Answers to Your Questions

Tightening Your Belt: Prepare for Site-Neutral Payment Reforms

On March 6, PYA hosted a webinar, "Tightening Your Belt: Prepare for Site-Neutral Payment Reforms."

PYA is pleased to provide answers to the salient questions asked during the webinar to further help hospital leaders and others prepare if site-neutral reforms result in significant cuts to reimbursement.

Webinar Q&A: Tightening Your Belt: Prepare for Site-Neutral Payment Reforms

Q: Will site-neutral payment reform impact provider-based rural health clinics (RHCs)? Home health?

A: An RHC is paid for RHC visits at its then-current all-inclusive rate (AIR). The calculation of that rate differs for provider-based RHCs and freestanding RHCs. For care management services, RHCs are now paid at the Medicare Physician Fee Schedule non-facility national payment rate for that service. Critical access hospital (CAH) inpatient, outpatient, and swing bed services are reimbursed at 101% of costs (subject to sequestration). No site-neutral payment reforms are presently on the table that would impact these providers' reimbursement, other than reimbursing swing bed stays under the skilled nursing facility prospective payment system.

For home health, nothing in the current site-neutral proposals will be of impact; although, the March 6 webinar did touch on the earlier proposal for a post-acute care payment methodology that would be site neutral. Currently, the Centers for Medicare & Medicaid Services (CMS) and others believe this is not needed because of the new 30-day payment structure for skilled nursing and home care.

Q: Don't the 340B drug payments come from drug manufacturers? What is meant by "reduce 340B drug payments?"

A: Hospitals paid under the Medicare Outpatient Prospective Payment System (OPPS) are reimbursed average sales price (ASP) plus 6% for drugs acquired through the 340B program. Proposals are pending that would reduce this to straight ASP or ASP less a fixed percentage. Medicare reimburses CAHs at 101% of their costs for drugs (less sequestration), which essentially negates any significant profit margin from the discounted 340B pricing.

Q: CAHs are sometimes penalized for their charges when the co-insurance is 20% of the charge while it is a set amount for a PPS. This can result in higher co-insurance for patients when they go to a CAH. Is there any hope that this could be corrected?

A: The Medicare Payment Advisory Commission (MedPAC) is including a discussion and recommendation to Congress (likely for its June 2025 report) that addresses reducing beneficiary co-insurance in CAHs in a budget-neutral manner. The slide presentation for the commission's September 2024 meeting in which it addressed the issue is available here. The matter is also on the agenda for MedPAC's meeting later this month.

Q: How do the cuts identified through the Department of Government Efficiency (DOGE) impact the tax cuts impacting healthcare?

A: As of March 6, discussions are ongoing on Capitol Hill regarding whether Congress should approve (or at least be consulted on) DOGE-recommended budget cuts. Stay tuned to see how these cuts will be treated in the reconciliation bill (i.e., whether they will be counted toward the goal of cutting $2 trillion from mandatory spending over 10 years).

Q: Are non-grandfathered off-campus Hospital Outpatient Departments (HOPDs) and grandfathered off-campus HOPDs for APC 5012 paid at MPFS rates or 40% of the applicable APC rate?

A: The intent behind this earlier site-neutral payment reform was to pay for services at the Medicare Physician Fee Schedule (MPFS) rate; however, due to the billing constraints of the hospital 837i vs. the 837p, CMS set the payment at 40% of the APC rate as an equivalent to the MFPS rate. We apologize if we left the impression during the March 6 webinar that HOPDs are paid the actual MPFS rate or that off-campus HOPDs cannot bill APC 5012. They can and do but are paid at 40% of the applicable APC rate.

Q: For imaging services, will only the physician be paid and no payment whatsoever for any of the technical components of doing an MRI or CT?

A: Under this proposed site-neutral payment reform, the rendering radiologist would be paid at the MPFS facility rate for their professional services. The hospital still would be reimbursed under OPPS, but the payment would be reduced to 40% of the applicable APC rate (the equivalent of the MPFS rate, according to CMS).

Q: Our Medicare payments show that our non-grandfathered off-campus provider-based clinics are reimbursed at 40% of Addendum B, not MPFS non-facility payment rate. So when the proposed regulations say "site neutrality," are they saying they are going to pay at 40% of Addendum B or actually switch to MPFS non-facility payment rate? Do you think they will target on-campus provider-based locations at all?

A: We assume CMS will implement any future site-neutral payment reforms in the same manner it has implemented prior reforms. Again, we apologize if we left the impression during the webinar that hospitals would bill for HOPD services under the MPFS. Instead, HOPD services still would be reimbursed under OPPS, but the payment rate would be consistent with the MPFS rate. (The webinar slides posted on our website include an updated Slide 17 on which this matter is addressed.) To date, on-campus HOPDs have not been the subject of site-neutral payment reforms, but that may change as Congress looks for more opportunities to cut spending. Note the MedPAC proposal included both on-campus and off-campus HOPD services.

Q: Is there a table of proposed APC rates that we can model to forecast our provider-specific financial impact?

A: We recommend modeling the 66 APCs listed in the MedPAC report, (pages 10-12), using your current Medicare HOPD reimbursement rates. The Medicare national payment rates for APCs are listed in Addendum B to the 2025 Medicare Outpatient Prospective Payment System Final Rule, the most recent version, which is available here. Those rates are adjusted for each hospital based on the applicable wage index and other factors.

Q: You mention the passage of site-neutral payments appears to be gaining momentum. Is North Carolina Rep. Murphy's proposal to increase physician reimbursement by 6.62% gaining any traction?

A: H.R. 879, the Medicare Patient Access and Practice Stabilization Act of 2025, has been referred to the House Energy and Commerce Committee, but to date the committee has not taken up the bill for discussion. You can track the bill's progress here. As you may recall, the original version of the American Relief Act, 2025, included an increase in Medicare payments to physicians; however, that increase did not make it to the final version of the legislation. It is possible Congress may include an increase in the next budget bill (the one to prevent the government shutdown on March 14), but we're not holding our breath.

Q: How would site-neutral payment reforms impact facilities that are currently PPS-exempt?

A: At this time, facilities that are PPS-exempt would not be impacted. Cancer hospitals, however, are paid under OPPS and only exempt from the inpatient PPS.

Q: Do you foresee any restrictions on moving current exams/procedures back to the hospital main campus?

A: As noted above, the MedPAC proposal included services performed in on-campus and off-campus HOPDs. If site-neutral payment reforms impacted off-campus HOPDs only, it would be difficult to enforce any provision prohibiting a hospital from relocating services to the main campus, especially if the hospital is presently providing the service in an on-campus HOPD.

Q: Are surgical hospitals paid at the ASC rates for OP services, or are they paid at the HOPD rates because their provider agreement is as a hospital?

A: If the facility is licensed as a hospital, the outpatient services it provides are reimbursed at HOPD rates.

For assistance with regulatory changes, Medicare reimbursement, and other issues, contact our webinar presenters:

Martie Ross
Principal
mross@pyapc.com

Kathy Reep
Senior Manager
kreep@pyapc.com

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