CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Addressing Site-of-Care Payment Differentials in the U.S. Health Care System

Policy Brief

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Summary of the Issue

Medicare is one of the most important health care programs in the United States as it provides robust health care to over 65 million Americans.[1] As the program continues to grow, increased Medicare spending has raised concerns about the financial sustainability of the Medicare program.[2] "From 2021 to 2022, Medicare spending grew to 5.9%[3] to $944.3 billion in 2022, reaching 21% of total National Health Expenditures.[4]

"Site-of-care" payment differentials contribute to this rising Medicare spending. These payment differentials also fuel provider consolidation by creating an "arbitrage" opportunity to shift referrals to hospital-based outpatient departments.[5] Research has found that site-based payment differences in Medicare incentivize consolidation between hospitals and physician practices, commonly known as *vertical integration*, raising health spending without necessarily improving patient outcomes.[6][7][8][9]

Site-neutral payments in Medicare have been discussed as a potential policy option that could address these payment differentials and as a means to reduce Medicare spending without impacting beneficiaries' access and quality of care.[10] These policies have received support from many across the healthcare industry. Still, others have some concerns about the financial impact site-neutral payments could have on hospitals and health systems, especially for hospitals in rural and underserved areas.

Policy Options Overview

1. *Uniform Payment Rates*
2. *Evidence-based Payment Adjustments*
3. *Monitoring and Evaluation*
4. *Enhance Transparency and Accountability*
5. *Ensure sustainability of rural and marginalized access to care*

Background & Overview of Site Neutral Payments

Over the past decade, policymakers have debated what site-neutral payments might look like in Medicare. Site-neutral payments would ensure that Medicare reimbursement would be the same for services, regardless of where that service is provided. Many services can be performed in both hospital and non-hospital settings. By statute, the Medicare program has higher reimbursement rates for services performed in a hospital than those performed in a non-hospital setting.[11] Medicare reimbursement varies for most common services depending on whether they are provided in a hospital outpatient department (HOPD), ambulatory surgery center (ASC), or physician's office.[12]

These policies have led to the Medicare program paying more for the same services depending on the care setting. For example, research has found that there are significant payment differentials at sites of care. Medicare pays hospital outpatient departments (HOPDs) an average of 125% more than the physicians' offices for evaluation and management visits and other commonly delivered health services.[13] Cardiac imaging, when delivered in an outpatient setting, costs $2,078 vs. $655 when delivered in physician offices, and colonoscopy costs $1383 vs. $625 when delivered in a non-hospital outpatient department (HOPD) vs. an ambulatory surgical center (ASC) setting.[14] Many non-hospital settings offer equivalent or better quality of care at a lower rate.[15]

Although there are potential fiscal benefits for Medicare and savings for patients, site-neutral policies have faced opposition from industry stakeholders, who argue higher payments are necessary to maintain hospital services.[16] These stakeholders argue that eliminating these differences in pay by site may induce inadequate funding to keep these services running efficiently.[16] However, on the other hand, higher payment rates for outpatient services encourage hospitals to acquire physician practices to shift care from physician offices to outpatient departments and charge higher prices.[17] The differentials are also found in the private sector with commercial insurance, where commercial insurers generally pay more for the same services when delivered in outpatient departments than physician offices. [13]

This brief discusses the history of interest in site-neutral payments, challenges and concerns for site-neutral payment policies, what the research has found on site-of-care payment differentials and their impact on quality of care, challenges and concerns about implementing site-neutral payments, the potential fiscal implications of site-neutral payments, and potential policy options to address site-of-care payment differentials.

History of Action and Interest by Congress and the Federal Government on Site-Neutral Payments

While the rise in site-of-care payment differentials is concerning, some steps have been taken to address them. Under President Obama, the Bipartisan Budget Act of 2015[18] established site-neutral payments under Medicare for services received at off-campus HOPDs. However, this bill included a grandfathering provision that exempted existing off-campus HOPDs from site neutrality. It also did not subject on-campus HOPDs to the law at all, and many of the

outpatient-style services were delivered via on-campus departments. The Trump administration also enacted site-neutral payments between on-campus hospital outpatient departments and physician offices for services, such as clinic visits, commonly provided in non-hospital settings and for ambulatory surgical centers.[19]

Congress has long debated the importance of implementing some form of site-neutral payments in Medicare. The House Energy and Commerce Committee held a legislative session[21] in April 2023 where they considered a bill to create site-neutral payments for ambulatory surgical centers under the Medicare program. Other bills have also been introduced to address site-neutral payments,[22] including the SITE ACT[23], which would ensure site-neutral payments for off-campus HOPDs and remove the grandfathering provision mentioned earlier, and the Medicare Patient Access to Cancer Treatment Act, which would impose site-neutral payments for cancer care services. The furthest action on site-neutral payments was when the U.S. The House of Representatives passed the Lower Costs, More Transparency Act[24] by a 320-71 majority, which contained a provision that would apply site-neutral payments to the fees associated with the drug administration services for Medicare Part B drugs.

Last June, MedPAC also recommended that lawmakers move to advance site-neutral payment for a select set of low-complexity medical services such as office visits, X-rays, minor procedures, and drug injections.[20] MedPAC stated that these recommendations could result in billions in savings for patients and taxpayers while reducing perverse incentives for consolidation. The growing interest in implementing site-neutral payment policies has increased due to the research on site-of-care payment differentials.

Site-of-Care Payment Differentials Fuel Consolidation

In addition to increasing Medicare spending, an unanticipated but important consequence of site-of-care payment differentials is creating incentives to consolidate health care markets. Site-of-care payment differentials create an "arbitrage opportunity" that drives vertical integration. Over the last decade, the share of physicians employed by a hospital or health system has approximately doubled. As a result of this *vertical consolidation* trend, the share of physicians who have left independent practice for employment or corporate ownership has increased over time, with over 55% percent of U.S. physicians now hospital-employed, and another 22.5% employed by other corporate owners.

By changing referrals to hospital-based settings, site-of-care policies can increase health system revenue. In one study, physicians employed by hospitals or part of a group owned by a hospital or health system were 65 percent less likely to use an ASC at all compared to physicians who were never a part of a vertically integrated system.[25]

Studies from our researchers at the Center for Advancing Health Policy through Research (CAHPR) have found that physicians that experience a hospital or health system acquisition were found to reduce the number of ambulatory surgical centers they rely upon by 13% and are 9% less likely to perform any procedures within an ASC.[25] CAHPR researchers have also found prices paid in HOPDs were 54.9% higher than those in ASCs for three ambulatory procedures: colonoscopy, knee or

shoulder arthroscopy, and cataract-removal surgery. The higher prices charged in those HOPDs for the procedures were not balanced by better quality.[26]

Challenges and Concerns

It is unclear how provider commercial prices may change in response to changes in Medicare and commercial revenues. Hospitals argue that site-neutral policies don't take into account differences between hospital outpatient departments and other sites of care. Hospitals continue to maintain that their outpatient departments generally see sicker patients and have higher overhead costs. However, with the current payment differentials, patients are paying two to three times more for drugs administered in hospital outpatient settings when compared with an independent physician office.[27]

According to MedPAC tailoring site-neutral payments towards a select set of low-complexity services, such as office visits, X-rays, minor procedures, and drug injections, could result in billions in savings for patients and taxpayers while simultaneously reducing perverse incentives for consolidation.[10] These incentives allow consolidated health systems that own former freestanding outpatient departments to charge higher prices for the same services once offered at a lower rate when the outpatient department previously held an independently owned status. The degree to which site neutral payments are applied in rural and other underserved settings should be determined by the measurable differences in resources and risk required to deliver care and maintain quality standards. [28]

Potential Fiscal Impacts of Site-Neutral Payments

To effectively implement site-neutral policies, flexibility in the site-neutral payment framework to accommodate changes in healthcare delivery models, advancements in technology, and evolving patient needs, must be maintained. Regular review and updates to payment policies to ensure they remain responsive to the dynamic healthcare landscape is essential to establishment of quality care standards. If this is done well, according to the Congressional Budget Office, a site-neutral payment bill would save Medicare $3.7 billion over 10 years and a recent analysis commissioned by Blue Cross Blue Shield Association found that adopting site neutral payment policies would save Medicare $202 billion over a 10-year period and save Medicare enrollees $67 billion on cost-sharing.[29]

Over the next decade, the Committee for a Responsible Federal Budget estimates that site neutral payment policy could reduce Medicare spending by $153 billion. Premiums and cost-sharing for Medicare beneficiaries are estimated to be reduced by $94 billion.[13] Assuming different levels of private sector spillover savings, this policy could also reduce total national health expenditures by a range of $346 to $672 billion, reduce the federal budget deficit by a range of $217 to $279 billion, and reduce private cost-sharing and premiums by a range of $140 to $466 billion. The site-neutral policy would only apply to a subset of services that are identically provided in both hospital outpatient departments and physician offices. [6]

MedPAC estimates that aligning payment rates across the ambulatory settings for the 66 APCs would have reduced Medicare OPPS outlays in 2021 by $6.0 billion and beneficiary cost sharing by $1.5 billion, for a total reduction of $7.5 billion (assuming lower payment rates were retained by Medicare as program savings), or 3.8 percent of aggregate Medicare revenue for OPPS hospital.[10]

The Center for Advancing Health Policy through Research is also currently working to fill gaps in the literature by working on a site-of-care payment differentials study with the hopes of providing some further guidance to stakeholders and policymakers on how to advance and improve policy options for site neutrality, including providing recommendations on how the reduce the potential impact on rural service lines.

Potential Policy Options to Address Site-of-Care Payment Differentials

Evidence-Based Payment Adjustments

Develop a system for adjusting payment rates based on evidence of severity of illness and quality outcomes across different settings. This would ensure that payment differentials are justified by measurable differences in resources and risk required to deliver care and maintain quality standards. According to the Commonwealth Fund, in evidence-based or value-based payment arrangements, healthcare organizations are incentivized for meeting certain quality, cost, and equity goals in healthcare.

Monitoring and Evaluation

Establish mechanisms for ongoing monitoring and evaluation of site neutral payment policies to assess their impact on access to care, quality, and cost containment. Regular reviews should be conducted to identify any unintended consequences and make necessary adjustments to the policy.

Enhance Transparency and Accountability

Ensure transparency in the payment methodology and decision-making process for site neutral payments. Provide stakeholders with clear information on how payment rates are determined and how they align with the goals of improving efficiency and quality of care. Additionally, holding healthcare providers and facilities accountable for delivering high-quality care regardless of the payment setting is necessary to ensure a sustainable healthcare system.

Enhance Sustainability of Rural and Marginalized Access to Care

Critical Access and rural hospitals receive the majority of their revenue from outpatient departments, and with this sector of the health market being a grave concern of congressional leadership regarding their respective financial viability, it's important to ensure site-neutral payments account for the already financially strained status of many rural and critical access

hospitals as well as those hospitals that are generally underfunded in marginalized communities. The current literature on how to sustain the financial performance of these hospital types is scarce, but the literature on uniform payment rates, evidence-based adjustments, and transparency and accountability is growing. Therefore, congress can implement evidence-based payment adjustments for severity of patient population found in these hospitals in addition to their overall need to maintain equitable access to care for the patients they serve.

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