Site Neutral Payment Policies for Ambulatory Services

Introduction

Total Medicare expenditures are projected to exceed $1 trillion in 2023 and grow at an average rate of 7.8% per year from 2025 to 2031.[1] Federal health policymakers, including Congress, are looking for ways to rein in spending and encourage cost efficiencies. One policy proposal receiving considerable attention is addressing site neutral payments in Medicare. Enacting such "site neutral" payment policies would have a meaningful impact on healthcare providers' finances and lead to reductions in Medicare payment rates for selected services and sites of care.

Background

Site neutral payments are not a new concept. The Deficit Reduction Act of 2005 capped physician payments for the technical component of imaging services at the rate paid to outpatient hospitals, substantially slowing the growth of imaging studies in independent diagnostic testing facilities.[2] The Bipartisan Budget Act of 2015 equalized payments for services furnished at many off-campus hospital outpatient departments to the amounts paid for those services when furnished in a physician's office or ambulatory surgical center.[3]

In April 2023, the US House of Representatives Energy and Commerce Health Subcommittee held a legislative hearing on various health policy proposals, including one that was heavily based on MedPAC's site neutral payment recommendation. That proposal would have reduced Medicare hospital outpatient department (HOPD) and ambulatory surgical center (ASC) payment rates for selected services, leading to a cut of more than $7 billion per year in Medicare payments if fully implemented. The proposal was withdrawn, but Committee Chair Cathy McMorris Rodgers (R-WA) noted that Medicare should not subsidize hospital services "by making patients and Medicare overpay on certain services." She stated her commitment to considering site neutral payment policies in the near future, thereby leaving the door open for similar legislation later this year.[4,5] Congress has since advanced a more narrow site neutral payment policy in the Lower Costs, More Transparency Act. Section 203 of that bill would reduce Medicare Part B payment rates for drug administration services provided at certain off-campus HOPDs to the rate paid in physician offices.

[1] Keehan SP, Fiore JA, Poisal JA, Cuckler GA, Sisko AM, Smith SD, Madison AJ, Rennie KE. "National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends." Health Aff(Millwood). 2024;42(7):886–898.

[2] MedPAC. June 2011 Report to Congress, Chapter 2. "Improving payment accuracy and appropriate use of ancillary services." See page 32. Accessed Jan 2024.

[3] MedPAC has also recommended site neutral payment proposals in the past. See their 2014, 2016, 2017, and 2018 recommendations.

[4] Michelle M. Stein, "E&C Panel Passes Site-Neutral Pay for Rx Administration, McMorris Rodgers Says More Coming." Inside Health Policy, May 17, 2023.

[5] Site neutral payments are an important political issue to many stakeholders. The American Hospital Association and the Federation of American Hospitals are advocating against site neutral payment rate cuts while other groups such as the physician-led Committee to Protect Health Care, are advocating for site neutral payment reforms.

MedPAC's June 2023 Site Neutral Payment Proposal for Ambulatory Services

MedPAC's proposal would more closely align payment rates for individual ambulatory payment classifications (APCs) based on the site of care where the APC is most commonly performed:

- If procedures within an APC are most commonly performed in the ASC, MedPAC recommends that Medicare payment rates for HOPDs for all services in that APC be aligned with the ASC payment rate.
- If procedures within an APC are most commonly performed in the physician office, MedPAC recommends that Medicare HOPD and ASC payment rates for all services in that APC be aligned with the physician office payment rate.
- If procedures within an APC are most commonly performed in the HOPD, there would be no change to Medicare payment rates for the HOPD, ASC, or physician office.

What is an APC?

All healthcare services are classified by a CPT or HCPCS code. Medicare pays for services provided in a physician office at the CPT or HCPCS code level.

In HOPDs, Medicare groups CPT/HCPCS codes into APCs on the basis of clinical and cost similarity. All CPT/HCPCS codes within an APC have the same Medicare outpatient payment rate.

MedPAC identifies 66 APCs that would be subject to site neutral payment cuts based on its methodology:

- 57 APCs where services are predominantly performed in the physician office. MedPAC recommends that HOPD and ASC payment rates be aligned with physician office payment rates for these services.
- Nine APCs where services are predominantly performed in the ASC. MedPAC recommends that HOPD payment rates be aligned with ASC payment rates for these services.

MedPAC provides an example of how site neutral payments would be aligned using 2023 Medicare prices for CPT® code 62323,[6] which is used to report injection of medicine into the space around the spine. MedPAC recommends reducing the HOPD payment rate to ensure that the sum of the physician facility payment rate and the HOPD payment rate is equal to the payment rate for CPT code 62323 when performed in a physician office, as shown in Table 1 below.[7]

[6] Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

[7] Although not shown in the example in table 1, MedPAC recommends recalculating the APC weights and making other adjustments. Therefore, actual APC rates may not be equal to physician rates for the same services. More detail on MedPAC's approach to recalculating APC weights for APCs subject to site neutral payment cuts can be found in MedPAC's June 2023 Report to Congress, Chapter 8. "Aligning fee-for-service payment rates across ambulatory settings."

Table 1: Illustration of 2023 Medicare Payments for CPT Code 62323 Under Current Policy, and as Revised Under MedPAC's Site Neutral Proposal

	2023 Payment Rates for CPT Code 62323		
	Performed in Office	**Performed in HOPD**	**MedPAC Proposal when Performed in HOPD**
Physician Work	$59.51	$59.51	$59.51
Practice Expense	$190.43	$31.08	$31.08
Professional Liability	$5.95	$5.95	$5.95
Total Physician Payment	**$255.89**	**$96.54**	**$96.54**
HOPD Payment	$0.00	$644.34	$159.35
Total Medicare Payment	**$255.89**	**$740.88**	**$255.89**

Source: Adapted from MedPAC. June 2023 Report to Congress, Chapter 8. "Aligning fee-for-service payment rates across ambulatory settings." See Table 8-4, page 365.

MedPAC identified APCs for site neutral payment rate cuts using Medicare fee-for-service (FFS) claims data for 2016 – 2019 and 2021, omitting 2020 data because of the COVID-19 pandemic's impact on patient volumes in ambulatory settings. For each APC, MedPAC determined the volume of services billed in the HOPD, ASC and physician office settings.

McDermottPlus performed a similar analysis using 2017 – 2019 and 2021 – 2022 Medicare FFS claims data. We found that most of the APCs originally identified by MedPAC for a site neutral payment cut continue to have most of their volume in the ASC or physician office setting. As an example, for APC 5373, Level 3 Urology and Related Services:

- 45% of total units are billed in the physician office,
- 41% of total units are billed in HOPDs, and
- 14% of total units are billed in ASCs.

The dominant site of service for APC 5373 is the physician office. This is primarily driven by two high-volume CPT codes 55700, *Biopsy of prostate*, and 52310, *Cystoscopy and treatment*, for which 57% and 65% of total volumes, respectively, are performed in the physician office.

Under MedPAC's proposal, all CPT codes that map to APC 5373 would be subject to a site neutral payment rate reduction when performed in the HOPD or ASC setting. This includes CPT codes that map to the APC 5373 even though they are predominantly performed in the HOPD setting.

As an example, CPT code 50387[8], which is used to report removal and replacement of a ureter stent, is performed in the HOPD nearly 99% of the time and was responsible for almost $8 million in Medicare HOPD spending in 2022. Under MedPAC's proposal, CPT code 50387 would be subject to a site neutral payment rate reduction because it maps to APC 5373, which in aggregate is predominantly performed in the

[8] Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation

physician office. See Table 2 below for the impact to the HOPD payment rate for CPT code 50387 under MedPAC's proposal.

Table 2: Illustrative Payment Rate Example for CPT Code 50387

	2024 Payment Rates for CPT Code 50387		
	Performed in Office	**Performed in HOPD**	**MedPAC Proposal when Performed in HOPD**
Physician Work	$57.30	$57.30	$57.30
Practice Expense	$468.90	$16.04	$16.04
Professional Liability	$5.89	$5.89	$5.89
Total Physician Payment	**$532.09**	**$79.23**	**$79.23**
HOPD Payment	$0	$1,940.66	$452.86
Total Medicare Payment	**$532.09**	**$2,019.89**	**$532.09**

The top portion of Table 3 below provides additional examples of CPT codes that are predominantly performed in the HOPD but would be subject to a site neutral payment rate reduction under MedPAC's proposal. The bottom portion of Table 3 shows CPT codes that cause APC 5373 to be most commonly performed in the aggregate in the physician office.

Table 3: Key Procedures that Map to APC 5373

		Medicare FFS Total for 2022			
CPT Code	**Short Description**	**Total HOPD Payments**	**HOPD Units Billed**	**Office & ASC Units Billed**	**% Units Billed in HOPD**
Selected codes that map to APC 5373 that are most commonly performed in the HOPD					
50435	Exchange nephrostomy cath	$47,309,608	137,473	2,760	98%
52204	Cystoscopy w/biopsy(s)	$25,858,627	106,647	51,320	68%
51102	Drain bl w/cath insertion	$13,649,806	43,450	9,620	82%
52005	Cystoscopy & ureter catheter	$10,976,335	79,437	39,280	67%
50432	Plmt nephrostomy catheter	$9,413,388	29,776	680	98%
50387	Change nephroureteral cath	$8,012,731	21,826	260	99%
Selected codes that map to APC 5373 that are most commonly performed in the physician office					
55700	Biopsy of prostate	$83,109,130	199,735	557,080	26%
52310	Cystoscopy and treatment	$36,106,005	113,562	345,740	25%
52287	Cystoscopy chemodenervation	$35,975,328	91,853	178,360	34%
52281	Cystoscopy and treatment	$18,343,666	61,653	232,240	21%

Source: McDermottPlus analysis of Medicare 100% outpatient and 5% carrier claims data for 2022. Results from the 5% carrier data are extrapolated to represent the full Medicare FFS population.

Key Services That Would Be Subject to MedPAC's Site Neutral Payment Policy

McDermottPlus identified services that would be subject to a payment rate cut under MedPAC's proposed methodology. For display purposes below, we show services potentially subject to a site neutral payment rate reduction:

- Where more than 95% of all units are billed in the HOPD using 2017– 2019 and 2021– 2022 Medicare FFS claims data, and
- Have more than $1 million in Medicare FFS HOPD revenue in 2022.

The top 10 codes by total Medicare outpatient revenue are provided in Table 4 below.

Table 4: Top 10 HOPD Services MedPAC Recommends for Site Neutral Payment Rate Reduction

		Medicare FFS Total for 2022			
HCPCS/ CPT Code	Short Description	Total HOPD Payments	HOPD Units Billed	Office & ASC Units Billed	% Units Billed in HOPD
71045	X-ray exam chest 1 view	$241,048,660	15,231,255	487,880	97%
93312	Echo transesophageal	$62,596,153	755,767	11,460	99%
50435	Exchange nephrostomy cath	$47,309,608	137,473	2,760	98%
93005	Electrocardiogram tracing	$43,932,563	49,873,688	1,883,540	96%
86900	Blood typing serologic abo	$38,169,698	9,059,732	26,740	100%
90870	Electroconvulsive therapy	$25,453,693	300,915	2,640	99%
50432	Plmt nephrostomy catheter	$9,413,388	29,776	680	98%
50688	Change of ureter tube/stent	$9,066,129	27,557	*	*
G0239	Oth resp proc, group	$8,939,456	1,161,280	26,740	98%
92950	Heart/lung resuscitation cpr	$8,751,861	232,488	820	100%

*Blinded to comply with Centers for Medicare & Medicaid Services small cell suppression policy.
Source: McDermottPlus analysis of Medicare 100% outpatient and 5% carrier claims data for 2022. Results from the 5% carrier data are extrapolated to represent the full traditional Medicare population.

Key Policy and Economic Considerations for Site Neutral Payment Proposals

Site of service can vary greatly for individual services, as identified by CPT code. If Congress adopts site neutral payment policies similar to MedPAC's recommendations, providers will experience payment cuts for many services that are commonly furnished in HOPDs.

Policymakers should therefore consider the clinical and economic factors that drive site-of-service differences for services at the individual CPT code level. MedPAC discusses several potential adjustments to mitigate impacts on providers, particularly those serving low-income beneficiaries. As policymakers continue to evaluate site neutral payment proposals, stakeholders should think through the policy and economic considerations discussed above.

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