Ineffective & Misguided: Why Congress' So-Called Site Neutral Policies Will Backfire on Medicare

Summary

Congress is considering a change to Medicare that will harm patients and providers alike and exacerbate hospital closures, particularly in rural and urban areas with less access to facilities. Guided by incomplete (and, at times, faulty) logic in both the 2022 and 2023 *MedPAC Reports to Congress*, legislators are considering a "site neutral" payment system, which pays for care at the lowest-possible rates. Under the proposals, Medicare would pay hospital outpatient departments (HOPDs) the same amount that it does when services are provided in physicians' offices and/or ambulatory surgical centers (ASCs)—i.e., a rate much lower than it pays for these services in HOPDs today.[1] [2]

Addressing the nation's high health care costs is a reasonable and necessary goal—but Congress is looking for savings in all the wrong places. Selecting the lowest-cost care setting (a physician office) and paying hospital-based clinics at that same rate is based on a fallacy: that hospitals, physician offices, and ASCs are all the same. The proposals under consideration ignore not only the reality of hospitals' unique responsibilities and costs, but also the significant and intentional differences the Medicare payment systems use to pay each provider type—physician offices, ASCs, and hospitals.

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Here's the big problem with this "site neutrality" proposal: it is based on the erroneous assumption that the payment that Medicare makes for a service—represented by a five-digit billing code—is for the *exact same* service across different sites of care.

What's the Background?

The Centers for Medicare & Medicaid Services (CMS) currently reimburses physician's offices based on rates set in the Medicare Physician Fee Schedule (MPFS). Those rates are deter-mined with the assistance of the American Medical Association (AMA) by surveying doctors about various elements that con-tribute to their costs (e.g., for physician time, building expenses, staff costs, supplies, etc.) The values that guide the rates are updated intermittently through additional surveys.

[1] H.R. 3561: Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act of 2023.
[2] US House of Representatives Energy & Commerce Committee, Health Subcommittee Legislative Hearing: "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care," April 26, 2023.

HOPDs, on the other hand, are paid by CMS through the Outpatient Prospective Payment System (OPPS). CMS sets OPPS rates annually, using hospital cost and claims data. For both inpatient and outpatient services, *hospitals are the only provider type that submits actual cost data for treating all patients to CMS annually.* Physician offices and ASCs do not have to do this. CMS audits ensure that these data are very precise and complete. Even though they are based on all this data, however, the OPPS rates only cover an average of 84% of hospital costs, largely due to the complex rate-setting methodologies CMS uses.[3]

Doctors, hospitals, and ASCs all use Current Procedural Terminology (CPT®) codes to bill Medicare. These numeric codes provide a uniform nomenclature for providers and payers alike to record their services on medical claims. For doctors' offices, almost every CPT®-coded service reported on claims generates separate payment: all lab tests, all drugs, all ancillary services, and so on. Under the OPPS, however, CMS rarely pays for the CPT® codes in this manner; rather, CMS pays for one or several codes reported on the claim using a concept called "packaging." Packaging in the OPPS is CMS' intentional way of paying for larger and larger bundles of items and services, rather than using a fee schedule model like the MPFS.

For example, CPT® code 96413, which can be billed in the physician's office or the HOPD, tells you exactly one thing—the patient received one hour of chemotherapy—and that's all. It provides *no* additional information about the differences in patient acuity or disease state, the specific chemotherapy and non-chemotherapy drugs administered, as well as whether any other services were provided to the patient during the visit. Without this type of information, any declaration that the service represented by CPT® code 96413 is the same across various sites and, therefore, should be paid the same would be misguided.

What's the Problem?

When Medicare gets a physician office claim and a HOPD claim containing CPT® 96413, it is true that both sites of care provided an hour of chemotherapy. But, Congress' site neutral proposals do not take into full consideration the fact that the payment made to each site represents much more than payment for an hour of chemo-therapy. The costs and complexity of the chemotherapy administration provided in the HOPD is hidden by the OPPS' packaging system. Until there's an analysis that includes *all* of the services provided during the visit, patient acuity, and total claim payment, we cannot have a meaningful discussion about the cost of care or the appropriateness of payments made across sites of care.

For an accurate analysis that could guide payment policy changes, Congress would need to use an apples-to-apples comparison—the current proposal is more pine-apples-to-grapes. An accurate analysis would require reviewing the amount and type of all drugs, labs, and other services provided, as well as full visibility about whether and what separate payments were made to the provider.

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[3] American Health Association (AHA), Fact Sheet: Underpayment by Medicare and Medicaid, Washington (DC): AHA, 2022. https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

Focusing on payment rates for *individual services*, rather than looking at *total claim payment,* warps any understanding of why variability across sites of care exists and why it is appropriate.

The "site neutrality" proposals also under-estimate (and often ignore) the very real differences in requirements and responsibilities that result in different cost structures. Anyone who has been to both a hospital and a doctor's office can readily see that they are very different. Hospitals are licensed by each state in ways that offices are not. They must comply with complex federal regulations that impact how the hospital facility is structured and maintained, and unlike physicians' offices, hospitals must furnish care 24 hours a day, 365 days of the year. Their services include emergency department care; disaster and trauma standby capacity; and a requirement to treat all emergency patients whether or not the patient has insurance or the ability to pay.

Conclusion

The U.S. health care system is vastly com-plicated, and CMS' various payment systems are even more so. Site neutrality focused on paying hospitals less is a quick way to reduce Medicare spending—using a hatchet rather than a chisel to craft much-needed improvements across all Medicare payment systems. If implemented, "site neutrality" proposals will result in U.S. hospitals being paid even less for services provided to Medicare recipients, and result in greater losses than they already face. This will compound the negative margins that many hospitals currently report. Further payment cuts will be problematic for all hospitals, but especially for those in health care shortage areas, such as rural and inner city areas. It is highly likely that site neutral payment cuts, if implemented, will force additional hospital closures. For beneficiaries, this means increased health inequities and a shortage of facilities where they can get the care they need.

Nimitt Consulting joins other stakeholders like the American Hospital Association (AHA), the Federation of American Hospitals (FHA), and others in protesting these proposals.

Congress should seek the opinion of knowledgeable experts to better understand how these complex payment systems work and how they can ensure future proposals protect—rather than harm—Medicare beneficiaries.

About Nimitt Consulting, Health Policy Partners| Nimitt Consulting provides strategic advisory services, education, and data-driven advocacy on health care reimbursement and the factors that drive it. Our unique focus on providers 'financial and operational realities enables us to help them and other stakeholders navigate coverage, coding, and reimbursement issues, especially for innovative treatments, including cell and gene therapies. For more information, follow us on Linked-In (*www.linkedin.com/company/nimittconsulting/*) or contact *Susan@Nimitt.com*.