advanced and the other two were offered and withdrawn. The committee passed H.R. 3261, which included:

Proposal #1: Site Neutral for Drug Administration Services (Sec. 302 of HR 3261)

As passed out of E&C Committee, this provision would create additional site-neutral payment cuts over four years for the administration of drug services furnished in an off-campus provider-based department.

Tennessee Impact
THA is especially concerned this would result in a major cut for HOPDs that provide essential drug administration services, including for vulnerable cancer patients, who may require a higher level of care as they receive essential treatments. **This would cut funding to Tennessee hospitals by $1.1 million in the first year. The American Hospital Association (AHA) estimates the 10-year impact for Tennessee would be $60.7 million.**

Proposal #2: Site Neutral Payments for Certain Services in Ambulatory Settings

As aforementioned, the enactment of the BBA meant hospitals would receive a reduced reimbursement for outpatient services if they were performed in sites opened or converted after Nov. 2015 and more than 250 yards from the hospital's main campus. Sites where hospitals were billing for services prior to Nov. 2015 were excluded or "grandfathered" from these rules and have been allowed to continue receiving hospital outpatient reimbursements for the last eight years.

This proposal (offered and withdrawn during House E&C's May 17 markup) would eliminate the grandfathering protections and hospitals would no longer receive hospital-based outpatient rates in any clinic/department that is more than 250 yards away from their campus.

Tennessee Impact
This first iteration of site-neutral payments allowed hospital-based reimbursements to continue in locations where services were already being provided. Many hospitals have HOPDs in locations that are more than 250 yards from their campus. These locations typically treat the same types of patients with the same complexities as the main hospital campus, so why should they be paid less for providing the same level of care simply because of their physical location? **This would cut funding to Tennessee**

hospitals by $28.4 million in the first year. The AHA estimates the 10-year impact for Tennessee would be $436.2 million.

Should this proposal go into effect, there will likely be some HOPD locations that close because hospitals will not be able to continue operating with increased losses. Medicare already does not fully cover the cost of providing hospital-level services in a HOPD. Further reducing the payments for these off-campus locations will result in decreased access to care for patients and could further disadvantage rural Americans since many times an off-campus HOPD is the only access to care they have.

Proposal #3: All HOPDs MedPAC Site Neutral Proposal

This proposal (offered and withdrawn during E&C's May 17 markup) would cut the reimbursement for all outpatient (OP) services provided by a hospital, without regard to the location.

Tennessee Impact

If reimbursement rates are changed for all OP services, the impact on access will be far greater. Again, Medicare rates do not fully cover the cost of providing services, so if all OP reimbursements are cut, there will likely be several unintended consequences to patient access. This is unprecedented and the impact would be devastating. **This would cut funding to Tennessee hospitals by $203.2 million in the first year. The AHA estimates the 10-year impact for Tennessee would be $3.2 billion.**

Some rural hospitals are the only provider of OP services in their communities, and if reimbursement rates are decreased dramatically, as in this proposal, rural providers will face even more financial strains and more will close and/or be at risk of closure.

- Nearly 60 percent of Tennessee hospitals had negative operating margins in 2022.
- 45 percent of Tennessee hospitals (with the majority of these being rural hospitals) are at risk of closure due to unsustainable metrics.
- Hospitals already are being forced to cut services – according to a recent survey of Tennessee hospitals, 57 percent of hospitals reported they are reducing or eliminating services.

Even in urban areas, hospitals will be forced to review the services they provide and assess which services they may need to reduce and/or eliminate. The review would not be limited to just OP services, which some will argue can be provided by freestanding providers, but also will have to include core inpatient and specialized services.