

# Examining the Impact of Site Neutral Payment on Costs for Cancer Care



## Key Findings

There are persistent trends of growth in Medicare Part B spending and acquisitions of independent physician practices. One driver of these trends is differential rates paid for the same services provided in different settings of care. Under existing reimbursement policies, hospital outpatient departments (HOPDs) are paid significantly more than independent physician practices for the same service. Policymakers have explored whether site neutral payments should be expanded under Medicare for outpatient services. A review of Medicare costs for services a hypothetical breast cancer patient receives in a calendar year found that:

- Services provided in HOPDs were reimbursed at a rate that was 3 times higher than services provided in a physician office setting;
- Certain services provided in HOPDs were reimbursed at rates that were more than 5-6 times higher;
- The hypothetical patient would have experienced a \$1,500 reduction in out-of-pocket (OOP) costs over the course of a year if site neutral payment had been implemented;
- Medicare Part B spending would have been \$7,750 less if site neutral payment were in place; and
- Targeted site neutral payment reforms could lower both patient OOP costs and overall Medicare Part B spending.

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## Introduction

Medicare reimbursement to providers for outpatient care varies by setting. Providers are reimbursed for their services under the Medicare Physician Fee Schedule (MPFS), a system that assigns payment based on 3 primary components: practice expense, physician work, and professional liability insurance costs. Furthermore, the MPFS establishes differential rates for services provided in non-facility settings versus facility settings, recognizing that services in a non-facility setting must be higher to account for overhead and equipment costs. When providers deliver services in an outpatient hospital setting, they are paid under the Outpatient Prospective Payment System (OPPS) using ambulatory payment classifications (APCs)<sup>1</sup> to make standard payments for services with similar levels of resource-intensity.

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<sup>1</sup> Medicare groups items and services into APCs based on their similarities both clinically and in terms of resource use.

Under the current reimbursement system, Medicare pays higher rates for services provided in HOPDs than services provided in physician offices, because HOPDs may qualify for both the OPFS payment for a service plus the MPFS payment (facility-based rate) for physician work.<sup>2</sup> This approach is generally justified under the reasoning that HOPDs have different resource needs compared to physician offices, including higher facility and labor costs. However, higher payments made to HOPDs may encourage hospitals to acquire physician practices, resulting in higher Medicare spending and beneficiary cost sharing.<sup>3</sup> From 2019-2021, hospitals acquired 36,200 physician practices and by January 2022, hospitals and similar corporate entities owned almost 54% of physician practices.<sup>4</sup>

In response to concerns from healthcare stakeholders and federal policymakers around site-based payment disparities, Congress passed the Bipartisan Budget Act (BBA) in 2015 to address spending limits for government programs funded by appropriations and also created payment parity (i.e., site neutrality) between off-campus provider-based departments (PBDs) and physician practices.<sup>5</sup>

While the law required services at some sites to be paid in a site neutral manner, it exempted many providers from site neutrality such as off-campus PBDs that were established prior to the law's passage including PPS-exempt dedicated cancer centers.

To evaluate the effects of these disparate payments, ACS CAN examined the effect that expanding site neutral payments to a broader list of services would have on Medicare program spending and beneficiary OOP liability. In particular, ACS CAN measured potential savings that could accrue to a hypothetical patient with breast cancer if certain services that could be safely provided in either physician offices or HOPDs were paid at the same rate (i.e., at the facility-based MPFS rate).

## **Background: Prior Site Neutrality Policy Actions**

In 2015, Section 603 of the BBA directed the Centers for Medicare and Medicaid Services (CMS) to pay the same rates to off-campus PBDs and independent physician offices for outpatient services using the MPFS non-facility rate. In 2017, CMS finalized the rules to operationalize Section 603 and reduced reimbursement for certain off-campus PBDs to 40% of the OPFS rate. The intent was to equalize payments between

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<sup>2</sup> Note: HOPDs are units within hospitals that provide services to patients who are not admitted for an overnight stay.

<sup>3</sup> Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending. Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler. *Health Affairs* 2014 33:5, 756-763. Available [Here](#).

<sup>4</sup> Physicians Advocacy Network. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021. April 2022. Available [Here](#).

<sup>5</sup> The term "provider-based departments" is the term utilized in the legislation. However, the term "hospital outpatient department" is the more commonly-used terminology.

the outpatient and physician office settings for a few services. However, the regulations did not apply to on-campus sites (i.e., HOPDs) or off-campus PBDs that billed services under the OPSS prior to November 2, 2015, encompassing all off-campus PBDs at the time of the BBA's passage.

In essence, CMS's policy restricted new off-campus PBDs from charging more for the same services rendered in physician offices. Additionally, the policy excepted physician practices bought and incorporated into grandfathered off-campus PBDs, minimizing its effect on slowing hospital acquisitions of physician practices. As a result, in recent years, CMS has implemented regulations to pay for certain services in a site neutral fashion.<sup>6</sup>

In 2019, CMS finalized a proposal to apply the MPFS rate for clinic visits (G0463) provided at off-campus PBDs reimbursed under OPSS. CMS phased-in the policy over 2 years, where excepted off-campus PBDs were reimbursed at 70% of the OPSS rate in 2019 and 40% of the OPSS rate in 2020 and beyond. In 2023, CMS finalized a proposal to exempt rural sole community hospital off-campus PBDs from site neutrality requirements.

Site neutrality has been the subject of discussion due to federal policymaker interest in reducing Medicare spending, physician interest in being compensated similarly for comparable work, and patient advocate interest in ensuring that patients can choose the best site of care. In response to increasing interest in site neutrality from federal policymakers, providers, patients, and other stakeholders, the Medicare Payment Advisory Commission (MedPAC) analyzed the effects of site neutrality. In MedPAC's June 2023 Report to Congress, the commission identified 57 APCs where OPSS payment rates could be aligned with MPFS payment rates.<sup>7</sup> MedPAC recognized that some patients do require HOPD care and limited their policy design to services that are commonly and safely provided in physician offices. In this report, MedPAC commissioners recommended that Medicare align fee-for-service (FFS) payment rates based on the resources needed to care for patients in the most cost-efficient site of care.

MedPAC's reports are part of a broader policymaker interest in site neutrality. For example, in 2023, the House Energy and Commerce Committee held a hearing on legislation that would implement site neutral payments similar to the MedPAC approach and the House Ways and Means Committee held a hearing to consider site neutral payment reforms for certain drug administration services. As concerns over patient costs and Medicare spending grow, it is likely Congress will continue to assess site neutrality policies to lower federal spending and slow provider consolidation. The

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<sup>6</sup> Critical Access Hospitals (CAHs) and some other rural providers are not paid under the OPSS and thus would not be subject to site-neutral payment policies.

<sup>7</sup> Medicare Payment Advisory Commission. June 2023 Report to the Congress: Medicare and the Health Care Delivery System. June 2023. Available [Here](#).

policies being explored could have a substantial financial effect on cancer patients given their higher utilization of drug infusion services, frequent visits to oncologists to manage treatment, and geographic diversity.

## Methodology

To determine how site neutral payment policies would influence Medicare spending and patient OOP costs, ACS CAN developed a hypothetical patient profile, based on actual service utilization and real patient experiences, for an individual with original (FFS) Medicare coverage who is diagnosed and treated for breast cancer during a calendar year.

Using the patient profile, ACS CAN calculated the difference in overall healthcare costs and patient OOP costs over 1 year. Over the course of that year, the hypothetical patient would receive the following services and treatments:

- Diagnosis: Diagnostic mammogram, chest CT scan, PET/CT scans, HR/PR/HER2 testing, breast MRI, bloodwork, specialist visits;
- Chemotherapy: Treatment with 4 chemotherapy drugs: liposomal doxorubicin (4 cycles), paclitaxel (4 cycles), gemcitabine (4 cycles), and eribulin (1 cycle); and
- Monthly visits with an oncologist.

Of all the services the hypothetical patient received in a year, ACS CAN identified which services could be provided in either a HOPD or physician office and could be influenced by site neutral payment policies using MedPAC's recommended list of 57 APCs that should qualify. For each service, ACS CAN determined the rates listed for each code and corresponding reimbursement amount from CMS under the Calendar Year (CY) 2023 MPFS and payment under the CY 2023 OPFS (using the Addendum B file).

Based on the hypothetical patient journey over 1 year, ACS CAN calculated total payment using the national payment amount in the physician office versus the HOPD setting and calculated differences between the rates. The profile ACS CAN developed assumed the standard 20% patient cost sharing for all services including drug administration and office visits under Medicare Part B. This assessment does not account for supplemental insurance such as Medigap.

## Results

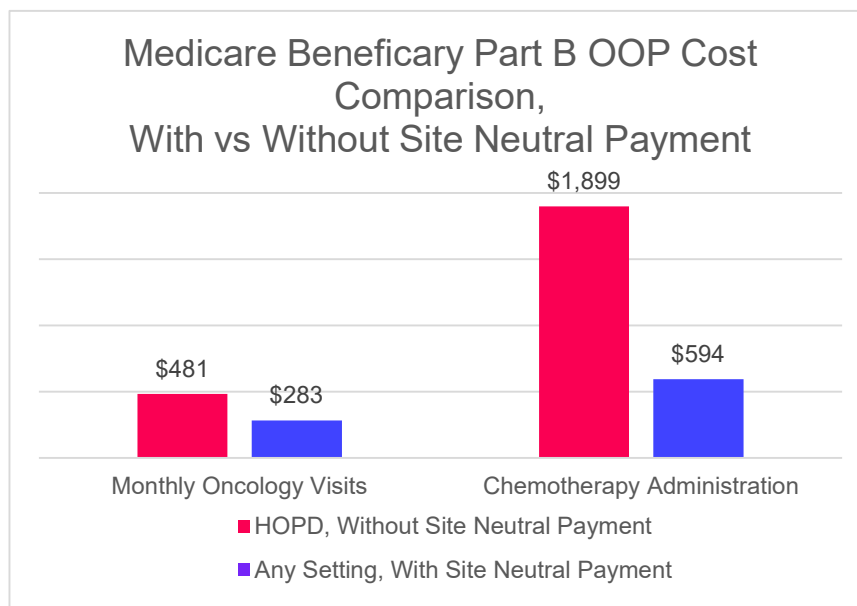
The analysis found that services provided in HOPDs were reimbursed at considerably higher rates than services provided in physician offices, as expected. Some services were paid at a rate more than 6 times higher than in the HOPD setting compared to a physician office setting. In fact, the analysis of services the hypothetical patient received that were subject to site neutral payment found that those services were on average reimbursed at rates 3 times higher in HOPDs compared to physician offices.

**Table 1:** HOPD Versus Physician Office Reimbursement for Select Cancer Treatment Services, CY 2023

CPT Code	Description	Physician Office Reimbursement	HOPD Reimbursement	Ratio HOPD:PO
96413	Chemotherapy administration, IV infusion	\$132.16	\$332.62	2.52
96365	Therapeutic, prophylactic, and diagnostic Infusion	\$ 64.72	\$ 206.57	3.19
96374	Therapeutic, prophylactic, or diagnostic injection; IV push	\$ 37.61	\$ 206.57	5.49
96360	IV Infusion, hydration	\$ 32.87	\$ 206.57	6.28

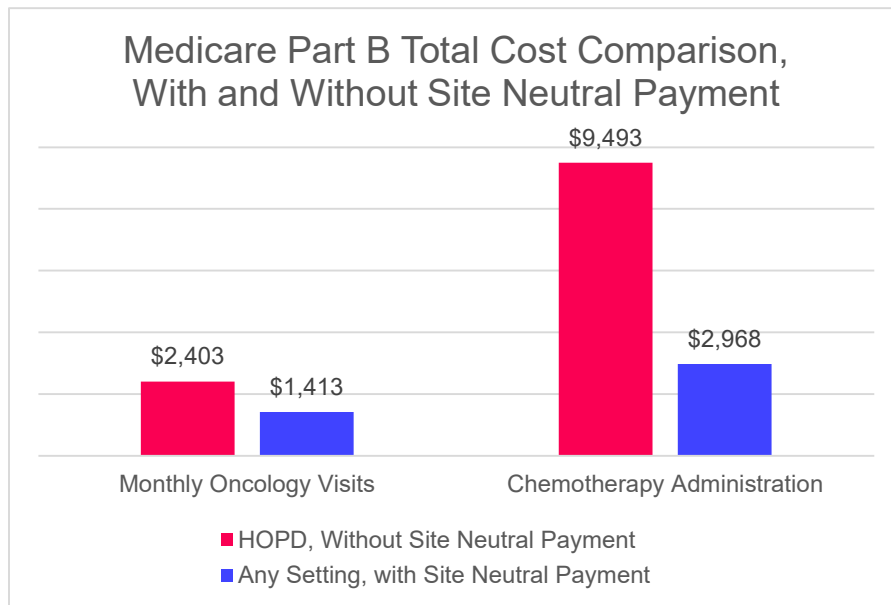
ACS CAN found that applying site neutral payment for the services received in a calendar year resulted in substantial OOP cost savings, as well reductions in Medicare spending. Figure 1 shows the difference in OOP costs for 4 rounds of chemotherapy treatment administrations and annual costs of monthly oncology visits. Based on all Medicare Part B-covered cancer services provided to the patient during the year, the hypothetical patient would have paid a total of \$1,550 less in OOP costs if MedPAC’s site neutral payment recommendations had been implemented. This reduction would come largely from savings on the chemotherapy administration services.

**Figure 1:** Patient OOP Cost Comparison, With and Without Site Neutral Payment, CY 2023



As noted below in Figure 2, the analysis also determined that applying site neutral payments for the services the patient received would result in lower Medicare Part B program spending. Among all services analyzed, the total Medicare FFS cost reduction (Medicare and patient liability combined) from the site neutral payment policy was \$7,750. These savings mainly accrue from more than \$6,500 in savings on chemotherapy administration services.

**Figure 2:** Medicare Part B Total Cost (Medicare and Patient Liability) Comparison, With and Without Site Neutral Payment, CY 2023



## Conclusion

Site neutral payment reform is a promising option for reducing patient OOP costs and lowering Part B spending. For cancer patients, site neutral payments potentially reduce OOP costs for their cancer care and provide greater flexibility in terms of where the patient chooses to get services—whether a physician office or a HOPD. Payment policies should not create incentives that push patients into higher cost settings when the same care can be provided in a lower cost, often preferable, site of care. Payment policies should also recognize the unique services provided by cancer centers – particularly for higher risk patients – and retain the current exemption for PPS exempt dedicated cancer centers.

The reduced Medicare spending rates resulting from site neutral payments could not only save the Medicare program money but could potentially positively influence Part B premiums which are based on 20% of program spending, the costs of supplemental coverage, and costs for Medicare Advantage. It is important that patients can access

care in the setting of their choosing and potentially decrease patient transportation burdens.

As policymakers consider site neutral payment reforms, they should account for the burdens cancer patients face. Policymakers should consider the unique burden and severe costs that may be incurred in the course of treatment and seek reforms that preserve freedom of choice and lower costs.

*This report was developed by Avalere Health, LLC.*