Site Neutrality

Introduction

On January 1st, 2017, in response to the significant payment differentials for same services in hospitals vs. physician practices, CMS implemented new rules stating that any new outpatient locations would reimburse activity at the physician office rate as opposed to hospital based payments. The hospital based rates are on average 30%-50%[1] higher depending on the service. Since this is a CMS initiative, the rule technically impacts Medicare payments only, although commercial insurers are likely to follow suit. The purpose of implementing such a rule was to help reduce the price discrepancy for similar commodity services (i.e. imaging) and to reduce the potential physician acquisition arbitrage that existed for hospitals by acquiring existing practices and flipping them to hospital-based reimbursement. The implementation of this rule certainly had profound financial implications on any hospital planning on new investments in ambulatory locations off the main campus. However, it has significantly changed behavior which may not necessarily reduce overall costs in the long-run as the rule is currently written.

Outpatient Reimbursement Rules / Site-Neutrality

"Medicare payment policies use two different payment methodologies for outpatient procedures based on the site of service. The hospital-based procedures performed at hospital outpatient departments are paid on the Hospital Outpatient Prospective Payment System while freestanding clinics are paid on the Medicare Physician Fee Schedule[2]." Essentially, Medicare's rates vary for the same service just in different settings. The reason for this is that in a hospital there are substantially more costs related to operations as opposed to a physician office with minimal infrastructure and overhead. To account for this difference, hospital outpatient departments (HOPDs) get a separate fee, substantially higher than the rate paid to the professional administering the service based on the physician fee schedule (PFS). In a physician office there is a single global payment at the lower PFS rate. This difference can be substantial compared to the hospital rate.

Although changing, historically consumers have had little interest in the overall price levels for healthcare services due to insurance coverage with low deductible/ low copay. Therefore, since there was little price elasticity from the consumer, and insurance covered the high cost service, hospitals did their best to take advantage of the revenue difference by maximizing the hospital-based rate whenever possible. As a result, when looking at similar services offered in two different locations, the cost to the insurer was drastic with no evidence of better service/outcomes.

---

[1] HFMA: Medicare's Site-Neutral Payment: Impact on Hospital Outpatient Services - https://www.hfma.org/Content.aspx?id=50525##

[2] Beckers: 12 Things to Know About Site-Neutral Payments: https://www.beckershospitalreview.com/finance/12-things-to-know-about-site-neutral-payments.html

To counteract that perverse incentive, CMS finalized "site neutrality" in November 2016 which stated that "off-campus provider-based sites that began billing under the Outpatient Prospective Payment System on or after Nov. 2, 2015 won't be paid for most services under OPPS after Jan. 1, 2017"[1]. Basically, since the rule was implemented on January 1st, 2017 – facilities that were operating prior to November 2nd, 2015 have not seen any changes to reimbursement. However, new outpatient locations (except for free standing emergency departments) – Medicare payments have been reduced to the physician fee schedule amount.

When the rule was proposed, "CMS' actuary has estimated that so-called site-neutral payments for ambulatory care, which Congress called for a 2015 spending bill, would save Medicare about $500 million in 2017"[3]. Since the year just ended, and data has not been released, it is unclear how well CMS is tracking towards the $500M in savings for this year. However, it is known that hospital systems have changed strategy because of the new rule which may have caused some unintended consequences that may offset some of the cost savings.

Hospital Strategy / Change in Behavior as a Result

Throughout the year, due to the new rule, there have been many strategic adjustments from health systems based on the way they are currently incentivized. Some of these were intended by CMS, but some may not have been. The list below begins to show some of the recent trends and outcomes implemented due to the site neutrality rule:

(1) Investment in "micro" bed platforms

Because the rule only pertains to new ambulatory investments that are more than 250 yards from a licensed hospital location, health systems are instead building "micro hospitals", "which have fewer inpatient beds to make room for lower-acuity patients, observation and short stays[4]" in geographies for which they want to expand to ensure hospital-based rates. Large systems such as Dignity Health in partnership with Emerus in Nevada and Christus Health in Texas and Louisiana have recently invested in "micro" hospitals as complements to their expanded ambulatory networks[5].

Prior to the rule, these investments may have just been large scale ambulatory platforms, but now systems are attaching the large ambulatory access point to a small-scale hospital. As a result, those facilities are higher cost platforms, with unneeded beds, that are going to bill at the higher of the two rates. Some may argue that these "mirco" hospitals are cheaper alternatives to a full scale inpatient platform. While that is true, that only applies when they serve as a replacement and not an incremental investment to reap HOPD rates. All those

---

[3] Modern Healthcare "Site-neutral pay rule leaves hospital-owned outpatient facilities with uncertain future" - http://www.modernhealthcare.com/article/20161102/NEWS/161109977

[4] Modern Healthcare "Micro-hospitals gaining favor with health systems amid shift to ambulatory care" - http://www.modernhealthcare.com/article/20180217/NEWS/180219951?utm_source=modernhealthcare&utm_medium=email&utm_content=20180217-NEWS-180219951&utm_campaign=am

[5] Modern Healthcare "Micro-hospitals gaining favor with health systems amid shift to ambulatory care" - m

factors typically result in adding cost to the system – a reverse of the desired effect. This strategy is more easily employed in states without CON.

(2) Fewer "big-box", multispecialty/multiservice ambulatory buildings

For more traditional "big box" ambulatory developments, the 30% to 50% reduction in potential revenue due to site neutrality means that these facilities often cannot generate the profit needed to justify the upfront capital and ramp-up costs. Prior to the rule, investment in these facilities were key components to any large system's strategic plan as they provided great access to patients without the licensing restrictions and intense capital requirements of a full-scale hospital. With a reduction in reimbursement, the cost structure of such entities is too hard to cover. As a result, systems have been hesitant to invest in such assets, and instead have focused regional ambulatory development on single specialty focused shops (i.e. GI/endoscopy, ophthalmology, etc.), or primary care outposts whose function is to sent referrals to the hospital where the rates are significantly higher.

(3) Strategic ambulatory investment is focused on driving more inpatient and high-end services to the hospital campus

Core ambulatory strategy has always been to create patient access portals that drive referrals to the hospital campus to help fill beds and operating rooms. However, over the last few years, with increased capability of technology and some payment reforms, hospitals worked to negotiate rates which focused on ambulatory books of business alone to help keep patients out of the hospital. The implementation of site-neutrality, coupled with the slow roll-out of fee-for-value payment methodologies have caused hospitals to double down on the strategic intent to drive patients back to the hospital hub as opposed to recent trends to keep patients out of the high cost center.

(4) Fewer large scale physician practice acquisitions as the arbitrage is reduced in flipping those practices to hospital-based practices

The impact to the rate at which hospitals and health systems were acquiring physicians is yet to be quantified. Certainly, the immediate financial upside that existed in converting an acquired physician's baseline clinical activity to hospital-based reimbursement is now gone (at least for Medicare books of business), though there still exist some strategic advantages to acquiring various physician practices (e.g., new market entrance, changing referral patterns, etc.) and that physician practices are continually looking to be acquired as the cost of running a practice continues to escalate. However, we may see other alignment vehicles (i.e. professional services agreements, co-management agreements, joint ventures, etc.) implemented more frequently than employment/acquisition.

Anticipated Changes / Future Strategy

Don't expect this to be the last adjustment to outpatient reimbursement from CMS – even in the short run. Some of the changes will certainly depend on how the data comes back since in

the implementation of site-neutrality rules. Many new proposals from CMS and others have started to come through as next steps:

(1) Adjustments to 340b reimbursement

Dominating the news recently has been the CMS proposed rule to slash 340b reimbursement by close to 30%. The rule states that, "OPPS will adjust payment for drugs purchased through the 340B program to the average sales price (ASP) minus 22.5%, a change from the current rate of ASP plus 6% constituting a 28.5% change of reduced reimbursement for some clinics and health systems"[6]. If this new rule is implemented, it will significantly impact the profitability of services that rely on drug margins for financial viability (e.g., cancer chemotherapy, HIV management). It is important to note that there are still some hospitals/providers that are exempt to this rule (i.e., rural providers).

(2) Outpatient imaging in its entirety may only be reimbursed at PFS rates

In August of 2017, Anthem came out and said it will "no longer pay for MRIs and CT scans performed on an outpatient basis for hospitals across the country"[7]. The rationale is that, hospitals can easily order outpatient scans in a non-hospital setting, therefore they don't need to pay the higher rate for the same service. We can expect to see more payers following suit with similar rules looking to reduce costs for commodity outpatient services.

(3) CMS will start to implement similar payment methodologies to grandfathered facilities over time

The current site-neutrality rule only affects new outpatient facilities built after Nov 2nd, 2015. Look for CMS and commercial insurers to push to implement the rule to older facilities as well as they intend to reduce costs further. There will be significant pushback from health systems as they anticipate the significant hit to the bottom line, so this may be a little way off, but eventually pressures will mount, and the rules will change.

(4) Health systems to push for more "at-risk" contracts with payors

If hospital based rates are going to be cut in ambulatory care settings, it makes sense for hospitals to start to push for more global, at-risk payments that baseline the payment at the current rates. If hospitals can lock down a top line global payment, then they will still be incentivized to maximize their existing ambulatory platform as the per-unit cost of delivering care in those settings is lower than utilizing hospital resources. Health systems that can shift to value-based payments quickly won't be as impacted by the current or future rule changes.

---

[6] Policy and Medicine: "Changes to 340B Program Reduces Hospital Reimbursement for Pharmaceutical Products by 28.5%"- http://www.policymed.com/2017/11/changes-to-340b-program-receive-mixed-reviews.html

[7] Modern Healthcare: "Anthem's new outpatient imaging policy likely to hit hospitals' bottom line" - http://www.modernhealthcare.com/article/20170826/NEWS/170829906?utm_source=modernhealthcare&utm_medium=email&utm_content=20170826-NEWS-170829906&utm_campaign=am

(5) There may still be some value in setting up new OP sites as HOPD

Some hospital systems are still considering setting up new outpatient sites as HOPD even though Medicare won't recognize the designation from a reimbursement perspective. The strategy implies that the system can still negotiate the higher rates through their commercial contracts. This has not been a widespread strategy and is not anticipated to be one. However, some systems may have enough leverage over certain commercial payors in their market where this will be a viable path.

(6) More price transparency

Even prior to the rule, hospital systems considered whether they would designate new outpatient centers as HOPD based on the competitive nature of their specific market. Some systems had determined that in their market they could get a competitive advantage by establishing lower prices for commodity services and create price transparency to drive foot traffic to their centers, and therefore, into the system. Now with the new rule, more health systems may be willing to post the lower prices to attract patient volume.

Strategic Path Forward

All of this begs the question – what should hospitals and health systems do to best position themselves for success long term? The answer to this question is certainly broader than just a response to the changing of the site neutrality rule and will continue to be dependent on the specific market and positioning of each system. However, we know there will be increased tightening of reimbursement as the government tries to control upward healthcare spending – meaning systems will need to be able to manage their costs. This ultimately means delivering care in the appropriate site for as little use of resource as possible. The quicker health systems can transition towards this path and push the reimbursement/incentives to follow the better off they will be to mange the changes in future healthcare regulations.