Site-Neutral Reimbursement: The Next Big Imaging Cut No One is Talking About

By John Schaeffler, GE Healthcare

Major changes are taking place in the way healthcare is being delivered and paid in an effort to reduce the cost of healthcare in the U.S.

In addition to significant programmatic changes, such as the Affordable Care Act, Medicare, Medicaid and many private insurers have concurrently been testing new payment methods that reward providers who deliver efficient, high-quality care, rather than simply paying for each test or procedure. Healthcare consumers are also coming out of the dark, demanding better price transparency as they take on a larger share of the healthcare cost burden.

But it's policymakers that are continuing to dramatically cut costs with new reimbursement legislation, and outpatient services, including imaging, continue to be in the crosshairs. In an effort to close the gap between payment rates that vary based on service settings.

Congress passed new legislation that substantially alters how and how much Medicare pays for outpatient services furnished by hospitals, and that change will have significant financial consequences for hospital providers. The change affects new acquisitions or newly constructed outpatient facilities that began to operate as a hospital outpatient facility after November 2, 2015.

To say there is a lack of clear understanding as to the potential implications of such legislation may be a huge understatement. As hospital providers create financial plans and budget for future investments and growth, they may be forced to take into account significant revenue shortfalls as a result of this legislation. Furthermore, if a site-neutral reimbursement policy is enacted across other areas, there will be significant implications in hospitals' future ability to effectively allocate resources and deliver adequate care.

Site-Neutral Reimbursement Reality

For years, the Medicare Payment Advisory Committee (MedPAC) has recommended site-neutrality as an effective payment reform, but successful lobbying on the part of the American Hospital Association (AHA) and other hospital interest groups, such as the Access to Medical Imaging Coalition, has kept the recommendation from being included in any legislation, until now.

On November 2, 2015, the Bipartisan Budget Act of 2015[1] was passed, and included in that legislation are a handful of Medicare and Medicaid-related provisions, such as site-neutral reimbursement, that should raise concerns.

What Is It?

Site-neutral reimbursement is exactly that—an equalization of payment for services across different care settings.

The legislation drives a stark divide in hospital outpatient economics depending on how a site was billing Medicare as of November 2, 2015. It could be a mistake to not adequately develop a strategy to deal with the substantial revenue losses that could result. Some believe it is important for healthcare providers to make their voices heard so that additional site-neutral reimbursement policies are not applied with a broad brush to healthcare to "equalize" payments, regardless of setting.

Site-neutral reimbursement is exactly that—an equalization of payment for services across different care settings. While some in the industry refer to site-neutral reimbursement as the "dumbing down" of complex reimbursement systems, others think it's valid to ask why you would reimburse differently for the same service. After all, because Medicare requires beneficiaries to share in the costs of care, beneficiaries will pay more when the payment for service is higher. Currently, public and private payers rely on a variety of methodologies to set payment rates.

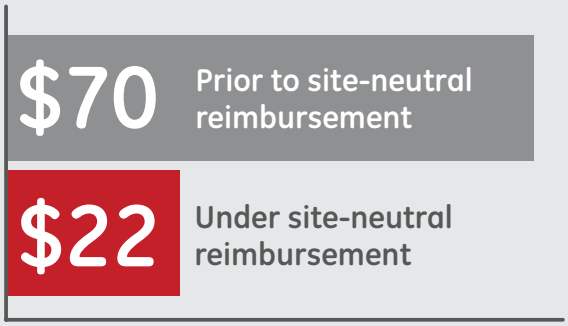
The location where the services are delivered, the costs of operating in that setting, and the different patient populations the settings serve, are all factors that determine

the rate, resulting in the same service provided in a variety of clinical settings being paid, at often times, dramatically different rates. According to MedPAC, Medicare may pay nearly 80 percent more to hospital outpatient departments (HOPDs) than independent facilities, such as Ambulatory Surgical Centers (ASCs) for the same procedure. Under site-neutral reimbursement, the reimbursement rate would be set to the lowest rate, regardless of the costs of operating in that setting.

A prime example can be found in radiology (see example below). Already suffering from dramatic reimbursement cuts as a result of the Deficit Reduction Act (DRA) in 2005, physician office and independent diagnostic testing facilities' reimbursement for performing a chest X-ray is currently $22, while the HOPD reimbursement rate for the same service is $70.[2] Prior to the site-neutrality reimbursement provision, if a hospital acquired or built an Independent Diagnostic Treatment Facility (IDTF), or a physician practice or clinic that became part of the hospital network, reimbursement for the chest X-ray would increase to $70.

Under the new legislation, if a hospital acquires or builds an IDTF or clinic located more than 250 yards from the main hospital campus, reimbursement for the chest X-ray would remain at the $22 rate, resulting in a significant revenue reduction when extrapolated to annualize the procedure volume of that facility.

Example: Chest X-ray Reimbursement



In a comment letter after the enactment of site-neutral reimbursement,[3] Patrick Hope, Executive Director of Medical Imaging and Technology Alliance (MITA), said "Implementation of site-neutral payment policies, without careful consideration of their impact on certain services, could have negative implications for patient access to those services, such as medical imaging technologies. Blindly applying physician office imaging rates for hospital-operated settings, without taking into account the decade-long history of those rates and the subsequent impact on physician-provided imaging, could result in the same impact on the hospitals. In recent years, a growing number of physicians' offices and imaging centers have closed due in part to inadequate payments from Medicare, resulting from 11 separate cuts to imaging services over the last decade."

MedPAC advisors watching industry trends based their site-neutrality recommendations, partly on the notable increase in acquisitions of physician offices and outpatient centers by hospitals, and on an ensuing increase in reimbursements they received as a result of those acquisitions being considered part of the hospital setting. Many speculate the increased activity by hospitals to acquire physician practices is a result of the Affordable Care Act, providing hospitals with a wider physician network from which to serve patients. Creating a broader hospital outpatient network gives hospitals a better opportunity to serve patients in surrounding community and provides better access to care.

Intended and Unintended Consequences of Site-Neutral Reimbursement

In a letter[4] from the Federation of American Hospitals to Fred Upton, Chairman of the House Committee on Energy and Commerce, President and CEO Charles N Kahn, III articulates the intended and unintended consequences of site-neutral reimbursement and stresses that further efforts to introduce site-neutral payment policies are premature, unwise and, at a minimum, should be tabled until the full implications of these policies are examined.

- By arbitrarily reducing reimbursement to newly acquired facilities beyond the main campus of a hospital, site-neutral reimbursement is counterproductive to best practice care delivery models and could ultimately increase the cost of care. Communities will be disadvantaged because this new legislation will generally prevent new facilities needed to accommodate the health care needs of growing populations from being built close to where they are needed.
- For some hospitals, on-campus expansion is not an option. There may simply be no room to expand, or the construction costs are prohibitive.
- Site-neutral payment policies ignore fundamental functional and cost structure differences between hospitals and physician offices, and the mission-critical services communities rely on hospitals to provide. For example, unlike physician offices and ambulatory surgery centers, hospitals provide 24/7 access to emergency care and disaster relief, serve as safety net providers, and treat more medically complex patients who are more often chronically ill, disabled and indigent.

Opposition to the legislation quickly pointed out that the new legislation would put patient care at risk. Thomas Nickels, executive vice president of government relations at the American Hospital Association, said in a statement[5] when the law was signed that the "untested idea may endanger patient access to care, especially among patients who are sicker, the poor, minorities and seniors who often receive care in hospital outpatient departments. Moreover, rural communities will be most adversely impacted, as hospitals will no longer be able to help physicians in these communities continue to provide access to their patients."

Additionally, the reimbursement cuts will have a significant effect on a hospital's ability to deliver the latest imaging technology to patients by forcing it to hold on to equipment longer, and potentially negatively affecting earlier disease detection, treatment and follow-up care. As a result of the site-neutrality cuts, the ever-shrinking budgets for diagnostic imaging will compel hospital administrators to maintain a keen understanding of market conditions in order to appropriately assess the potential return on investment on any capital investments to upgrade or replace major imaging equipment.

As it stands, the average usable life for imaging equipment seems to have doubled since the passage of the DRA. With the additional cuts courtesy of site-neutral reimbursement, that usable life may further extend to the point that hospital administrators are disincentivized to reinvest and replace imaging equipment, ensuring their budget forecasts reflect the fully-realized decreases in reimbursement before contemplating capital investments. This could have a negative ripple effect on the overall financial stability of the organization with potentially negative effects to clinical outcomes, as well as an inability to remain competitive.

According to the legislation, the site-neutral payment provision and a one-year extension of a two percent sequester cut were expected to cut Medicare spending by $9.3 billion[6] over 10 years and consequently reduce hospital revenues as much as $1.44 billion each[7] year as a result of the initial cut.

If policy makers find that the current site-neutrality cuts are effective, industry experts suggest that additional equalization efforts, perhaps reaching back into existing outpatient operations, may result in deep revenue shortfalls that could affect the hospital across all of its service lines, regardless of the November 2, 2015 dividing line.

Taking Steps to Strengthen Your Position

As hospital providers, the AHA and the Federation of American Hospitals, as well as other hospital interest groups such as MITA, have demonstrated their support of you. They initially reached out to lobby against site-neutral reimbursement and were effective in delaying legislation and implementation until this year. It is speculated that there will be increased efforts by these and other groups to lobby against further recommendations for site-neutral reimbursement reductions. The leadership and vision to partner with these hospital interest organizations, as well as patient advocacy groups for patients in affected areas, to align efforts against additional cuts may be key.

Another critical component to a successful effort to prevent further reimbursement reductions is a comprehensive strategic and tactical plan for each provider organization. Preparations may include the need to declare that the facility is under threat by the current site-neutral legislation, and explaining how the current and additional proposed cuts would negatively affect the care provided would be an important next step.

Understanding and being able to use your market and facility data to support that position provides credible validation to the argument. An intimate knowledge of surrounding community demographics, utilization figures and competitive market data will highlight key strengths and weak areas to give additional context. Telling that story with the help of public relations professionals and lobbyists will help illustrate to key audiences the dramatic, potential effects of this legislation.

Summary

The full impact of the initial legislation introducing site-neutral reimbursement has not yet been realized and with the impending change in administration, it is certain that site-neutral reimbursement will remain one of the cost-cutting options on the table. So it seems inevitable that whether through legislation or a new administration, extending site-neutrality based cuts into more areas is a matter of when, not if. The concept of broadly applied site-neutral reimbursement policies should spark a sense of urgency for many health system leaders because of the dramatic expected decreases in revenue. In light of that, it is going to be important to develop a strong strategy that aligns the organization's economics with goals centered around value, outcomes, and patient access.

[1] https://www.congress.gov/114/plaws/publ74/PLAW-114publ74.pdf

[2] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx-?Y=0&T=0&HT=0&CT=3&H1=71010&M=5

[3] http://www.medicalimaging.org/2016/02/19/mita-comment-letter-on-site-neutral-pay-ment-policies/

[4] http://fah.org/upload/documents/Federation_Letter_Strongly_Cautions_Against_Expan-sion_of_Site_Neutral_Policies.pdf

[5] http://www.aha.org/presscenter/pressrel/2015/151027-pr-budgetdeal.shtml

[6] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf

[7] http://www.aha.org/advocacy-issues/letter/2016/160212-let-siteneutral.pdf

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