Delivering on the Promise of a Patient First Health Care System

A Compromise Approach to Site-Neutral Payments

Written by

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INTRODUCTION

Medicare is an incredibly important program, providing more than 65 million Americans with access to robust health care benefits.[1] As the program has grown, mounting concerns have been raised about its affordability for Medicare beneficiaries and the sustainability of its spending and financing structure.

According to recent survey data from the Kaiser Family Foundation (KFF), more than one-third of Medicare beneficiaries have delayed or forgone important medical and surgical procedures because of concerns about their cost of care.[2] Medical costs continue to put a significant strain on the finances of many Medicare beneficiaries, with one in four beneficiaries having less than $17,000 in retirement savings to draw from to cover their out-of-pocket health care needs.[3] KFF also has documented that Medicare beneficiaries spend more total dollars and a larger percentage of their household finances on health care than households with no Medicare members.[4]

In addition to affordability concerns, the financial underpinnings of the Medicare program are unstable. In 2022, Medicare spending reached almost $1 trillion and accounted for 21 percent of national health expenditures.[5] The Medicare Trustees

[1] Medicare Enrollment Dashboard - Centers for Medicare & Medicaid Services Data (cms.gov)
[2] KFF Survey of Consumer Experiences with Health Insurance | KFF
[3] Income and Assets of Medicare Beneficiaries in 2023 | KFF
[4] Medicare Households Spend More on Health Care Than Other Households | KFF
[5] NHE Fact Sheet | CMS

now estimate that the Hospital Insurance Trust Fund will be depleted by 2031,[6] but that date could move up as the result of increased spending, inflation, or other unanticipated events. The driving force behind Medicare spending is payments for hospital, physician, and clinical services, which accounted for more than half of total Medicare expenditures in 2021.[7] Therefore, to address the financial solvency of the Medicare program, payment reforms to these services should be a priority.

One such reform is site-neutral payments, which would equalize payment for the same services across all settings of care. Though site-neutral payments can apply across all settings, the policy is most commonly considered in connection with outpatient, or ambulatory, settings. Because out-of-pocket costs for Medicare beneficiaries are based on a percentage of the total reimbursement costs, any policy that reduces reimbursement for some services would result in savings to Medicare beneficiaries.

Though this policy approach has significant support, hospitals have raised concerns about the impact of site-neutral payments on their bottom line. Hospital-based outpatient departments currently receive higher reimbursement rates for the services they provide than other ambulatory settings providing the same service. As hospitals play an irreplaceable role in their communities, providing lifesaving services to every person, regardless of their background or insurance situation, it is important to fully support them in their efforts to fulfill their mission. At the same time, however, it is critical that policymakers address payment distortions that are driving up costs to Medicare beneficiaries and the Medicare program.

This paper proposes a compromise approach to implementing site-neutral payments that benefits beneficiaries, hospitals, and the Medicare program. It calls for lowering out-of-pocket costs to Medicare beneficiaries, improving the financing of the Medicare program by addressing a payment distortion, and reinvesting in hospitals through new targeted funding and inclusion of policy priorities.

[6] 2023 Medicare Trustees Report (cms.gov)
[7] What to Know about Medicare Spending and Financing | KFF

APPROACH BENEFITS

Implementing site-neutral payments would ensure predictable, more affordable cost-sharing for Medicare beneficiaries.

OVERVIEW

Understanding Site-Neutral Provider Reimbursement

For more than a decade, Congress and health care stakeholders have debated the merits of implementing site-neutral payments in Medicare, meaning Medicare reimbursement would be the same amount of money for the same service, regardless of where that service is provided. Under current law, Medicare reimbursement varies for common, non-complex services—such as an injection, biopsy, urology services, or application of a cast—depending on whether they are provided in a hospital outpatient department (HOPD), ambulatory surgery center (ASC), or physician's office, collectively referred to as ambulatory or outpatient settings.

In addition to costing the Medicare program more money than if payments were the same across all ambulatory settings, the current payment approach results in additional cost-sharing for patients. Medicare beneficiaries currently must pay a percentage of the total Medicare reimbursement—20 percent for outpatient services. As a result, they are charged more for the same service provided in an HOPD than in their doctor's office.

In contrast, with a site-neutral payment approach, Medicare's payment to a provider for common, non-complex services would be the same regardless of whether the services were provided in a HOPD, ASC, or physician's office. Implementing site-neutral payments would ensure predictable, more affordable cost-sharing for Medicare beneficiaries.

Though a site-neutral payment approach has support from many health care policy experts across the political spectrum (i.e., patient advocacy organizations, insurers, many physician groups, and employers), most hospitals and health care systems have raised concerns about the financial implications of this shift in the reimbursement methodology. In the past, these concerns have made congressional leaders hesitant to adopt new policies that would implement site-neutral payments in Medicare.

Recent Congressional Interest in Site-Neutral Reimbursement Policies

Recent Congressional action indicates growing bipartisan support for advancing some form of site-neutral payments. On June 12, 2023, a group of bipartisan senators introduced the SITE Act, legislation that would broadly implement site-neutral Medicare payments for outpatient services.[8] On December 11, 2023, the US House of Representatives passed the Lower Costs, More Transparency Act[9] by an overwhelming, bipartisan 320-71 majority. The legislation contained a targeted provision that would apply site-neutral payments to the fees associated with the drug administration services for Medicare Part B drugs.

Though this limited, site-neutral provision advances the issue, Senate passage remains unlikely in the short-term, and hospital concerns persists. In reviewing the policies on site-neutral payments in House-passed legislation, senators have expressed particular hesitation about the potential impact on rural and safety-net hospitals. However, exempting these providers from site-neutral payment requirements while implementing it for other ambulatory providers would effectively force Medicare beneficiaries who live in rural areas or who have low incomes to arbitrarily pay more for the same services than Medicare beneficiaries who live in urban and suburban environments. Rather than exempting rural and safety net hospitals from site-neutral payments, new funding should be targeted to support rural and safety-net hospitals in their unique missions and needs.

PROPOSED COMPROMISE

Unlike previous site-neutral payment proposals, this framework reinvests the bulk of the savings into targeted funding and policy priorities for hospitals.

Site-Neutral Reimbursement and New Support for Rural and Safety Net Hospitals

To further the dialogue on patient-first, value-driven health policy that lowers out-of-pocket costs for Medicare beneficiaries while addressing the concerns of some hospitals and elected federal officials, this paper proposes the following compromise policy framework for implementing site-neutral payments in Medicare. Unlike previous site-neutral payment proposals, this framework reinvests the bulk of the savings into targeted funding and policy priorities for hospitals. This model reflects research and analysis of existing proposals, published policy priorities for hospitals, and interviews with key opinion leaders and congressional and administration officials. If implemented, the changes would reduce health care costs for Medicare beneficiaries, reduce payment disparities that researchers say are contributing to provider consolidation, and fund critical hospital and health system priorities and services.

[8] Senators Braun, Hassan, Kennedy lead bipartisan bill to fix part of Medicare billing structure, saving billions - Senator Mike Braun (senate.gov)

[9] H.R.5378 - 118th Congress (2023-2024): Lower Costs, More Transparency Act | Congress.gov | Library of Congress

Components of a Compromise Framework

To achieve these goals, the compromise policy framework includes:

- A new unified ambulatory payment system (UAPS) for common, non-complex outpatient services
- Targeted reinvestment in the needs of rural, safety net, and other community hospitals
- A new common reimbursement language for services provided in both inpatient and outpatient settings for a future unified payment system
- A new unified post-acute care payment system (UPAC) for a limited number of services performed in skilled nursing facilities (SNFs) and inpatient rehabilitation hospitals (IRFs)

Unified Ambulatory Payment System

Under the new UAPS, a select group of common non-complex outpatient services provided in HOPDs, ASCs, and physicians' offices would be carved out of the existing payment systems and instead used as the foundation for a new site-neutral fee schedule. Reimbursement under the UAPS for 57 of these identified services would be equivalent to the current payment under the Medicare physician fee schedule (PFS). For nine of the identified services, the reimbursement would be equivalent to the ASC payment rate. This new payment system would reduce payments to hospitals for these common, non-complex services provided in the outpatient setting and pay them at the same rate as other providers receive for delivering the same services.

For off-campus HOPD services not included in the UAPS, the framework would eliminate the grandfathering provision in the 2015 Bipartisan Budget Act for services provided in off-campus HOPDs.[10] Off-campus HOPD services are defined as outpatient services that are provided outside an emergency department that are performed off the main campus of the hospital and more than 250 yards away from the facility.[11]

Under current law, off-campus HOPDs that furnished services before November 2, 2015, are reimbursed at outpatient prospective payment system (OPPS) rates. The UAPS framework would eliminate this exception; instead, all off-campus HOPDs would bill for services under the PFS, which is a lower payment rate. These amounts align with the current payment rates for non-exempted, off-campus HOPDs. This approach eliminates an inequity that is advantageous to some providers based solely on when the off-campus HOPD was built.

[10] https://www.congress.gov/bill/114th-congress/house-bill/1314/text
[11] 2016-31774.pdf (federalregister.gov)

Important inpatient services and complex outpatient services would not see their reimbursement change under this proposal.

Investing in Rural, Safety Net, and Other Community Hospitals

The framework recognizes that many community hospitals that bill under both the inpatient prospective payment system (IPPS) and OPPS have unique policy and funding needs and would experience a reduction in reimbursement for some OPPS services under this proposal. Hence, this paper proposes a number of policies that would reinvest funds in critical services and long-sought community hospital policy priorities. This funding would ensure that rural, safety net, and teaching hospitals, along with hospitals that provide trauma and burn care, can continue to fulfill and expand their essential missions. It is important to note that while some common, non-complex outpatient services would see a reduction in payment, important inpatient services and complex outpatient services would not see their reimbursement change under this proposal. In fact, this framework instead proposes using some of the savings to increase payment for these important inpatient services. The framework also includes new funding specifically for rural and safety net hospitals, along with expanding federally funded graduate medical education slots for teaching hospitals.

Inpatient and Post-Acute Care

In the future, additional unified payment approaches should be considered to pay for common, non-complex services that can be safely provided in both inpatient and outpatient settings, as well as for services provided across all post-acute care settings. Recognizing that more research and policy development is warranted before policymaking on these issues, this framework proposes steps to remove barriers to creating unified payment approaches in the future for services provided in these settings.

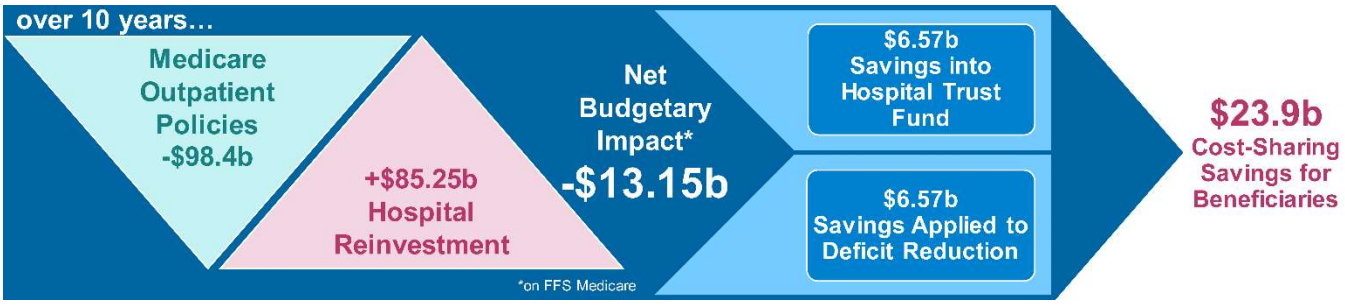
Path Forward and Budgetary Impact

Given the current political dynamics, it is possible that Congress would enact the policy framework as a component of a larger reform package that includes additional policy changes to other parts of Medicare. One methodological limitation should be noted: The budgetary impact of the policies included in this proposal reflects only the effect on the Medicare fee for service (FFS) system. The proposed policies are estimated to have a similar budgetary impact on the hospital spending components of the Medicare Advantage (MA) program, but those effects are not included in the model.

Questions remain about how the MA savings and the reinvestment policies included in the framework would, in turn, be disbursed to the MA program. For instance, more research and modeling must be done to understand if changes to inpatient and some outpatient reimbursement rates would be carried forward to some or all of MA through payment arrangements with hospitals or how those changes should be incorporated into the bid, benchmark, and rebate approach used in the MA program.

This compromise framework provides a balanced, nuanced, and productive starting point for a complex issue that Congress has recently expressed significant interest in pursuing.

Unified Ambulatory Payment System (UAPS) implements site-neutral payments across outpatient settings.



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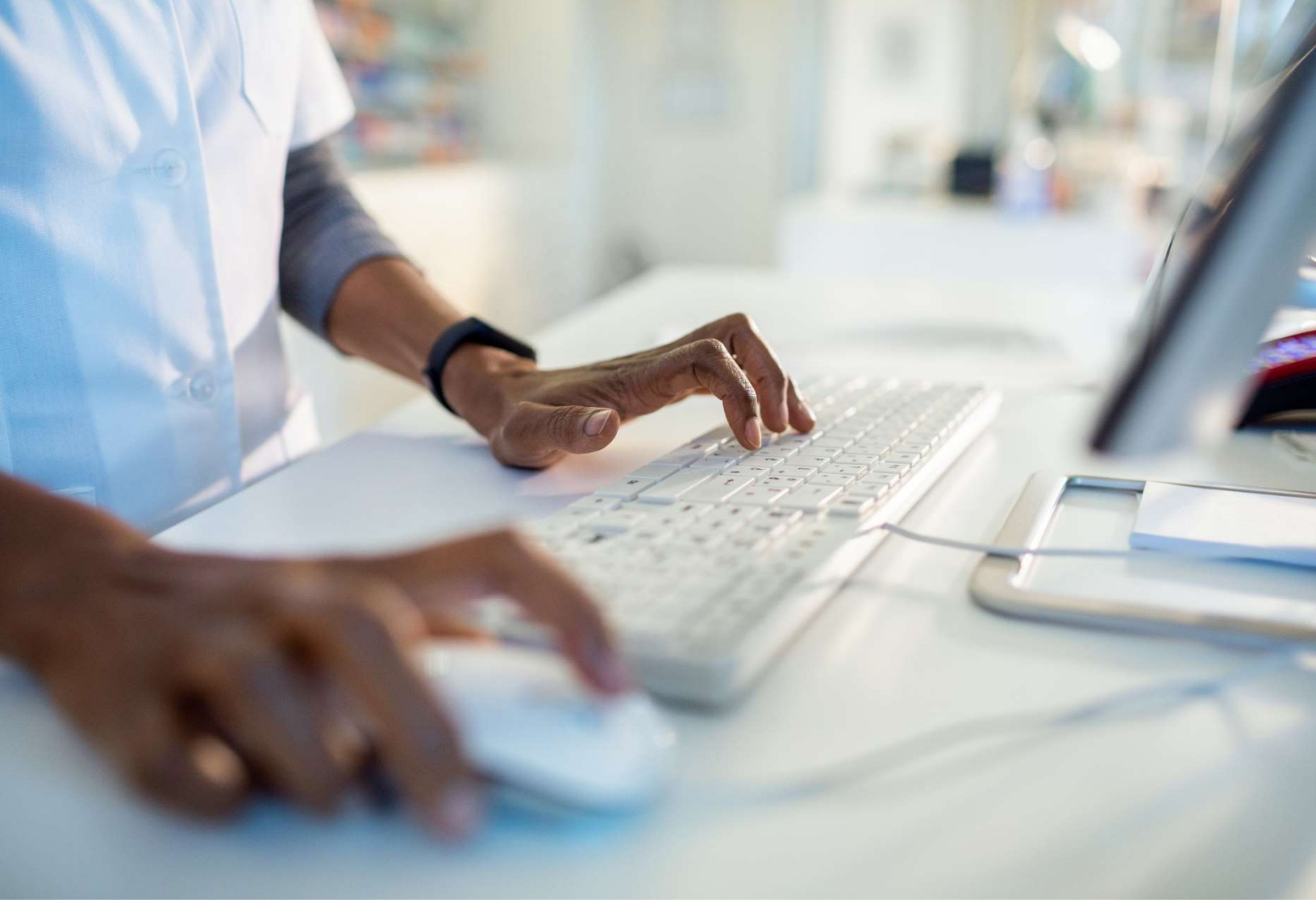


PART 1: UNIFIED AMBULATORY PAYMENT SYSTEM

The new UAPS would take effect on January 1, 2026, and would carve out commonly provided services associated with the 66 Ambulatory Payment Classifications (APCs)—which the Medicare Payment Advisory Commission (MedPAC) identified in its June 2022 report to Congress—from the OPPS, ASC payment system, and PFS. Most of those services would be reimbursed at the current PFS rate.[12] In line with the MedPAC proposal, nine of these services would instead be reimbursed at the ASC payment rate.

This framework also proposes eliminating the HOPD grandfathering provision from the 2015 Bipartisan Budget Act for services provided in off-campus outpatient provider-based departments. As a result, these services also would be reimbursed at the current PFS rate. Details on the design and implementation of both policies are included in the following recommendations.

[12] June 2022 Report to the Congress: Medicare and the Health Care Delivery System—MedPAC

Recommendations

Establish a UAPS that pays the same rates for the same services, regardless of delivery setting.

- As part of this new unified payment system, the Centers for Medicare & Medicaid Services (CMS) will set a base payment rate for the identified services equal to PFS (or ASC payment rate for nine identified services) as of December 31, 2025.
- Such payment shall apply to all providers that currently bill for the included services under the OPPS, ASC payment system, and PFS. This payment shall apply to all rural providers, except for critical access hospitals that use a cost-based reimbursement system, which shall continue as currently implemented. This framework also would not apply to PPS-exempt cancer hospitals.
- CMS may risk adjust the UAPS base payment rate to account for severity of illness and risk of mortality.
- CMS may create targeted adjustments to the risk-adjusted base payment rates to account for geographic factors, wage index, and high-cost outliers; however, such adjustments in total may not increase or decrease a base payment rate for an individual provider by more than 5 percent.
- The UAPS will take effect on January 1, 2026.
- The current payment systems will continue to operate for all other services not included in the UAPS, unless affected by the elimination of the grandfathering provision that was included in Section 603 of the Bipartisan Budget Act of 2015, discussed further below.
- CMS will have the flexibility to engage in rulemaking and comment to expand the services included in UAPS by up to another 20 APC-related services without congressional approval.
- This policy shall be implemented without regard to the budget neutrality adjustments included in the current fee schedules.

Eliminate HOPD grandfathering provision from the 2015 Bipartisan Budget Act.

- Eliminate the grandfathering of certain off-campus outpatient provider-based departments and instead reimburse them at PFS rates beginning January 1, 2026.
- Though many services that are provided in the affected settings will be reimbursed under the new UAPS, this policy will address unfair, higher payments to a limited number of providers for the services not captured in the UAPS.
- This policy shall be implemented without regard to the budget neutrality adjustments included in the current fee schedules.

Estimated budgetary and patient impact:

- $98.4 billion reduction in spending over 10 years (only FFS)
- $23.9 billion reduction in patient cost-sharing over 10 years (only FFS)

PART 2: TARGETED INVESTMENT IN COMMUNITY HOSPITALS

Medicare beneficiaries and policymakers agree that hospitals play an irreplaceable role in their communities, providing lifesaving services to every person, regardless of their background or financial situation. Everyone wants to fully support hospitals in their efforts to fulfill their mission. At the same time, it is critical that policymakers address payment distortions that are driving up costs to Medicare beneficiaries and the Medicare program. In recognition that hospitals billing under both the IPPS and the OPPS would experience reduced reimbursement for some OPPS services under the UAPS, this paper proposes a number of targeted policies, discussed below, that would reinvest dollars in critical IPPS hospitals and services. These policies would ensure that rural, safety-net, and teaching hospitals, along with hospitals that provide trauma and burn care, have the resources they need to fulfill their essential missions.

Recommendations

Increase the base Medicare Severity Diagnosis Related Groups (MS-DRG) market basket.

- In recognition of the concern that inpatient services are generally under-reimbursed, this paper proposes temporarily increasing the IPPS market basket by 1 percent for three years starting January 1, 2026.
- This policy should be implemented without regard to the budget neutrality adjustments in the current fee schedule.
- Estimated budgetary impact: $10 billion in increased spending over 10 years

Community Hospital Support Fund.

- Allocate $5 billion annually for 10 years to the newly created Community Hospital Support Fund, starting in fiscal year (FY) 2026.
- CMS should distribute the funds to each state proportionally based on the agency's projected total reductions in Medicare payments to hospitals in each state under the UAPS.
- States should then distribute their share of the funds in a manner determined by each state to any hospitals therein that meet one of the below definitions:
    - **Rural hospital:** A sole community hospital, Medicare-dependent hospital, rural emergency hospital, rural community hospital, critical access hospital, low-volume hospital, or any PPS hospital located in a state with a population density of fewer than 25 people per square mile. This definition excludes urban hospitals reclassified under Section 1886(d)(8)(E) of the Social Security Act.
    - **Metropolitan anchor hospital:** An acute care hospital paid under the IPPS that is located in a metropolitan statistical area and spent at least 3 percent of its operating expenses in the previous calendar year on charity care as defined by the Internal Revenue Service

Community Hospital Support Fund Continued.

  - **Essential Health System:** An acute care hospital paid under the IPPS that is a non-federal or private nonprofit hospital and met two out of the three following criteria in the previous calendar year, as determined by CMS
    - Disproportionate patient percentage (DPP), which captures a hospital's portion of Medicaid and low-income Medicare beneficiaries, of 35 percent
    - Deemed disproportionate share hospital (DSH) status (or a variation in the instance where a state does not recognize deemed DSH hospitals)
    - Medicare uncompensated care payment factor (UCPF) of at least 0.0005
- Estimated budgetary impact: $50 billion in increased spending over 10 years

Five-year extension of the Acute Hospital Care at Home Program.

- Reauthorize the Acute Hospital Care at Home Program, which allows approved hospitals to provide certain inpatient care services in a patient's home instead of the hospital and be reimbursed at the same inpatient payment rates, for five years.
- The current program is set to expire on December 31, 2024.
- Estimated budgetary impact: No cost, as payment rates under the program are the same regardless of whether the services are provided at home or in an inpatient hospital

Permanent telehealth flexibility extension.

- Permanently extend the same telehealth coverage flexibility under Medicare FFS that was allowed during the COVID-19 pandemic.
- This flexibility is set to expire on December 31, 2024.
- Estimated budgetary impact: $9.9 billion in increased spending over 10 years

Expand Medicare-funded medical residency positions.

- Gradually expand the number of Medicare-funded graduate medical education residency positions by 14,000 over 10 years.
- Require that at least 15 percent of new Medicare-funded residency slots go to rural hospitals (current law is 10 percent).
- Rural hospitals will be defined as sole community hospitals, Medicare-dependent hospitals, rural emergency hospitals, rural community hospitals, critical access hospitals, low-volume hospitals, or any PPS hospitals located in a state with a population density of less than 25 people per square mile. This definition excludes urban hospitals reclassified under Section 1886(d)(8)(E) of the Social Security Act from qualifying, closing a loophole that exists under current law and allows urban hospitals to reclassify as rural hospitals for the purposes of increasing graduate medical education reimbursement.
- Estimated budgetary impact: $14.1 billion in increased spending over 10 years

Extend and expand the Teaching Health Center Graduate Medical Education Program

- Reauthorize the Teaching Health Center Graduate Medical Education Program for five years. The program is set to expire on December 31, 2024.
- Increase the annual appropriation amount to $250 million from $126.5 million.
- Estimated budgetary impact: $1.25 billion in increased spending over 10 years

Direct additional savings to Medicare Part A Hospital Insurance Trust Fund and to deficit reduction.

- $6.575 billion from the estimated remaining savings from implementation of the UAPS should be directed into the Part A Hospital Insurance Trust Fund to assist with Medicare sustainability efforts.
- $6.575 billion from the estimated remaining savings from implementation of the UAPS should be directed to deficit reduction.

PART 3: UNIFIED PAYMENT SYSTEM FOR SIMILAR INPATIENT AND OUTPATIENT SERVICES

The framework includes inpatient policy recommendations that would advance the foundation of a unified payment system for services that can be performed in both inpatient and outpatient settings, while recognizing more work needs to be done prior to implementing such a system. This policy would build off the work already mandated by Congress in Section 15001 of the 21st Century Cures Act[13] and executed by CMS[14] to map out ("crosswalk") which inpatient codes correspond to similar outpatient codes. This approach would create a common reimbursement language for services provided in both inpatient and outpatient settings for a future unified payment system or, if appropriate, potential inclusion in the UAPS. Additional details on this policy, along with other policies to advance analysis in this space, are outlined below. Policies included in this section of the policy framework would have no or minimal impact on the federal budget.

[13] https://www.congress.gov/bill/114th-congress/house-bill/34?q=%7B%22search%22%3A%5B%2221st+Century+Cures%22%5D%7D&s=2&r=22

[14] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

Recommendations

Increase the number of MS-DRGs cross-walked to the Healthcare Common Procedure Coding System (HCPCS).

- Increase the number of surgical MS-DRG codes cross-walked to HCPCS from 10 to 20.
- Add a requirement for CMS to cross-walk 20 medical MS-DRG codes to HCPCS.
- Authorize $5 million in funding to support CMS in carrying out this work, which must be completed by January 1, 2026.
- Sample legislative language for this proposal is as follows:

Amend subsection (t) of Section 1886 of the Social Security Act by:

- Striking "January 1, 2018" in (1) and replacing it with "January 1, 2026;"
- Striking "10 surgical MS-DRGs" in (2) and replacing it with "20 surgical MS-DRGs and 20 medical MS-DRGs;" and
- Adding "(5) Authorization of Appropriations – To carry out this section, there is authorized to be appropriated $5,000,000 for fiscal year 2025."

MedPAC report on current cross-walked codes.

- Require MedPAC to produce a report for Congress on the 10 existing surgical MS-DRG codes cross-walked to HCPCS with recommendations on payment policies tied to such codes.
- The report should be published by March 31, 2025, on the MedPAC website.

MedPAC report on additional cross-walked codes.

- Require MedPAC to produce a follow-up report to Congress on the additional surgical and medical MS-DRG codes cross-walked to HCPCS, with recommendations on payment policies tied to such codes.
- This report should be published by March 31, 2027, on the MedPAC website.

MedPAC study on Inpatient Only List.

- Require MedPAC to conduct a study of the Inpatient Only (IPO) list analyzing utilization rates and quality.
- MedPAC should include an analysis on the future of the IPO list, including recommendations on whether such a list continues to be necessary.
- The report should be published by June 30, 2026, on the MedPAC website.

PART 4: UNIFIED PAYMENT SYSTEM FOR A LIMITED NUMBER OF POST-ACUTE CARE SERVICES

The post-acute care policy recommendation included in the framework aims to advance a unified payment system for post-acute care (UPAC), while recognizing more work needs to be done before broadly implementing such a system. The recommended policy focuses on building the foundation of UPAC by implementing such an approach for a limited number of services commonly provided in IRFs and SNFs, as identified by MedPAC.[15] This policy would generate savings to both the Medicare program and Medicare beneficiaries; however, more modeling must be done to fully understand the complete budgetary impact. Such modeling could naturally lead to additional refinements or considerations for this policy recommendation.

Recommendations

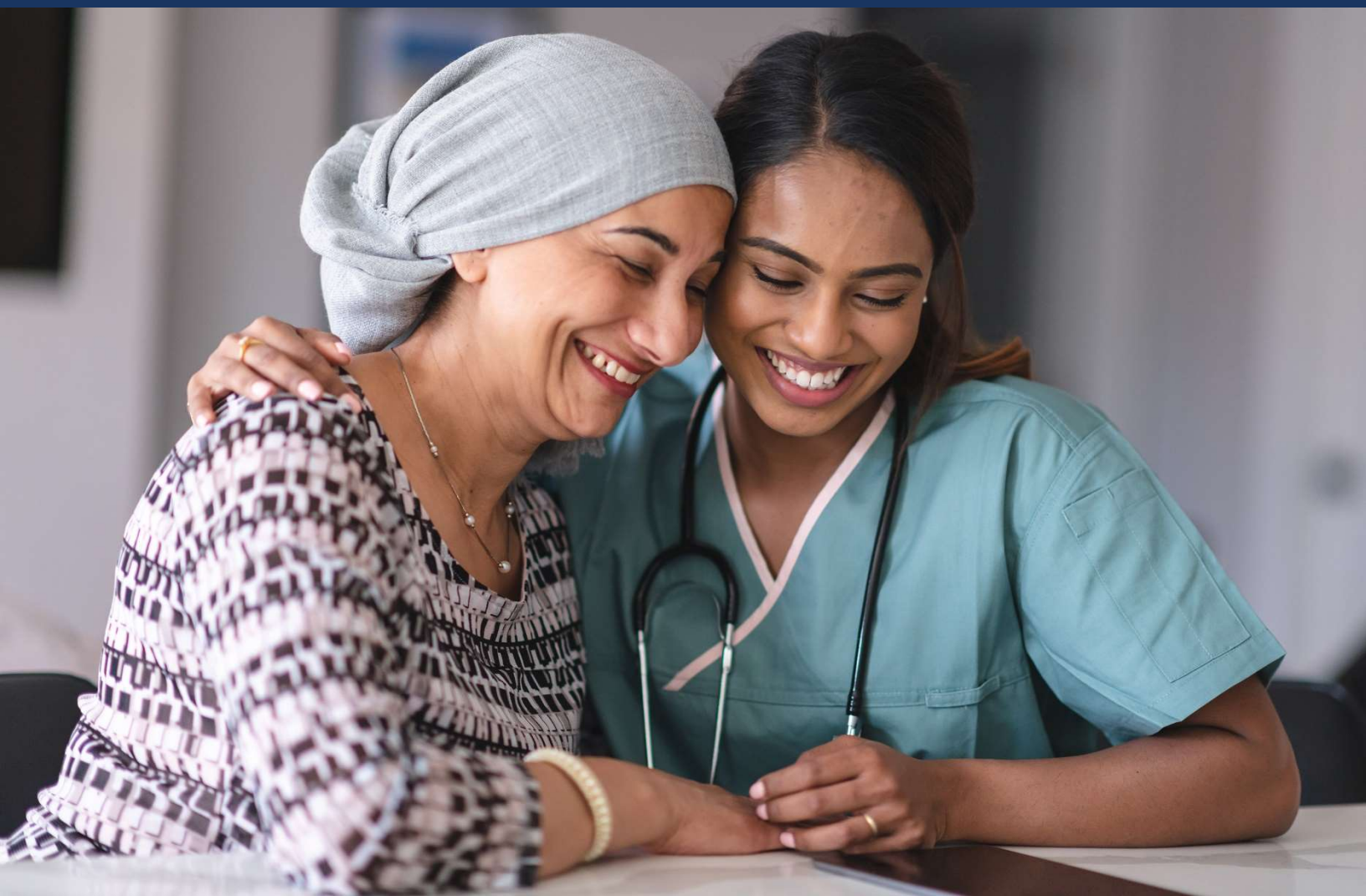
Unified payment for similar therapy and rehabilitation services provided in IRFs and SNFs.

- Direct CMS to create a UPAC for similar therapy and rehab services provided at IRFs and SNFs within 30 days of discharge from an acute care hospital after the following MS-DRGs have been billed (in line with services that MedPAC previously looked at for significant pricing variation):
    - MS-DRG 64 (Stroke with MCC)
    - MS-DRG 65 (Stroke with CC)
    - MS-DRG 66 (Stroke without CC)
- The UPAC base payment rate should be equal to the mean payment amount for IRFs and SNFs under the current fee schedules.
- CMS may risk adjust the UPAC base payment rate to account for severity of illness and risk of mortality.
- CMS may modify the risk-adjusted base payment rates to account for geographic factors, wage index, and high-cost outliers; however, such adjustments in total may neither increase nor decrease a base payment rate by more than 5 percent.
- Such payment system will take effect January 1, 2026.
- The current payment systems will continue to operate for all services not included in the UPAC.
- CMS will have the flexibility to engage in rulemaking and comment to expand the UPAC to include services provided at IRFs and SNFs within 30 days of discharge from an acute care hospital related to an additional five MS-DRGs without congressional approval.
- This policy should be implemented without regard to the current budget neutrality adjustments included in the current fee schedules.

[15] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities.pdf

CONCLUSION

Congress has an opportunity to lower out-of-pocket costs to Medicare beneficiaries, improve the financing of the Medicare program by addressing a payment distortion, and reinvest in hospitals through new targeted funding and inclusion of policy priorities. This policy framework provides a compromise path forward on site-neutral payments that would accomplish all three goals. Hopefully, Congress will consider it as lawmakers debate nuanced health policy priorities during the remainder of 2024.



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