Healthcare Regulatory Roundup #90 Webinar Transcript

Tightening Your Belt: Prepare for Site-Neutral Payment Reforms

Presented March 5, 2025

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SPEAKERS

Martie Ross, Kathy Reep, PYA Moderator

SUMMARY KEYWORDS

Site-neutral payments, healthcare reform, budget reconciliation, Medicare reimbursement, outpatient services, physician fee schedule, cost-based reimbursement, swing beds, critical access hospitals, commercial payers, telehealth flexibilities, budget neutral, Medicaid cuts, rural health clinics, cost shifting, Outpatient Prospective Payment System, OPPS, quality of care, access to care, Medicare Payment Advisory Commission, MEDPAC

WEBINAR SUMMARY

The webinar discussed the implications of site-neutral payment reforms in healthcare, emphasizing the shift from cost-based reimbursement to uniform rates across care settings. Key points included the potential impact on reimbursement rates for services like drug administration and imaging, the elimination of grandfathered status for off-campus outpatient departments, and the potential reduction in swing bed reimbursement for critical access hospitals. The discussion highlighted the need for hospitals to analyze their financial impact and consider strategic responses, such as expense reduction and service relocation, to mitigate losses. The webinar also stressed the importance of advocating for individual hospital needs to policymakers.

The webinar focused on 9 key topics:

1. Introduction and explanation of site-neutral payments
2. Impact of budget reconciliation process
3. Focus on site-neutral payments
4. Detailed analysis of payment methodologies
5. Site-neutral provisions and recommendations
6. Impact on rural health and critical access hospitals
7. Commercial and employer-sponsored plans
8. Recommendations for hospitals
9. Proactive and prepared for changes, next steps

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ACTION ITEMS

- ☐ Calculate potential losses from different site-neutral payment proposals at the department and organization level.
- ☐ Identify options to respond to lost revenue, such as expense reductions, service relocations, and contract negotiations.
- ☐ Evaluate the impact on physician contracts and employment arrangements.
- ☐ Consider affiliation or management arrangement options if the impact on margin is significant.

TRANSCRIPT

PYA Moderator 00:10

Thank you for joining us. The webinar will begin shortly.

Good morning, everyone. Welcome to the latest episode of PYA is Healthcare Regulatory Roundup webinar series. Today's topic is *Tightening Your Belt: Prepare for Site-Neutral Payment Reforms*. PYA is happy to present today's webinar on this important topic.

You may submit questions during the webinar by typing a message into the Q&A pane of the control panel. Also immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional comments or questions. Any questions posed during the webinar will be responded to via email after the webinar. We've posted a PDF copy of the presentation slides for your reference in the resources pane. Also, you'll receive an email later today with a copy of the slides and a recording of the webinar. You can customize your viewing experience by resizing, moving or minimizing all of the pains within the webinar.net. platform.

With that, I'd like to introduce our presenters, Martie Ross and Kathy Reep.

Martie Ross 01:36

Thank you, Jennifer. So, here we are in early March. Here in Kansas City, March is definitely coming in as a lion. I assume Kathy down there in Orlando, it's just lambs as always, correct? Absolutely. But where it is certainly a lion.

In Washington, DC, where there is a lot going on right now. And while nothing is officially labeled healthcare reform, there is many of the proposals, many of the executive orders are directly impacting healthcare and truly at a day-to-day operational level. So, one can sit back and wait and watch to see what happens, or you can be proactive and try and understand how these changes can impact your organization, how you can prepare your organization as best possible. And so that's our goal here with the next several webinars, is to really drill down on what's going on in Washington. And we're going to start with site-neutral reform, because if Kathy and I were betting ladies, we would say the odds are really high that this one will go forward. And we'll talk about why we have really believed there's a focus on site-neutral payments, and really try to address the impact different proposals will have on organizations. And wrap up with some recommendations to help you, again, take a proactive stance in the middle of all of this.

So, let's start with what are site-neutral payments, and Kathy, tell us all about it.

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Kathy Reep 03:15

Sure. I think it's kind of self-explanatory. Site-neutral payments is paying for the same type of service or the same level of service across all sites of care at the same amount. So, essentially, what we're looking at is paying a service that could be provided in the physician's office at the physician rate, no matter where it's provided. So, if it's provided in a hospital outpatient clinic, pay it as a physician office rate, as opposed to under the Outpatient Prospective Payment System.

The problem with doing this is, if you take Outpatient Prospective Payment System as an example, it was established using cost, and it was intended to mirror our cost trends forward. But if we start saying, now we're going to pay a hospital like a physician, we're taking ourselves further and further away from that cost-based basis that we were intended to have. So, it is going to be an issue. And we see Congress looking at this and identifying the dollars associated with changing payment methodologies, some of the examples of site-neutral payments you've got the hospital inpatient only list, those services that can only be provided in a hospital. Well, we experienced several years ago the elimination of that inpatient-only list, and services started to be provided in an ambulatory surgical center. What about those services that can be provided in a hospital or an ASC or in a physician's office? How do you pay those there was discussion of a unified payment amount for all post-acute care, pay skilled nursing and home care, and patient rehab same amount. Does that really work?

We're going to talk a little bit about skilled nursing facility rates versus what a critical access hospital gets reimbursed from a swing bed perspective. And then also, we have this issue of geographic adjustments. It could be the wage index. It could be paying differently for different types of services, different types of facilities, based upon where they're located. But as an example, we've got a lot of urban areas that are currently classified under the Medicare program as rural. Is this something that Congress is going to strike down and say we can't have in the future. Martie?

Martie Ross 05:46

So, obviously, for that explanation, one can tell that there are a number of policy challenges associated with site-neutral payment reform. One part is, how does one determine whether it's safe to provide a service in a certain location, and you can ensure appropriate quality of care in certain circumstances. We could say, take everything that's done in an HOPD and pay it at the same rate as a physician clinic. But there are certain services, certain patients, where you need that backup of the quality of the care and support that can be provided in the hospital. So, how do you draw that line? And we'll talk about how different policymakers have proposed to do that.

There's also the question of, how do you preserve access to care? Certainly, as you cut reimbursement, providers will do their best to enhance efficiency, cut their costs, and continue to provide the service. But where is the point of no return, where providers no longer can furnish services at a loss because they cannot shift costs elsewhere, or they simply don't have the opportunity for available resources elsewhere? And finally, and I think this is a question we're going to revisit several times over the next several months, is, how do you dismantle an existing payment methodology without knocking the whole system down? We started in 1983 with the Inpatient Prospective Payment System, and we built up prospective payment across multiple provider types all the way till 2014, when we implemented fairly Qualified Health Center PPS reimbursement. How do we now just pull out one component of that cost-based reimbursement system without effectively dismantling everything that has been built upon that?

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Kathy Reep 07:46

And Martie, we're going to talk about this, I know, but when we get to the issue of Medicare making these adjustments, then we've got to start thinking about what happens when you say shifting costs. Then does it go to commercial payers? No, because we've contracted with them, and what are they really going to pay? We've got to look at the debt. You know, we can't just focus on the impact on our Medicare population. We've got to talk about all of our population of patients that we treat.

Martie Ross 08:18

Exactly. So, why this issue now? And I think you have to take snapshot of where things are in Congress right now, and that is the budget reconciliation process.

What we have as of today is a house budget resolution that passed by one vote last week. The budget resolution creates the parameters around which Congress will then build the federal budget for the upcoming federal fiscal year 2026. And typically, the budget resolution is going to establish revenue targets and spending targets, and typically over an extended period, usually 10 years, not in fact, what this budget resolution does, how much we're going to project collecting, how much we intend to spend. That budget resolution then becomes the basis for developing a federal budget and through the reconciliation process. Why this is such a big deal is that a budget reconciliation package does not require or exact, excuse me, it is not subject to the filibuster in the Senate, so you can pass the budget with a civil majority in the Senate, whereas everything else except, you know, appointments, federal appointments to cabinet positions and judges, they all require that 60 vote to close debate and thus move forward on legislation. So, that's not applied here. So, this is your one chance, one bite at the apple to get it right.

The balance budget resolution is built around securing $4.5 trillion in tax cuts over the next 10 years. It then includes instructions to several House committees to identify reductions in spending to total 1.5 trillion over the next 10 years, and that is focused on what's referred to as mandatory spending. We'll come back and discuss that in a second. Specifically, you have a direction to the Energy and Commerce Committee to cut $880 billion. Medicaid is within the jurisdiction of ENC. That is where you're seeing these headlines talking about House approves cuts to Medicaid program. The Agriculture Committee has been directed to find two $30 billion. Agriculture, of course, has the SNAP program, food stamp program. So again, you're seeing those same headlines talking about those cuts. There are a number of other directives to other committees to reduce a billion here, a billion here, and eventually it's real money, right?

We are on a short leash here. The committees are required to submit their proposed legislation to the House Budget Committee for drafting of the final bill. Their work is to be completed by March 27, right at three weeks from today. I just checked the E and C website. They have no hearings or any markup scheduled with respect to the budget resolution yet, but we are certainly watching that carefully. But here's the kicker, and the real problem for those of us in the healthcare space, there is, in addition to the 1.5 trillion that's allocated out to the individual committees, there is also a mandate to find another half-trillion in spending reductions, which can be picked up by any committee to propose what those may be. So, what we have is 1.5 trillion with specific committee directives, half a trillion with no specific directives, but with a kicker, there's an enforcement provision that if they are not successful in identifying that additional half a trillion dollars in spending, they're going to reduce the tax cuts accordingly. So, if they can only find 1.7 billion in tax cuts, you're going to reduce that in spending cuts, that ends up reducing that 4.5 down to four to 4.2. But if they do a really great job of finding fraud, waste, and abuse and other things to

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cut in the federal deficit, they can actually increase that tax cut. So, if you find 2.3 billion to cut, that will increase the tax cut up to 4.8 trillion. So, clearly, a system that is incentivized to find opportunities for reduction across the system. We have….

Kathy Reep 12:46

Before you go on, one of the things that I'm seeing in the chat individuals saying, how will this impact and how will this impact rural health clinics? How will this impact home health? The issue is, it's, what else are the committees going to do? And it's hard to say on today, on March 5, what's going to happen by March 27 in terms of all of the various verbiage and what they're going to come up with. We're going to talk about some options that are out there, but recognize nothing is in writing that really gives us any clear, truly clear, direction in terms of what programs, all of them, they will target. Obviously, Martie mentioned the Energy and Commerce and the impact on Medicaid. Well, if you're a home health agency and you take Medicaid patients, you've got to keep an eye out on that. So, it's hard to define by a particular type of provider what impact you're going to have, but recognize you've got to pay attention.

Martie Ross 13:51

If the House bill, the House budget resolution, which is sometimes referred to as one big, beautiful bill, because it is doing two things at once. It's cutting, it's renewing the 2017, tax cuts and extending additional tax cuts in certain areas. It is also providing for additional spending for defense and border security, and that it has the pay for, obviously the cuts built into it. The Senate Resolution is what we refer to as the two step, because the Senate had preferred to go first with the increases in funding for defense and border security and then come back later in the year to the tax cut issue. So, the Senate Bill, excuse me, the Senate Resolution, calls for an increase in spending for border security and national defense at about $350 billion. There is no specific pay for identified in the Senate budget resolution. Instead, the committees that are charged with drafting the legislation will determine the funding source, i.e., the spending cuts, so they be defined.

You know, three 50 billion on the Senate side. What's going to happen at this point is sort of, still kind of unclear, although there have been indications from some senators that the Senate budget resolution was really only intended to be a backstop in the event that the House bill, keep calling it a bill, it's a resolution. The House Resolution didn't go forward because it was up to the very last second whether there will be the votes in the House to pass that resolution. So, we'll watch very carefully in the next couple of weeks to go forward. But right now, we are operating on the assumption that the House bill is taking the lead, and so we are looking at that $2 trillion in spending cuts that they're trying to identify.

Kathy Reep 15:37

So, why are we focused on site-neutral today? Why did we say we want to talk about site-neutral? Well, because in a report that was generated by the House Budget Committee, they clearly identified site-neutral payments as a significant issue in this publication that came out last year. It was actually called reverse the curse, and it was proposals or ideas that they could put into place that covering the next 10 years to identify reductions, and as it addresses site-neutral their section is entitled creating payment parity for the same services.

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Unnecessary costs and healthcare are not only breaking the budgets of working families, but they are bankrupting our country. It goes on to say because Medicare pays more, seniors also pay more and out of pocket cost sharing requirements as well as Part B premiums and deductibles. It identifies payment for lower complexity services such as office visits, imaging, and drug administration, which the Medicare Payment Advisory Commission, MEDPAC, and you're going to hear more about MEDPAC today, has noted are safe and effective to be delivered in a physician's office. So, we know that they have targeted in on this issue as potential for cost savings.

There was also a 50-page document that was generated, I believe, January of this year by the Republican Party that basically went through committee by committee by committee, what can we cut and how much will it be worth? And on that document, they identified numerous site-neutral provisions of which we're going to talk about today.

Martie Ross 17:22

Yeah, I mean, this may have concerned the FY 25 budget, this particular reverse the curse publication, but so much of what was in this document was pulled forward to that publication. Yeah, it's one of those believing when they tell you what they're going to do circumstances. And it's really one of the more specific proposals that it was in either of those two documents.

Kathy Reep 17:44

And if you look at this document, and you look at the document that was published in January, you're almost looking like at a Chinese menu. Pick one from column one and one from column two, add them up and see how much money you have.

Martie Ross 17:57

Well, we made reference previously to the spending cuts coming from mandatory spending, and the difference between mandatory and discretionary is that mandatory are automatic expenditures. They don't have to go through the annual appropriations process. And so, if you want, and in fact it's mandatory spending that's making up the majority of the federal budget at this point in time, you see there on the right-hand side of the screen, sort of a description from the Congressional Budget Office of what constitutes mandatory spending. This is FY 23 numbers, but as you can see it, federal healthcare programs and Social Security are really the dominant components of mandatory spending. And what we know is you can move the other but it's not going to make the bigger deal. I mean, for example, as I referenced, the Ag Committee has been charged with reducing SNAP to a tune of two 30 billion. That's really the other big chunk that has you have an opportunity to come after, if you're not looking at Social Security or federal healthcare programs. Well, but however, it's been very clear, and everyone who has addressed this issue has said Social Security benefits are off the table. We're not going to cut any of those social security benefits, whether they be old age, disability, any of those programs, that's not part of the program. However, they also say that we're not going to cut Medicare benefits to seniors. That's off the table as well, so coverage may remain the same. The issue is, what happens to the payments to providers and therein, is the opportunity for mischief in terms of budget cutting. And as we've referenced at the top of that list is budget neutral site-neutral budget reforms, I can say that correctly, which weighs in and the numbers vary, but it's generally around $150 billion over 10 years for these reforms. So, Kathy, what are other options? As you referenced your Chinese menu. Yeah.

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Kathy Reep 19:58

340 B drug payments. I mean, currently you're reimbursed for your 340 B drugs that average sales price plus six. Will it be average sales price? Will it be average sales price minus these? Because that's why you see this variation in terms of the 15 billion versus the 73-and-a-half billion dollars, that essentially becomes a, it depends on which one they pick. Do we do average sales price, or do we go down average sale price minus payment for Medicare bad debts? This has been an issue that's been on the table for years. We used to get reimbursed 100% of our Medicare bad debts, currently reimbursed 65% will we see a further reduction? Will they eliminate completely reimbursement for bad debts, drop it down to 45, 25, eliminate it completely? Those are the options that are on the table.

Revise the payment methodology for graduate medical education payments. Will they consolidate the payments into a different program, where they are literally not paying you as an add-on to your Inpatient Prospective Payment System, but a different methodology. Will they just reduce the pool of money that is available, wage index, integrity. This is kind of something that I hinted on earlier those urban areas that have reclassified to urban. Are they going to allow providers to continue to reclassify to an area where they really aren't, that we've had geographic reclassification since almost the beginning of the Inpatient Prospective payment system? But will they let us continue physician payments? You can see the reform for physician payments, 10 billion. Issue is, we want to see reform of the physician payment methodology that is a plus, not a minus, to increase overall reimbursement for physicians.

Martie Ross 21:58

And before we start delving into specific opportunities for site-neutral payment reform. Keep in mind, this is FY 26 these would cuts that would take effect at FY 26. We still have the small issue of not enough money to finish out FY 25. And, as you recall, right around Christmas time we got a continuing resolution that would get us through the federal government continue operating through March 14, which is now a whopping nine days away. So, in addition to working on this proposal of how they're going to address spending in 26, there is also this consideration of what are we going to do with 25. So, there will need to be some sort of continuing resolution here in the next nine days that will continue, most likely, continue funding at current levels. It's a question of how far they'll how far down the road they will kick the can.

And of course, we have special attention on this issue, because wrapped up in this is the continuation of the telehealth flexibilities, because at this point in time, those sunset on March 31. So, it would be that vehicle of the continuing resolution through which Congress would either renew for some period of time or even make permanent those telehealth flexibilities. So, there's two reasons we got, like a split screen that we have to watch in Congress right now. About the only thing we've heard last Sunday on the morning shows, Representative Johnson, the speaker, said that they were working on a clean bill, and he didn't see any issues arising. But we haven't seen any bill so, but that's where we are those as well.

So, just a little pre- you know, look back at 25. But let's now talk about 26 and specifically proposals around site-neutral payments. So, why do we have different payments at different locations? You start with just how the hospital Outpatient Prospective Payment System works. Okay, it is a prospective payment system, meaning that it is not directly tied to the provider's cost in delivering the service. It is a method we're very familiar with. There's a conversion factor that is multiplied by the weight assigned to a given service, and then there are in a series of adjustments. Those weight assignments are the ambulatory payment classifications or APCs.

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So, different HCPCS codes crosswalk over to assigned APCs, which have a value and then a weight assigned to them, and then again, you multiply the conversion factor by the weight.

So, let's talk more deeply on the subject of a conversion factor. This is the base rate that's intended to represent the national average cost for an average Medicare case described as a one. So, if you think of the average case is one, right? Then the weights of the APCs vary. One, so it may be 1.6 it may be 0.,7 so the base rate, again, is that intended to be reflective of the national average cost. So, when we implemented OPPS in 2000, CMS then went through the exercise of determining what the base rate would be looking at 1999 Medicare Part B payment amounts, plus the patient coinsurance. So, that became where we started. We started 99 where we were on cost-based reimbursement levels, and then we are moving them forward based on annual adjustments. The annual update for that, just to refine the payment amount, the conversion factor is adjusted 60% based on hospital wage index, so that adjusts for the wages, the cost of labor within your specific market. And then we go through this market basket adjustment with certain additional adjustments made based on productivity. Just again, true up and prevent any gaming of the system, as they say, with those types of adjustments.

So, again, just want to reiterate this system, though it's prospective payment, has at its roots cost-based reimbursement and a continuing process to adjust that those routes to account for changes in the marketplace.

Kathy Reep 26:23

And the changes that we're going to talk about are taking us further and further away from those routes of based on cost, right?

Martie Ross 26:32

So, we get to this issue of same service, different Medicare reimbursement, depending on where the service is delivered. So, if you are at a free-standing physician clinic, your reimbursement is paid under the Medicare Physician Fee Schedule rate at what's referred to as the non-facility rate. So, it is a that that rate is a combination of work RVUs, so the practitioner effort, practice expense RVUs, and the malpractice expense RVUs. You add those together multiply by the conversion factor. Whammo, you've got the payment under the Medicare Physician Fee Schedule for free-standing physician clinics.

If you are an HOPD, the reimbursement there is split, shall we say, and you'll often hear the term split billing. The hospital is reimbursed for its costs associated with the delivery the service under OPPS, and that is the particular service defined by a HCPCS code is then cross-walked over to the APC. But note, there are many services that can be furnished in an HOPD, that do not cross walk to an APC, meaning there is no additional reimbursement for the hospital for that particular service. If you want to get a dive deep, the source on this is Addendum B of the annual OPPS rule. That is the crosswalk with the pages and pages of HCPCS codes that are then cross-walked over to an assigned APC, and you see the weight for the APC there. There are then also assigned status indicators, because CMS appreciates that, well, if you provide this service the same time you're providing that service, it would be duplicative to pay you certain costs. And so, we have status indicators that say if A, then not B; if C, pay half of D. And there's a whole list of those status indicators that are assigned in addition to the hospital being reimbursed.

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Then, if there is a practitioner who is furnishing a professional service in addition to the technical facility costs associated with that service, that practitioner is paid for the professional services furnished in an HOPD on the Medicare Physician Fee Schedule, but at a different rate, what we refer to as the facility rate. That rate is lower because it is an adjustment on the practice expense RVU, so you don't get the same level of reimbursement. You get the Medicare in the non-facility rate under the Medicare Physician Fee Schedule. You get that lower, downward adjusted practice expense. Then the truth is, if you in fact, have a HCPCS code delivered a service delivered in an HOPD, that reimbursement is going to be higher than the reimbursement for the same service delivered in a clinic, because the practice expense review is not as high as the APC assigned weight. The issue, of course, is if the service is not cross-walked to an APC, no dollar payment to the hospital. Or if it is subject to these status indicators, you'll see a lower payment. So, it's not always exactly a one-to-one measure.

The third payment methodology is ASC reimbursement. Ambulatory Surgery Center reimbursement, limited to those procedures that are on the approved Ambulatory Surgery Center list. You have to be for Medicare purposes, got to be on the list or you don't get paid, it's very simple. So, they're paid at a percentage of the HOPD rate, which is approximately 60% of the OPPS rate. And again, the practitioner is paid separately for any professional services provided in the AFC, again, at the Medicare Physician Fee Schedule, facility rate.

So, it kind of is pretty easy to say, well, why should you get paid more if you're delivering the service in the HOPD, and this is what critics are critical of this payment methodology. You very often hear that this system has driven hospital acquisition and physician practices, and that, in turn, has been driving up commercial rates. And that's true. Hospital ownership of physician practices has increased from about 24% up to 29% 28% since 2004 so definitely seeing that increase. However, at the same time, look at corporate ownership of physician practices. So, this is the insurance companies and private equity buying acquisition practices, that has increased from 14.6% in 2029 up to 30% in 2024 and remember, these folks don't have the incentive of HOPD reimbursement. They are also increasing their practices, their acquisition of these clinics creating the same issues.

You also hear this question, this issue, in the quote that Kathy read from the reverse the curse that this all results at higher out of pocket costs for Medicare beneficiaries. But keep in mind that 89% of traditional Medicare beneficiaries have some sort of additional coverage that generally covers either copays or deductibles. 42% have Medigap, there are union--sponsored benefits for another 31%, and 16% have Medicaid. So, when we say out-of-pocket for a Medicare beneficiary, we're talking about that 11% that doesn't have coverage, and then the potential of increases in the actual premiums that are paid for these services as well.

And then finally, you have the argument providers need incentives to improve efficiency by caring for patients at the lowest cost site appropriate for the condition. But remember, if you're providing a service at an HOPD, you are still responsible for complying with all applicable regulatory requirements, including the obligation to provide emergency care services and to maintain standby capacity. So, yes, the cost structure is higher in an HOPD, and the question then becomes, if you don't pay for those costs through these payments, you adopt site-neutrality, where do these costs go in the system? That becomes the issue of cost-shifting.

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Kathy Reep 32:45

And Martie, are the critics saying anything about quality?

Martie Ross 32:49

No, Kathy, they are not. And they are not providers. And when we get to the question of how do you determine whether a service is safe to provide in a physician clinic, the metric – has it been provided in a physician clinic, as opposed to any site of actual measure of the service itself?

Kathy Reep 34:42

So, Martie, shall I cover what they're talking about? Please throw some numbers out there. So, some of the provisions that have been addressed and that have actually been detailed out in the various reports in terms of opportunities to move forward with site-neutral payment. The first one we're going to touch base on is drug administration and imaging services. So, for those services, drug administration imaging that are provided in an off-campus HOPD, the proposal would be to reduce their reimbursement to the physician fee schedule, which is about 40% of the current rate that you're getting now, some of the options they're throwing in there. Let's apply this to those grandfathered HOPDs as well, not just, you know, there's already, not just those that are off-campus, but even those that are off-campus but grandfathered. What about applying this to on-campus facilities as well? Should we take drug administration that is provided in the hospital, say, outpatient chemotherapy within the hospital setting, but pay that as the physician office practice would receive? And what about outpatient imaging services wherever they are provided. Should the reimbursement level for those? This is why we start looking at this as if, you know, as they start working with this, they might implement it. Let's just do this and make a change for imaging services that are in grandfathered facilities. Now let's move it on-campus. How far will they take all these actions as we move forward?

Next option that they are looking at is the total elimination of grandfathered status, not just for imaging and drug administration, but let's take that grandfathered HOPD and reimburse it as a free-standing physician clinic, as we are doing with those that are not grandfathered. The impact is significant on this one. But what happens? How are you going to respond to this? Are you taking those services that you currently provide in that grandfathered HOPD and moving them back into your hospital? Are you going to move drug administration back into the hospital? Got to think about it from the perspective of, this is a way to perhaps keep my reimbursement, but it depends on whether they start moving this to reduce on-campus drug administration as well.

But what happens to the reason that you moved some of these services off-campus? It was for patient convenience, patient access, less exposure truly sick patients, when you could provide these services more within the community where the patient lives. So, recognize the impact, not only on your reimbursement, but the impact on the community and on the patients you serve as well.

There was a report in June of 2023, from the Medicare Advisory Commission. MEDPAC, essentially advises Congress on changes to the Medicare program. They address on an annual basis what kind of rate increases should be approved for various provider types. They also do special reports. One report that they did in 2023 was looking at site-neutral and how can we modify reimbursement? Look at the dollar amount on this one, we're looking at $180 billion over 10 years. The methodology that MEDPAC proposed was

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that if the highest volume for a particular service is in a free-standing physician clinic, then we're going to take the payment rates for outpatient hospitals, outpatient services, and ambulatory surgical centers and pay them the Physician Fee Schedule rate. That was about 57 existing APCs. This was in 2023. If the volume is higher in an ASC, then we're going to pay the hospital outpatient department the ASC rate, which is a 40% reduction in their rates, but they would not change the current reimbursement rate for that same service being provided in the physician office, they were only looking at about nine APCs that would be impacted. However, if the highest volume is in the HOPD. There would be no change in the rate for the reimbursement rate. So, altogether, we're looking at about 169 APCs that they examined. There would be more APCs today than I think we looked at back in 2020, all of your emergency care, all of your trauma cases, things like that, no way would those be addressed. These are merely more routine services that are provided in multiple settings. There were about 66 APCs that were addressed from the emergency trauma perspective. MEDPAC assumed that this would be done in a budget-neutral manner.

Our concern, and budget-neutral means that they're going to take away on this, but they're going to increase your reimbursement elsewhere. Our concern now is that this will not be implemented in a budget-neutral manner. It will be as a savings methodology. Martie, you had something on that as well.

Martie Ross 41:04

And that's the key, right? Because if CMS makes the change, you know, then, and they're doing it without direct, you know, legislative change, they're just reimburse. They're changing the reimbursement. It always has to be done in a budget-neutral manner. So, if you cut the reimbursement rates for these 66 APCs, then you're going to increase the amount on the other APCs. But that's when CMS is making the change. When Congress makes the change, they're not telling you to slice the pie differently, they're taking the whole piece out of the pie, and so you're reducing the monies available.

So, the example would be with 5012 right? When 5012 came off that you could no longer build that off-campus. What they did was they took that revenue and spread it out. But these types of proposals are coming from Congress. It's out of the system.

Kathy Reep 41:50

And before someone puts "What do you mean we can't build that off-campus?", you can build it off-campus. Your reimbursement is going to be lower, right, right? Okay, just clarify, because I can't start typing right now.

Let's go that was the MEDPAC proposal, and again, this was their initial study. This would be expanded, and I think more services would be identified. This is an example out of that MEDPAC report that essentially gives you the example. This was for an epidural injection into the lumbar region and the reimbursement, total payment in a physician's office, $255 a total payment. In a hospital outpatient department, $740. What they're proposing to do is to pay everyone the $255, so you need to take a look at the list of services that are on that list. Because I think what you're going to want to do is to look at your volume on these various services, see where it is performed, and look at your outpatient volume significant, and focus on that inpatient-only list. Remember a few years ago, during the prior Trump administration, the inpatient-only list was eliminated. There were 298 services that were removed, and essentially, they could be done in an outpatient setting. And once it can be done in the hospital outpatient setting, then it is evaluated for the ASC covered procedures list that withdrawal of those 298, services

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only lasted for a year. They went back on we still have the inpatient-only list, but this is another area that was listed as a potential target for reduction to the tune of ten billion over 10 years.

Those services that are currently said are extremely high, complex, high-risk and should only be performed in a hospital outpatient setting. Would we start seeing things or more things drop, or the entire list leave altogether in terms of the inpatient only list, and if you again do the change, there we go. If you do the change for the inpatient-only list, you're going to be looking at expansion of the covered procedures list for ambulatory surgical centers. Again, what we saw previously when they removed 298 services from the inpatient-only list. 267 of those were added to the ASC list. Immediately, they have now been taken off of the ASC COVID procedures list, but these were services that, essentially, CMS decided they could be performed in an ambulatory surgical center. And to me, to go from inpatient-only to ASC within the same year is very dramatic. And so, this is another area of concern.

There was a proposal for unified payment rate for post-acute care that would essentially make skilled nursing, inpatient rehab, home health, and even long-term acute care, they evaluated all of those to make a single, unified payment system. Basically, do a single payment methodology rather than the multiple PPS systems, prospective payment systems, rather than multiple systems, there would be a single one, but then with some adjusters based upon the actual facility or location of the services being rendered right now. Not a lot of focus on this one because of modifications to both home health and skilled nursing prospective payment systems and the 30-day payment methodology. They feel that they have addressed what they need to for now.

Last but not least is we're very concerned about swing beds in critical access hospitals. There was a report from the Office of Inspector General that essentially said that the Congress could save billions of dollars in the Medicare program if the swing bed services and critical access hospitals were reimbursed as skilled nursing facility beds. CMS essentially has said the OIG said that they recommend that CMS seek a legislative change to allow it to reimburse critical access hospitals at the lower rate. And CMS argued that that reduction would likely impact the ability of cause to continue to be viable. However, in the team transforming episode Accountability Model Final Rule, they said perhaps hospitals that transfer patients to a critical access hospital swing bed should transfer to a SNF bed instead, because it would save them money. So, where they are saying at one point an argument to the OIG that this would impact the viability of rural hospitals, they are saying in another rule maybe it'd be a good idea. You'd save some money, providers so concerned about where they might take us there, Martie.

Martie Ross 47:37

Yeah, those of you that have been around rural health, you're saying to yourself, I did I see that report a few years back? And yes, it's a resecuritization, in some ways, of a prior OIG report where they went after swing bed reimbursement. They, however, failed to make – and a little bit on my soapbox here real quickly, Kathy – but in their analysis, they say the comparison is between the daily rate of an SNF versus daily swing bed. What they don't take into account is the impact on the total cost of care for the episode, because the data clearly shows that cost swing bed admissions are significantly shorter than SNF admissions. Five days versus 30 days. Roughly, there are fewer swing bed patients that are admitted again for inpatient care. So, lower readmission rates for patients taken care of in a swing bed. More cost swing bed, patients end up being discharged to home, as opposed to another level of service, which frequently occurs in SNFs. SNF patients have separate HOPD charges, so if you need a CT scan for a patient in the

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SNF, you load them up the ambulance to transport him to the hospital swing bed, you roll him down to the CT scan, and there's no separate charge. And finally, they're not taking into account the impact that would have on charge.

Kathy Reep 48:49

But no separate reimbursement.

Martie Ross 48:53

No, well, right, exactly. No separate reimbursement for the call. It'd be part of the cost-based reimbursement. But part of this is if you no longer had cost-based reimbursement for swing beds, that means your rates for inpatient services would go up because you'd no longer have the operating costs to spread the rest of the bed. So, again, just an example of how if you don't really understand how the payment system works, and you try and pull something out to save money, you have a tendency to destroy the entire system, or at least do serious damage to components of the system.

Martie Ross 50:24

If you're talking about site of service differentials, then we also get to provider designations, so everything from a low-volume hospital program, which is the enhanced program set to expire at the end of the month.

Anyway, right now, Medicare-dependent hospitals, so community hospitals, rural emergency hospitals, all of these are, even though so far as critical access hospitals, it's all a recognition of higher costs in these settings and adjusting reimbursement appropriately. So, are we, by cracking or breaking that link between payment and costs, opening up even more mischief down the road? The other question is, well, we've just talked about Medicare at this point in time. What about the impact on commercial and employer sponsored plans? And interestingly, we found a study that was done back in 2024, or at least published in 2024, where they looked at the estimate of the impact if commercial and employer-sponsored plans adopted the MEDPAC recommendations. You see there on the screen, what they expected the impact of that to be reduction in premiums as well as increased federal tax revenue, because dollars would no longer be tax exempt because they were going to healthcare costs. So, there's a pretty big carrot for commercial payers to reevaluate the systems they have. A lot of contracts are tied to the Medicare reimbursement model. So, the Medicare reimbursement model changes, you'll see those negative impacts on the commercial side as well. You are seeing some state and even federal legislation that is proposing that would prevent hospitals from charging any add-on fees or facility fees.

So, yeah, cost controls, that would be what we have there, or a rate control, and then we have just the changes in your negotiating position. Should Medicare go through site-neutral reform, suspect that the payers would then be in a position to negotiate, well, why are you charging us differently? So, that idea of cost shifting from commercial, you know, cost shifting over to commercial by increasing rates, you already have the big payer saying we're not going to absorb losses in Medicaid, and presumably they're not going to absorb losses in site-neutral and, in fact, likely to cut their site of service differential payments as well.

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Kathy Reep 52:47

And what we're going to be facing is that, as we have hospitals that are trying to advocate against site-neutral payments, we're going to be having employers, non-healthcare employers, but others within the area who are going to be saying, but it's going to save me money. My premiums are going to go down for my employees, my cost sharing is going to go down for my employees. So, we've got to be very clear that there is a strong lobby that will have a different position than what hospitals and healthcare providers will have.

Martie Ross 53:16

A lovely transition over to now. What to do in all of this if we think the Congress is going to be prepared to act? And our best advice, know your numbers and identify your options. Now is the time on at an individual facility level to be calculating your potential losses from different site-neutral proposals, both at the department level and understanding the overall impact on your operating margin. Specifically at this point in time, we would be recommending that you're running the options of drug administration, imaging, the discontinuation of grandfathering, the MEDPAC proposal; and for those of you critical access hospitals with swing beds, the impact it would have if you lost that swing bed reimbursement.

Kathy Reep 54:03

And I would stage that analysis by off-campus grandfathered, and then off-off-campus grandfathered, and then what if they do it on-campus? So, recognize that you are going to stage that analysis as well both drug and include traditional Medicare, obviously.

Martie Ross 54:21

But also explore the impact on your commercial contracts that have current site of service differentials. So, if you have an MA plan that is paying you a basis of HOPD rates, you need to consider what the impact would be if that follows on to a change that they're made in Medicare payment methodology.

The other half, once you know your numbers, it's time to identify your options. How are you going to respond to lost revenue by department? Assess your ability to cover losses with revenue from their department, as Kathy likes to say, how exactly you're going to rob Peter to pay Paul this time. But see if you have that opportunity to support the continuation of services in a particular department, either from intradepartmental revenue or interdepartmental revenue. Explore, of course, expense reduction strategies that do not impact access to care, such as non-clinical reductions in force, changes in salary and benefit for current staff, or setting scaling back planned capital investments. And it's scary, as we're seeing more and more headlines of hospitals going through reductions in force of administrative staff, they already feeling these pressures on margin. This could increase that.

Next is evaluating service reduction and relocation options, as Kathy discussed, you take all your views and therapy and move it back on-campus and understanding what's the impact in terms of quality of care and access. When you accomplish that, can you increase volume sufficiently on the on-campus, in an on-campus facility? Is that wrong to generate access issues for your patients? Investigate opportunities for commercial payer volume rate or volume increases, and also value best contracting options? Again, think there's going to be minimal opportunity for cost-shifting for some of this with commercial payers. But as the appeal of participation in value-based contracting grows, as you see more and more this decline in fee

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for service reimbursement, consider the impact on physician contract removals. Because in many cases, the math made sense for acquiring a physician practice when you considered the facility fees you would be able to build, and if those are no longer available, the math may no longer make sense now. Certainly, the physician's compensation package was evaluated for fair market value did not include in that compensation dollars that were attributable to any referrals made by that position, such as facility fees. But if the revenue from a department has declined so significantly, what are your circumstances for continuing the employment of that position? How can you potentially negotiate on price, the renewals, and certainly, how competitive is your market, so that others may you know quickly offer opportunities that you can no longer provide to that provider?

And finally, consider your affiliation options. If the impact on margin is so great that you need to be reaching out and considering becoming part of the system or looking for a management arrangement. That certainly may be an option on the table. Our other good advice should know your numbers is tell your story to your elected officials and your community. I cannot emphasize enough, there is no such thing as an average hospital. If you look at the Coppin Hall flash report, they're telling you that hospitals enjoy a 5.8% margin right now. But if you dig a little deeper as to KFF in their recent publication, while the aggregate may be 5.8% there is a significant number of hospitals below that, and I think right now the numbers three in five. Three in five hospitals are actually operating at a negative margin. So, it's a matter of diving more deeply. You need to be aware that we are being characterized as the healthcare industrial complex, the terminology used in the fact sheet that accompanied the executive order on price transparency, referencing to large corporate entities like hospitals and insurance companies. I do not know when a community hospital became the equivalent of United Healthcare, but they have successfully characterized hospitals as doing just fine and able to take the hits. And so, it's a matter of our being able to tell the story.

We've done here at PYA, some analysis using 2023 cost report data for all PPS hospitals, and you can see here the variations in total margin, both median and average measured two different ways. You see in the ownership type of hospital, significant differences in margin as well. But let's take this a step further. Let's actually look at it by quartiles and what operating margin does at the core tile level. And again, you see this differences in ownership type from a for-profit, not-for-profit government hospitals, like county-owned hospitals, for example, you see significant variation in the quartiles that are not-for-profit. Hospitals more evenly distributed, but our county hospitals are certainly in the end game of that.

So, figure out where you are and be able to tell your story in comparison to this type of data. Because it's going to be, we can't talk about the impact on hospitals, we have to talk about the impact on your hospital and the impact that has on your community. See similar type of analysis on total margin as we did on operating margin. Luckily, y'all get the slides so you can take a deeper look at this, and then do that type of analysis.

Kathy Reep 1:00:22

Let me throw in one thing real quick. We keep saying, tell your story about your hospital. Please make sure that you do that. I know that there are some people on this call who have are not on the finance side, they're more on the advocacy side within their organization. You have got to make sure that you tell your story. Don't just rely on someone else to tell it for you, because, again, you are not average. You've got to address your story.

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Martie Ross **1:00:54**

Well, site-neutral is so much fun, but Capital, yeah. We'll be back on March 27 that's a Thursday. We're usually on Wednesdays, but March 27 we have a conflict. On the 26th we can't, we can't move. So, on March 27 we are, we are going to do a Washington update, assuming we have something to talk about. We will certainly talk about executive orders. We'll talk about what happened with the continuing resolution, whether, in fact, the government is open at on March 27 whether or not it isn't.

Also, in addition to joining us for that webinar, you'll have a chance to register when you get your email later today that has a copy of the slides and a link to the to our I want anyone would want to listen to this again, but you have a link to the recording. Please. Please comment on topics you'd like to have future HCRRs, because we certainly want to make this responsive to your needs. We try to do our best to sort of see what's going on in the industry, but we're just the two of us, well and all of our fine colleagues throughout PYA, we'd love to hear back from you on topics that you can share. And with that, Jennifer, back to you.

PYA Marketing **1:01:58**

Back to me. Thanks to our presenters, Martie and Kathy, later today, you'll receive an email with their confirmation contact information and recording of the webinar. Also, the slides and recordings for every episode of PYA is healthcare regulatory roundup series are available on the Insights page of PYA’s website, pyapc.com. While at our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA. Please remember to stay on the line once the webinar disconnects, to complete a short survey and post any questions you may have.

On behalf of PYA. Thank you for joining us. Have a great rest of your day.

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