BILL CASSIDY, M.D. U.S. Senator for Louisiana

MAGGIE HASSAN
UNITED STATES SENATOR FOR NEW HAMPSHIRE

LOWERING HEALTH COSTS FOR SENIORS FRAMEWORK

U.S. Senators Bill Cassidy, M.D. and Maggie Hassan are working together on the below policy options for site-neutral payment reform. This paper explores policy options for payment reform that would reduce health care costs for patients and taxpayers, improve the financial stability of Medicare, reduce provider consolidation, and provide assistance to hospitals serving rural and high-needs communities.

INTRODUCTION

The high cost of health care in the United States is a significant burden on families and taxpayers. Three in four adults worry about their ability to afford unexpected medical bills for themselves or their family.[1]

As hospitals expand their ownership of physician practices and outpatient care facilities, patients are increasingly paying high hospital prices in these previously low-cost settings. Under the Medicare program, taxpayers and patients now share the cost of hospital "facility fees" – hundreds of dollars in additional fees which are now being charged when a patient gets basic care, such as a steroid injection or an allergy test. Patients with private insurance are also facing hundreds of dollars in facility fees for basic care, without ever setting foot in a hospital.

While many factors drive health spending, rising health care costs have in part resulted from an increase in consolidation among hospitals and outpatient care settings – such as physician offices and ambulatory centers. While two thirds of doctors practiced independently or in non-hospital settings a decade ago, today at least half of physicians are hospital-employed.[2] At the same time, patients are more frequently receiving care in outpatient facilities, and inpatient admissions to the hospitals are trending downward.

SITE-NEUTRAL OVERVIEW

Many health care services are safely and commonly provided in three different settings: a physician office, an ambulatory surgical center, and a hospital outpatient department. Within the Medicare program, the same procedure is often reimbursed at different rates depending on whether the procedure is performed in a hospital, an ambulatory surgical center, a physician's

[1] Kaiser Family Foundation, "America's Challenges with Health Care Costs", March 2024. https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[2] American Medical Association, Policy Research Perspectives, May 2021. https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf

office, or another setting. The cost of a procedure in a physician office is often doubled if performed in a hospital outpatient department (HOPD), due to the facility fee billed by the hospital. Under Traditional Medicare, patients and taxpayers share the facility fee cost burden (patients typically pay 20 percent cost-sharing for outpatient services).

These cost differentials drive up costs for patients and also increase incentives for provider consolidation, driving up hospital ownership of non-hospital care settings such as physician offices. Consolidation reduces patient choice among providers and drives up overall health care costs for patients in highly consolidated markets.[3]

Further, evidence suggests that the payment differences between these settings are not based on differences in care quality, and often create distorted incentives for providers to bill services in the highest-cost setting.[4] The Centers for Medicare & Medicaid Services, the Government Accountability Office (GAO), and the Medicare Payment Advisory Committee (MedPAC) have all found that for many low-acuity procedures, these different reimbursement rates do not reflect real differences in the quality of a procedure or the provider's cost of performing a procedure.

MedPAC and GAO have recommended for nearly a decade that Congress improve the financial stability of the Medicare program and control patient costs by re-balancing Medicare reimbursement rates to reflect the actual value and cost of providing basic care. Congress attempted site-neutral payment reform through the Bipartisan Budget Act of 2015, which included a provision requiring off-campus locations of a hospital to receive reimbursement at the physician or ambulatory rate. However, most hospitals were exempted from the 2015 law, meaning that most hospital-owned physician offices continue to bill Medicare and patients under the hospital rate.[5]

Hospitals have raised concerns about the possible impact of site-neutral payments for rural providers and other providers that rely on a high proportion of Medicare and Medicaid reimbursement. MedPAC has previously reported wide variation in the margins that hospitals make on Medicare reimbursement.

To better understand and address the impacts of payment reforms on more vulnerable hospitals, staff held a series of discussions with providers and provider associations, including by posing a series of questions about the unique challenges that they face in providing care in their communities and for their patient populations.[6] Staff collected feedback from provider groups on how current Medicare designations and reimbursement methods could be improved to better support rural hospitals and hospitals that rely disproportionately on public payers. These discussions helped inform the policy options presented below.

[3] Medicare Payment Advisory Commission, March 2020 Report to Congress on Medicare Payment Policy, Chapter 15: Congressional request on health care provider consolidation. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf

[4] Government Accountability Office, GAO-16-189: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform, https://www.gao.gov/assets/d16189.pdf

[5] Bipartisan Budget Act of 2015, Section 603: https://www.congress.gov/114/plaws/publ74/PLAW-114publ74.pdf

[6] The discussion questions are available upon request.

Below are policy options for two site-neutral payment reforms, followed by options for reinvesting the savings from site-neutral reforms in rural and high-needs hospitals. Tables 1 and 2 then provide analysis of the effect of these policy options on hospitals and on patients.

SITE-NEUTRAL REFORMS

1. Establish Site-Neutral Payments in Off-Campus Hospital Outpatient Departments

The Bipartisan Budget Act of 2015 included a provision that would implement site-neutral payment in some HOPDs at rates comparable to physician rates, but the legislation excluded these rates from applying to facilities that existed or were under construction at the time of passage. Recent estimates suggest that the 2015 law had a negligible effect on Medicare outpatient spending, impacting less than 1 percent of all Medicare outpatient claims.[7]

Policy Option: Eliminate the grandfathering exception included in the Section 603 of the Bipartisan Budget Act of 2015, extending the site-neutral payment policy to all hospital-owned sites of care away from the hospital's main campus.

2. Establish Site-Neutral Payments for Common Outpatient Services

The Medicare Payment Advisory Commission has proposed to reimburse services commonly provided outside of the hospital at one rate under Medicare, as opposed to the current system, which reimburses at different rates based on the site of care. This reform would impose the lower non-hospital rate – physician or ambulatory – for services that are most commonly performed in either a physician or ambulatory setting. For example, MedPAC has identified one method of identifying services that are most commonly performed in the freestanding office setting.[8]

Policy Option: Require the Secretary of Health and Human Services to identify procedures that are safely and commonly performed in a hospital setting, ambulatory surgical center, or physician office. The Secretary would review four years of data and determine the setting where each procedure was most commonly performed. The Secretary would then set the reimbursement rate according to the site where the procedure was most commonly performed.

HOSPITAL REINVESTMENT

Along with Policy Option 2, we propose a scalable model for reinvesting in rural and safety net hospitals through Medicare. The options below include two definitions – one for rural hospitals, and one for high-needs hospitals – and two possible reinvestment mechanisms.

Based on staff analyses of claims data and discussions with provider groups, Policy Option 1 would not have a substantial impact on the overall revenues of rural and high-needs hospitals.

DEFINING RURAL HOSPITALS

This reinvestment mechanism would assist hospitals that serve our rural communities. Many rural hospitals across the country are facing financial difficulties. According to a 2024 report

[7] Medicare Payment Advisory Commission, June 2022 Report to Congress on Medicare and the Health Care Delivery System, Page 165; https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/

[8] Medicare Payment Advisory Commission, June 2022 Report to Congress on Medicare and the Health Care Delivery System, Page 162; https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/

from the Center for Healthcare Quality and Payment Reform, more than 100 rural hospitals have closed in the past decade and more than 700 rural hospitals are at risk of closing because of serious financial problems.

The Senate Finance Committee held a hearing on rural health care stability, during which witnesses testified that rural hospital closures are partially driven by low patient volume in rural areas; by financial losses during the pandemic that depleted hospital reserves; and by relatively lower reimbursement rates from public payers for certain services, such as obstetrics. As financial pressures continue to build for low-volume and geographically isolated hospitals, Medicare reimbursement rates can be used to improve the stability for unprofitable lines of service that are critical to communities.

We have identified three designations that capture most rural-serving hospitals across the country, and under this reinvestment mechanism these hospitals would receive additional reimbursement for the Medicare services that they provide:

1. Sole Community Hospital;
2. Low-Volume Hospital;
3. Medicare-Dependent Hospital

DEFINING HIGH-NEEDS HOSPITALS

This reinvestment mechanism would also assist designated high-needs hospitals. Eligible hospitals would be located in urban or suburban areas and would have a dedicated emergency room.

Additional metrics could be used to narrow the hospitals that qualify for reinvestment, to target those hospitals that are most reliant on revenue from public payers and from uncompensated care programs. Possible metrics include:

- Percentage of total payer mix from public payers, charity care, and bad debt;
- Percentage of dual eligible inpatient days as a percentage of total inpatient days; or
- Total uncompensated care per bed above a certain amount

Another possible condition to qualify as a high-needs hospital could be a hospital located in a county or parish with a high number of major disaster declarations.

REINVESTING IN CORE LINES OF SERVICE

Rural and safety net hospitals are sometimes the sole provider in a community of essential health services such as maternity care, psychiatric care, and emergency services. Many essential services are critical to a community but are not profitable for hospitals, and costly services are often scaled back or eliminated when hospitals face financial shortfalls.

Services like maternity care and emergency psychiatric services are often extremely valuable to local communities, but very labor- and time-intensive, posing a financial challenge for hospitals that are low-volume. This reinvestment mechanism would provide an incentive for all hospitals

to keep these essential services operational by creating an additional Medicare reimbursement bonus for hospitals that operate the following:

- Level I or Level II Trauma Center
- Obstetrics Department
- Burn Unit
- Neonatal Intensive Care Unit
- Emergency Psychiatric Services

VALUE-BASED REIMBURSEMENT

This reinvestment mechanism would use Medicare alternative payment models to provide a transitional benefit to hospitals during the implementation of site-neutral payments.

Some alternative payment models run by the CMS Innovation Center allow participants to join a one-sided risk contract with the Medicare program, where they must meet specific quality and spending benchmarks in exchange for a payment bonus at the end of the year. Other alternative payment model participants join a two-sided risk contract with the Medicare program, where providers either share in the savings that they create for the Medicare program, or assume financial responsibility for any excess costs to Medicare.

Two options are discussed below that would encourage hospitals to move into two-sided risk models. These options focus on two-sided risk models rather than one-sided risk models because two-sided financial risk increases provider accountability for their Medicare patient outcomes and for their Medicare costs.

Alternative Payment Model Option 1: Allow a hospital that is currently in a two-sided risk advanced alternative payment model, or one that enters a such a model, to receive an increase in reimbursement, or a higher capitated payment rate per member per month payment. Alternatively, hospitals could receive a payment adjustment for the share of inpatient days for patients attributed to any alternative payment model.

Alternative Payment Model Option 2: Provide rural and safety net hospitals with an opportunity to enter a new accountable care model that sets their Medicare spending benchmark based on the time period before the enactment of site-neutral payments. The model would start out as one-sided risk in the first two years, allowing hospitals to recoup some outpatient revenues if they meet basic quality and performance standards (based on the standards in MSSP.) The model would transition to two-sided risk in the following years, and the benchmark would phase out the pre-site-neutral time period.

TABLE 1. RURAL AND HIGH NEEDS HOSPITAL CASE STUDY

	Designations	Essential Services	Total Outpatient Department Revenues from Medicare [9]	Estimated Impact on Revenues – Site-neutral for Off-Campus Hospital Outpatient Departments [10]	Estimated Impact on Revenues – Site-neutral for On-Campus Hospital Outpatient Departments [11]	Reinvestment Total [12]	Cumulative Impact of Site Neutral on HOPDs + Reinvestment (% of outpatient revenues)
HOSPITAL A *Large Urban Medical Center in the Southwest*	High-Needs Hospital	• Level 1 Trauma Center • Obstetrics • Burn Unit • NICU	$29,453,287	-$305,798	-$4,281,737	$4,123,460	-$464,074 (1%)
HOSPITAL B *Mid-Size Urban Medical Center in the Pacific Northwest*	High-Needs Hospital	• Level I Trauma Center • Obstetrics • Burn Unit	$11,133,222	-$77,301	-$1,391,105	$1,224,654	-$243,751 (2%)
HOSPITAL C *Large Rural Medical Center in the Southeast*	Rural Hospital (Sole Community Hospital)	• Obstetrics	$49,461,095	$0	-$4,418,180	$5,440,720	+$1,022,540 + 2%
HOSPITAL D *Small Rural Medical Center in Northern New England*	Rural Hospital (Sole Community Hospital)	• Obstetrics	$6,553,465	$0	-$702,807	$720,881	+$18,074 + less than 1%

[9] Data Source: Analysis of CMS Limited Data Set Calendar Year 2022
[10] ibid
[11] ibid
[12] 10 percent of total outpatient revenues from Medicare, plus an additional 1 percent reinvestment for each core line of service.

TABLE 2. ESTIMATED COST TO PATIENTS AND TO MEDICARE OF AN ANESTHETIC INJECTION (NERVE BLOCK) BY SITE-NEUTRAL POLICY OPTION

	Off-campus services		*On-campus services*	
	At independent doc office	**At hospital-owned doc office**	**At hospital outpatient department**	**When admitted to the hospital**
STATUS QUO	Medicare: $79 Patient: $19	Medicare: $562 Patient: $140 *Includes $644 facility fee*	Medicare: $562 Patient: $140 *Includes $644 facility fee*	Medicare: $562 Patient: $140 *Includes $644 facility fee*
Injection cost under a site-neutral reform limited to off-campus hospital outpatient departments	Medicare: $79 Patient: $19	Medicare: $79 Patient: $19	Medicare: $562 Patient: $140 *Includes $644 facility fee*	Medicare: $562 Patient: $140 *Includes $644 facility fee*
Injection cost under a site-neutral reform inclusive of on-campus hospital outpatient departments	Medicare: $79 Patient: $19	Medicare: $79 Patient: $19	Medicare: $79 Patient: $19	Medicare: $562 Patient: $140 *Includes $644 facility fee*

Note: Patient contribution is calculated for a beneficiary covered by Original Medicare paying standard 20% coinsurance for Part B services after meeting their deductible, per CMS: See https://www.medicare.gov/basics/costs/medicare-costs (Subheader: Part B (Medical Insurance) costs)

Sources: Centers for Medicare & Medicaid Services, "Hospital Outpatient Prospective Payment—Notice of Final Rulemaking with Comment Period (NFRM), CY 2023", Addenda; Center for Medicare & Medicaid Services, Procedure Price Lookup Tool, HCPS Code 64420; https://www.medicare.gov/procedure-price-lookup/; As cited in Yale Tobin Center for Economic Policy, "Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program", Page 6. https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf