GUIDE TO THE ISSUES

HOUSE REPUBLICAN POLICY COMMITTEE

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MENDING MEDICARE THROUGH SITE-NEUTRAL PAYMENTS

Medicare covers about 23 percent of U.S. personal health expenditures, and is the second largest source of financing behind private health insurance, which funds about 33 percent.[1] Medicare spending has increased over time due to numerous factors, including the program reimbursing providers differently across settings (site-based payments) for the same service. The Medicare site-based payment model has led to increased market concentration through hospital acquisitions of physicians and, because hospitals charge higher prices for same services, overpayment for services that does not translate to better patient care. Congress should reform Medicare's payment model to a site-neutral reimbursement structure that would encourage greater provider competition, lower prices, increase quality of care, and improve the financial solvency of the program.

BACKGROUND

- **Medicare has grown to the second largest funding source for U.S. health care expenditures.**
  - Health care costs in the U.S. have increased substantially over time. In 1960, national health expenditures as a share of the U.S. economy totaled about 5 percent and by 2021 has risen to over 18 percent (Figure 1).
    - Hospital care services is the largest expenditure in the nation's healthcare system, with upwards of 37 percent of personal health spending in hospital care settings. The next largest percentage was spent on physician and clinical services (24 percent).[2]
    - Prices for hospital care services have also risen faster than physician prices, with one study showing hospital prices growing 42 percent between 2007 and 2014 compared to 18 percent for physicians.[3]
    - Overall, health and medical care services is one of the most highly regulated industries in the U.S., and cost inflation in these industries has significantly outpaced general inflation (Figure 2). (*For more information, see RPC guide titled "Regulatory Costs Worsen Inflation"*)[4]
  - Medicare represents the largest federal health program, and is the second largest source of financing of personal health expenditures in the U.S., second to private health insurance coverage.[5]
    - Medicare has increased to account for about 12 percent of the federal budget[6] (3.1 percent as a percent of the economy[7]) and upwards of 21 percent of national health spending.[8,9,10]
    - The Medicare Board of Trustees reports that about 65 million people— comprising of approximately 57.1 million persons 65 years of age and older and 7.9 million disabled persons— were enrolled in Medicare as of 2022.[11] In 2022, Medicare net expenditures totaled $747 billion, and spending per beneficiary increased to $15,727, up about $10,000 per person over the past two decades.[12,13]
    - 48 percent of Medicare spending is for Part B benefits (primarily physician and hospital outpatient services), 40 percent for Part A benefits (hospital inpatient services), and 12 percent for Part D (prescription drugs).[14]

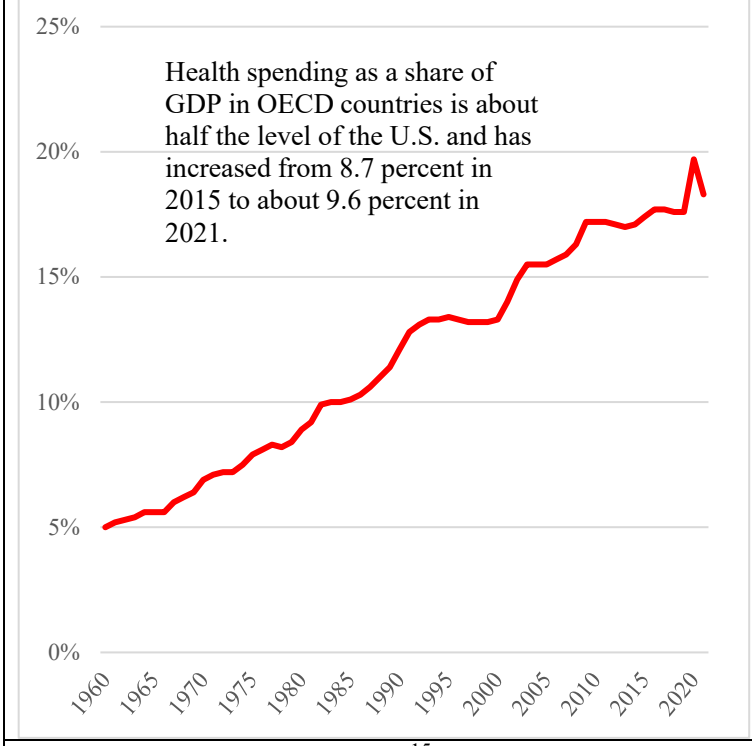

Figure 1[15]

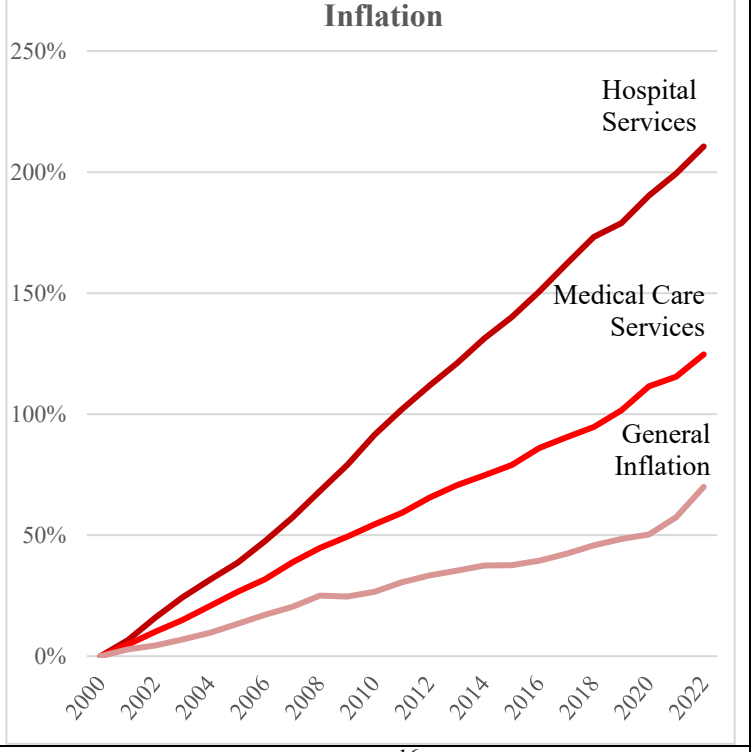

Figure 2[16]

- **Increased market concentration and reduced competition from hospital-acquired physician integration.**
  - Current law and regulation allows different reimbursement to providers in Medicare depending on where the service is performed and billed.[17] This reimbursement structure is referred to as "site-based" payments, where Medicare uses different reimbursement rates for the same service (e.g., echocardiography and chemotherapy) depending on the facility where care is provided (e.g., physician-owned practice versus an off-campus hospital-owned physician office or hospital-based outpatient department).[18]
    - The 2015 Bipartisan Budget Act[19] established site-neutral payments in Medicare for services received at off-campus outpatient departments, but the bill exempted most hospitals by excluding all current and those under construction (at the time) off-campus Hospital-based Outpatient Departments (HOPDs), ambulatory service centers (ASCs), stand-alone emergency departments, and on-campus HOPDs.[20]
    - Because of the exemptions, the Medicare site-based payments structure allows providers at hospital-acquired off-campus outpatient sites to charge higher hospital rates for the same service, and higher than the same service performed for an identical patient at a non-hospital physician-owned site. Thus, Medicare overpays for certain services, allowing medical care providers to charge different amounts for the same service to an identical patient depending on the care setting.
  - In the 2023 Report to Congress, Medicare states that the higher payment rates to HOPDs embeds indirect subsidies to certain activities into the payment rates for all services and gives hospitals incentive to acquire physician practices.[21,22]
    - The market concentration arising through hospital acquisitions of physician-owned practices shows in the shift in billing of services from physician fee schedule (PFS) to Outpatient Prospective Payment System (OPPS).[23]
    - In important ambulatory billing services, the share in OPPS has increased significantly between 2012 and 2021. Between 2012 and 2021, OPPS share of billing has increased from 9.6 percent to 12.8 percent for office visits, from 35.2 percent to 51.9 percent in chemotherapy administration, from 33.9

percent to 47.6 percent in nuclear cardiology, and from 31.6 percent to 43.1 percent in echocardiography.[24]

- Broadly, the percentage of physicians that were part of practices at least partially owned by hospitals or that were employees of hospitals increased from 29.0 percent to 39.8 percent between 2012 and 2020.[25]

- **Site-based payments have resulted in higher prices and costs across care settings for same services.**
  - Medicare site-based reimbursement payments have resulted in industry concentration from hospital acquisitions of physician-owned practices, which has reduced competition and pushed up costs.
    - Economic research has shown that hospitals can charge higher prices, especially in highly concentrated markets with limited competition,[26] that are double Medicare payments on average.[27] In several hundred hospitals across the nation, hospital prices in the commercial market are at least triple Medicare.[28,29]
  - Higher prices paid at certain health care sites does not translate to higher quality of care and, in some settings, may represent an impediment to higher quality of care.
    - The high prices paid at hospitals do not translate to higher quality. In a study using Center for Medicare and Medicaid Services (CMS) Hospital Value-Based Purchasing (HVBP) administrative data shows that industry concentration tends to correspond negatively with total performance, clinical care and patient experience, particularly at facilities with government oversight and higher government reimbursement which perform even worse across HVBP metrics.[30]
  - The overpayments that occur in site-based payments structure cost taxpayers billions and, absent reforms, will add to any financial solvency concerns projected in Medicare.
    - The Congressional Budget Office (CBO) estimates that site-based Medicare reimbursements to hospital outpatient departments and off-campus hospital-owned physician offices has resulted in overpayment totaling $141 billion compared to physician office rates, which has added to the financial strain that the government oversight agencies project will occur in Medicare in the next decade.[31,32]
    - The Medicare Board of Trustees reports that projected spending will exceed income by $38.5 billion in 2031 and $136.5 billion in 2032 in the Medicare Part A Hospital Insurance Trust Fund.[33] They report that projected revenues will meet spending obligations in the Medicare's Supplemental Medical Insurance (SMI) Trust Fund, which covers payments for outpatient services, including physicians' services.[34]

POLICY SOLUTIONS

- Congress needs to address cost challenges in our nation's healthcare system, which must include reforms that protect the financial security of the Medicare program. It is crucial that Congress take steps to eliminate overpayments in Medicare that undermines the financial solvency of the program and forces seniors to pay higher prices. Implementing reforms that align payments for site-neutrality across care settings, on- and off-campus hospital services and post-acute care, could save and protect the financial integrity of the Medicare program as much as $220 billion over 10 years.[35,36,37]
- Congress should pass reforms such as the *Site-based Invoicing and Transparency Enhancement Act* (SITE Act)[38] that align payment rates across care settings and move Medicare to site-neutral payment model.

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[1] Personal health expenditures—outlays for goods and services that relate directly to patient care, such as hospital care, physicians' and dentists' services, prescription drugs, eyeglasses, and nursing home care—account for about 85 percent of total national health expenditures in the U.S. Health, United States, 2020-2021: Health Care Expenditures. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm#:~:text=In%202019%2C%20hospital%20care%20spending,%25)%2C%20and%20home%20health%20care%20(

[2] *Id*.

[3] Zack Cooper, Stuart Craig, et al. Hospital Prices Grew Faster Than Physician Prices for Hospital-Based Care in 2007-2014. Health Affairs 38 (2). February 2019. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424

[4] Regulatory Costs Worsen Inflation. House Republican Policy Committee. September 30, 2022. https://republicanpolicy.house.gov/sites/evo-subsites/republicanpolicy.house.gov/files/evo-media-document/regulatory-costs-worsen-inflation_0.pdf

[5] Sean P. Keehan, Jacqueline A. Fiore, et al. National Health Expenditure Projections: 2022-2031: Growth to Stablize Once the COVID-19 Public Health Emergency Ends. Health Affairs. June 14, 2023. https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00403
[6] Budget Basics: Medicare. Peter G. Peterson Foundation. April 18, 2023. https://www.pgpf.org/budget-basics/medicare#:~:text=Key%20Facts,percent%20of%20total%20federal%20spending.
[7] Over the next decade, the Congressional Budget Office (CBO) projects that net Medicare spending could increase to 16 percent of the federal budget and 4 percent of the economy (as measured by Gross Domestic Product, GDP). An Update to the Budget Outlook: 2023 to 2033. Congressional Budget Office. May 2023. https://www.cbo.gov/system/files/2023-05/59096-Budget-Outlook.pdf
[8] National health spending accounts for the total expenditures on health care and related activities such as private and public health insurance, health research, and public health activities. https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm#:~:text=In%202019%2C%20hospital%20care%20spending,%25)%2C%20and%20home%20health%20care%20(
[9] The Facts About Medicare Spending. Kaiser Family Foundation. June 2023. https://www.kff.org/interactive/the-facts-about-medicare-spending/
[10] Medicare funding accounts for 26 percent of total spending in the U.S. on hospital care, 26 percent of national spending on physician and clinical services, and 32 percent of national spending on retail prescription drugs. Juliette Cubanski and Tricia Neuman. What to know about Medicare Spending and Financing. Kaiser Family Foundation. January 19, 2023. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/
[11] 2023 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. March 31, 2023. https://www.cms.gov/oact/tr
[12] Budget and Economic Data – Supplemental Table 2. Congressional Budget Office. May 2023. https://www.cbo.gov/data/budget-economic-data#1
[13] 2023 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. March 31, 2023. https://www.cms.gov/oact/tr
[14] https://www.kff.org/interactive/the-facts-about-medicare-spending/
[15] Center for Medicare and Medicaid Services. OECD.
[16] Bureau of Labor Statistics; Retrieved from FRED, Federal Reserve Bank of St. Louis
[17] Public Law 114-74 (Bipartisan Budget Act of 2015) provided statutory authorities to include certain exemptions in site-neutral Medicare OPPS payments. CMS provides citations to relevant federal statute and regulations in Medicare payment systems. Medicare Payment Systems. Center for Medicaid and Medicare Services (CMS). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html
[18] The June 2022 Medicare Payment Advisory Commission illustrates how different payments occur across care facitities for the same "level 2 nerve injection" service. Table 6-3. Report to Congress: Medicare and Health Care Delivery System. Medicare Payment Advisory Commission. June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v3_SEC.pdf
[19] Section 603. Public Law 114-74 – Bipartisan Budget Act of 2015. https://www.congress.gov/bill/114th-congress/house-bill/1314/text
[20] https://www.crfb.org/sites/default/files/managed/media-documents2022-02/HSI_EqualizingPayments_0.pdf
[21] Report to Congress: Medicare and the Health Care Delivery System. Medicare Payment Advisory Commission (MEDPAC). June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[22] Different payment rates across care settings, regardless of safety or clinical effectiveness, contributes to higher health care prices. Using administrative claims data from 2007 to 2013, economists have estimated that hospital-acquired primary care physicians receive an average of 14.1 percent higher prices after hospital-acquisition. Additional research shows that physician office clinic visits average 60 percent the payments made in HOPDs, which creates incentives in the health care system to deliver services in costlier facilities, even when the care, for all intent and purposes, is equally safe and effective. Cory Capps, David Dranove, and Christopher Ody. The effect of hospital acquisitions of physician practices on prices and spending. The Journal of Economics. May 2018. https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X. See also, Brian Blasé, PhD and Joe Albanese. Turning the Tide on Red Ink: Commonsense Policies to Make Federal Health Programs More Sustainable. Paragon Health Institute. https://paragoninstitute.org/wp-content/uploads/2023/05/Turning-the-Tide-on-Red-Ink_Brian-Blase_Joe-Albanese_FINAL_202303072031.pdf
[23] https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[24] *Id*.
[25] *Id*.
[26] https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext
[27] Moving to Site Neutrality in Commercial insurance Payments. Committee for a Responsible Federal Budget. February 14, 2023. https://www.crfb.org/sites/default/files/media/documents/Moving_to_Site_Neutrality_in_Commercial_Insurance_Payments_4.pdf
[28] *Id*.
[29] In the past decade, several studies have estimated the impact site-based payments has had on prices and industry concentration (i.e., physician integration to hospitals). In one study using Medicare claims data from 2010 to 2016, researchers estimate that Medicare reimbursements for physician services would increase $114,000 per year per physician under hospital-acquired integration. The authors estimate in this paper the added revenue that an average physician for these subcomponent could receive if integrated into a hospital and billing from a hospital outpatient department. The Hospital-Office ratio was 1.78 for primary care, 1.74 for medical specialties, and 2.24 for surgical specialties. Brady Post, Edward C. Norton, et al. Hospital-physician integration and Medicare's site-based outpatient payments. Health Services Research. 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7839648/
[30] Brad Beauvais, Glen Gilson, et al. Overpriced? Are Hospital Prices Associated with the Quality of Care? Healthcare (Basel). 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7349401/
[31] The figures account for CBO's estimate of savings over ten years by paying all off-campus hospital-owned physician offices and hopsital outpatient departments at physician office rate. The overpayment could be as high as $220 billion when including the $79 billion for

"excessive payment for post-acute care providers" in Medicare. Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget. Congressional Budget Office. March 25, 2020. https://www.cbo.gov/system/files/2020-03/56245-2020-03-medicare.pdf
[32] https://www.cms.gov/oact/tr
[33] Table II.E1. *Id*.
[34] *Id*.
[35] https://www.cbo.gov/system/files/2020-03/56245-2020-03-medicare.pdf
[36] https://paragoninstitute.org/wp-content/uploads/2023/05/Turning-the-Tide-on-Red-Ink_Brian-Blase_Joe-Albanese_FINAL_202303072031.pdf
[37] According to the Medicare Advisory Payment Commission (MEDPAC) in its 2023 report to Congress, aligning payments across settings under budget neutrality would not likely result in adverse effect for access and quality of care among rural households. The report states that rural hospitals have better financial performance than urban hospitals under the Medicare fee-for-service payment systems and, in many instances, would remain unaffected because certain rural hospitals receive payment rates separate from OPPS in safety-net, critical access, and rural sole community hospitals. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[38] S. 1869 – Site Act. 118th Congress. https://www.congress.gov/bill/118th-congress/senate-bill/1869/text