Washington State Health Care Authority

# Outpatient Site-Neutral Policy Estimate - Executive Summary

Historically for both Medicare and Washington Medicaid, two separate payments were made for an outpatient service at an off-campus hospital clinic: 1) an outpatient facility payment and 2) a professional service payment. The combination of the outpatient facility payment and the professional service payment was generally greater than the payment for the same service in a physician' office. To better align payment for outpatient clinic services with the Medicare Professional Fee Schedule, CMS adopted a new Medicare outpatient "Site-Neutral" payment policy effective January 1, 2017. This policy reduces the outpatient facility payment for services provided at off-campus clinics established on or after November 2, 2015 by **50 percent** (clinics established before this date are "grandfathered" and payments are not reduced).[1] The 50% reduction factor is based on the average value of professional service payment as a percentage of the Medicare outpatient payment amount for off-campus services.

The Washington State Health Care Authority (HCA) has conducted an analysis to estimate the fiscal impact of a Medicare-style site-neutral payment policy in its Medicaid outpatient payment system, without a "grandfathering" clause (in other words, payment reductions would be applicable to all off-campus clinics). This analysis required several high level assumptions, because off-campus clinics are not currently separately identifiable in the Medicaid outpatient claims data.

Key analysis data and assumptions were as follows:

- *Outpatient claims data*: Based on SFY 2016 outpatient FFS claims and MCO encounters extracted from ProviderOne.
- *Off-campus clinic volume*: Fiscal impact estimate includes all outpatient claims billed with "PO" modifier, and 20% of outpatient claims without the PO modifier. Medicaid billing instructions currently require providers to report the PO modifier for outpatient off-campus clinic services; however based on discussions with the provider community, HCA does not believe providers have used the PO modifier on all off-campus claims (20% scenario is for impact estimates only – exact percentage is unknown).
- *Estimated payment impact*: based on 50% reduction to outpatient claim payments for estimated off-campus clinic volume.
- *Estimated state share*: State share versus Federal share of payment reductions based on a federal share percentage (56.57% for FFS and 73.68% MCO), estimated based on statewide averages for outpatient services.
- *CPE hold harmless impact*: The state share of payment reductions is offset by estimated increases in hold harmless settlements for Certified Public Expenditure (CPE) hospitals, which are 100% state funded.

Under a scenario where 20% of SFY 2016 outpatient claims without the PO modifier were provided at off-campus clinics, the estimated state share of OPPS payment reductions is **$20 million**. Most of state savings – approximately $17M - would be for managed care services, requiring reductions to capitation rates to MCO plans. Should the Legislature enact this policy, HCA recommends following CMS's Medicare outpatient methodology and reducing payments for off-campus clinic outpatient services submitted on an institutional claim by 50%.

[1] CMS Federal Register / Vol. 81, No. 219 / Monday, November 14, 2016 / Rules and Regulations: https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf