



**Testimony in Support of**  
**Senate Bill 23: An Act Requiring Site-Neutral Payments for Health Care Services**  
**Submitted by Lynne Ide, Director of Program & Policy**  
**Universal Health Care Foundation of Connecticut**  
**February 7, 2017**

Universal Health Care Foundation of Connecticut supports Senate Bill 23: An Act Requiring Site-Neutral Payments for Health Care Services.

Consolidation of hospital systems is a challenge in the health care landscape that Connecticut has been facing for years. Hospital systems have also been acquiring physician practices, and ambulatory surgery centers. If you were a hospital administrator, and you know that the hospital system got paid a higher rate for conducting a medical procedure on the hospital campus, why would you refer a patient to the ambulatory surgery center where you got reimbursed at a lower rate?

This measure is one way to prevent a hospital or health system's market power from increasing health care costs for payers, which ends up costing patients more, as costs are shifted to them. While this bill is still being developed, I urge the Committee to consider how a site-neutral payment policy could constrain costs for the state, payers, and, most importantly, the patients who need care.

Medicare is establishing rules for site neutral payment policies. MedPAC, the Medicare Payment Advisory Council, has recommended site-neutral reimbursement for its potential cost-savings<sup>i</sup>, while retaining quality of care. We urge the Committee to examine the work done in this area while considering and developing this bill. A July 2014 policy brief from *Health Affairs* goes deeper into this issue (see attached).

This is not the first time site-neutral payments have come up in the state's health care cost containment discussion. In Public Act 15-146, the Insurance Department was supposed to lead a study on health care cost drivers in the state, and consider site-neutral payment as a potential cost containment strategy. Due to a lack of resources, the Insurance Department was unable to complete that report.

Consider, that site-neutral payments:

- Could save both the consumer and the health care system money
- Allow consumers to choose a facility that is easily accessible to them, rather than be steered to a hospital location that may be difficult to get to
- Give patients more choices without having to decide where to have a procedure simply by cost
- Allow providers to recommend the most appropriate setting for the patient without having to worry about one setting or another being more expensive for the patient
- Protect access to quality care in the community<sup>ii</sup>

There is no one easy solution for making health care more affordable. There are many players, many stakeholders, and many factors affecting our health. Affordable health care requires a coordinated

approach with interconnected measures. This is one such measure, protecting payers and consumers from paying more for the exact same procedure, simply because of where the treatment occurred.

We have to remember that health care affordability isn't just about lowering costs in the larger system – it's also about consumers getting the high-quality health care they need, at a price they can afford.

*Universal Health Care Foundation of Connecticut's mission is to serve as a catalyst that engages residents and communities in shaping a democratic health system that provides universal access to quality, affordable health care and promotes health in Connecticut. We believe that health care is a fundamental right and that our work is part of a broader movement for social and economic justice.*

---

<sup>i</sup> See *25 things to know about site-neutral payments*, Becker's Hospital Review, June 29, 2015:  
<http://www.beckershospitalreview.com/finance/25-things-to-know-about-site-neutral-payments.html>

<sup>ii</sup> For more research on how site neutral payments can help lower health care costs while preserving patient choice, see the Alliance for Site Neutral Payment Reform's Research page here:  
<http://www.siteneutral.org/research/>

# Health Policy Brief

JULY 24, 2014

## **Site-Neutral Payments.** Medicare uses different payment systems depending on where care is delivered. Recent proposals seek to eliminate this differential.

### WHAT'S THE ISSUE?

Medicare uses more than a dozen different payment systems to set payment rates for the medical items and services the program covers for beneficiaries. The location where a beneficiary receives a service determines which payment system applies. Each system has its own methodology for rate-setting reflecting costs of operating the setting and the different patient populations served in each.

However, these methodologies rarely account for the amount Medicare might pay for the same service provided in a different clinical setting. As a result, services that can be provided in a variety of clinical settings may sometimes be paid for at dramatically different payment rates.

Recently, the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) have been exploring options to eliminate this differential payment for certain services. This brief explains the origins of these differential payments and the debate over approaches that have been proposed for developing so-called site-neutral payments.

### WHAT'S THE BACKGROUND?

Medicare beneficiaries can receive services in different settings and from different types of

providers. In some cases, the same service can be provided in more than one setting. For example, a beneficiary could undergo a surgical procedure as either a hospital inpatient or an outpatient or could receive chemotherapy in a physician's office or a hospital outpatient department. A stroke patient could receive rehabilitation services in a skilled nursing facility or an inpatient rehabilitation facility.

In some cases, the capabilities of the facility or the clinical needs of the patient dictate that a certain setting is necessary, but often the decision is discretionary. And the setting in which a particular service is provided determines how much Medicare and the beneficiary pay for the service.

Each Medicare payment system has its basis in Medicare law, which provides general parameters for how each type of provider is paid. CMS implements the law and develops more detailed elements of the payment systems through rulemaking. The core elements of the systems are generally the same—payment is based on a set rate, often calculated from the average cost of providing a unit of service across providers under the system and updated annually for inflation—but the specific features are different for each system.

Elements such as the unit of payment, the degree to which payment is made for individual services versus bundles of services, the

methodology and data used to set payment rates, and the factors used to adjust for inflation vary between systems. Exhibit 1 shows different elements of key payment systems.

**Units of payment.** Inpatient payment systems typically pay for bundles of items and services provided during a certain period: For example, under the inpatient prospective payment (PPS) system, acute care hospitals are paid in a single payment for each Medicare discharge for most of the care provided during an inpatient stay. Skilled nursing facilities are paid per day for services provided to beneficiaries. Payments are typically broken down more narrowly for ambulatory services. For most services, hospital outpatient and physicians' offices receive individual payments for each service provided.

However, even under this general framework, some services are paid separately in some settings and packaged in others: For example, the hospital outpatient department payment system (called the outpatient prospective payment system) includes packaged payment for elements that are considered integral to certain procedures, such as radiopharmaceuticals and drugs required to perform certain diagnostic tests, but are paid separately when provided in a physician's office.

**Different methodologies.** Most Medicare payment systems are expected to appropriately reflect the relative cost of providing a particular service or bundle of items and services compared to the cost of providing other items and services in the same setting. The relative

weight of each service or patient case under these payment systems is specific to the universe of services within that particular payment system. The same service may be more or less costly compared to the other services performed in different settings.

Each payment system uses information specific to its particular type of provider to set the relative weights and payment rates under that system. Hospital payment systems such as the inpatient and outpatient prospective payment systems use Medicare hospital claims data to set rates based on an estimate from those claims of the average cost across hospitals of providing a service or caring for a type of patient. Payments for ambulatory surgical center (ASC) services are generally based on the relative weights set under the outpatient prospective payment system, but the ambulatory surgical center payment system has different inflation updates and other features that lead to payments that are well below outpatient PPS rates for the same procedures.

The payment system for physician services (called the physician fee schedule) is the only Medicare payment system that uses a "micro-costing" approach to set payment rates for the practice expense component of the fee schedule (which is analogous to the outpatient PPS and ASC payments for facility services). Under the physician fee schedule, an estimate of the average price of each of the individual items expected to be used to provide a service (equipment, supplies, labor, etc.) is summed to determine the Medicare rate for the costs of providing services in an office setting.

## EXHIBIT 1

### Elements of Key Medicare Payment Systems

Payment system	Setting	Unit of payment	Inflation update	Annual update
Inpatient prospective payment system	Hospital inpatient	Per discharge	Hospital Market Basket Index	October 1 (fiscal year)
Skilled nursing facility prospective payment system	Skilled nursing facility	Per day	Skilled Nursing Facility Market Basket Index	October 1 (fiscal year)
Outpatient prospective payment system	Hospital outpatient	Per service, with moderate packaging of some items	Hospital Market Basket Index	January 1 (calendar year)
Physician fee schedule	All settings with different practice expense amounts for services furnished in facility vs. office settings	Per service, with limited packaging	Medicare Economic Index	January 1 (calendar year)
Ambulatory surgical center payment system	Ambulatory surgical centers	Per service, with moderate packaging of some items	Consumer Price Index	January 1 (calendar year)

**SOURCE** Compiled by the author. **NOTE** Packaging refers to when a system provides one payment to cover both a procedure and other elements considered integral to that procedure.

**Choice of providers.** Some services can be provided in a variety of clinical settings and are, therefore, paid under multiple payment systems. For example, some facilities such as long-term care hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities specialize in treating certain types of patients, but the services provided by those specialized facilities can also be provided by more general, acute care hospitals or other types of institutions such as skilled nursing facilities. Medicare typically pays more for care provided by the specialized facilities than it does when the care is provided by a general acute care hospital.

Similarly, doctor visits can be provided in a physician's office or a hospital outpatient clinic, and some outpatient surgical procedures could be provided in a physician's office, a hospital outpatient department, or an ambulatory surgical center. CMS considers payment rates used in other settings when determining the rates for a few specific types of services, such as diagnostic imaging services provided in a physician's office or services provided in an ASC. In most instances, the payment rates developed under one payment system have no connection to the rates for the same service in other settings.

Health care providers often have the ability to determine under what system they are paid depending on how they are structured and licensed. Many physician practices that are owned by a hospital and meet key requirements regarding clinical and financial integration with the hospital can bill Medicare and other payers as a hospital outpatient de-

partment and receive an additional payment for what is called the "facility fee."

The facility fee reflects the cost of the office, nurses, administrative staff, equipment, etc., needed to perform the service. For Medicare, the payment under the inpatient prospective payment system, outpatient prospective payment system, or ambulatory surgical center payment system is the facility fee and that facility fee is provided in addition to payment for the physician's professional service under the physician fee schedule.

In contrast, a physician's office that is independent of a hospital receives one payment under the physician fee schedule that includes both the facility costs and the professional costs of providing a service. The physician office payment is typically less, and often considerably less, than the combined outpatient prospective payment system and professional payment for the same service in a hospital outpatient setting. See Exhibit 2 for an example of how payment for the same patient visit can differ.

While clinical considerations are expected to play the primary role in determining treatment decisions, differences in payment rates may encourage providers to operate in certain ways or offer certain services. For example, physicians have the ability to operate an ambulatory surgical center as well as a physician's office.

The physician can decide to offer different surgical services in each setting or to refer a patient to a hospital outpatient department for

#### EXHIBIT 2

### Differences in Medicare Program Payments and Beneficiary Cost Sharing for Midlevel Outpatient Office Visits Provided in Freestanding Practices and Hospital-Based Entities, 2014

	Service provided in freestanding physician practice	Service provided in a hospital outpatient department		
	MPFS physician office rate <sup>a</sup>	MPFS physician facility rate <sup>a</sup>	OPPS rate <sup>b</sup>	Total hospital-based rate
Program payment	\$58.46	\$41.26	\$74.02	\$115.28
Beneficiary cost sharing	\$14.62	\$10.32	\$18.51	\$28.83
<b>Total payment</b>	<b>\$73.08</b>	<b>\$51.58</b>	<b>\$92.53</b>	<b>\$144.11</b>

**SOURCE** Medicare Payment Advisory Commission table updated by the author with 2014 payment rates from Centers for Medicare and Medicaid Services website. The *Current Procedural Terminology* code used for this example under the physician fee schedule is 99213. The Healthcare Common Procedure Code Set code used for this example under the outpatient prospective payment system (OPPS) is G0462. **NOTE** MPFS is Medicare physician fee schedule. <sup>a</sup>Paid under the Medicare physician fee schedule. <sup>b</sup>Paid under the OPPS.

**\$15 billion**

The Office of Inspector General recently estimated that Medicare could save \$15 billion during 2012–17 if it applied the ambulatory surgical center payment rates to hospital outpatient services with low or no clinical risks.

a procedure. Physicians would be unlikely to offer a service in the ambulatory surgical center or office setting if the Medicare payment rate were insufficient to cover the cost of providing the service.

**Shift in site of service.** Recent shifts of services from the physician’s office to the hospital outpatient department have been of particular concern to MedPAC and others. MedPAC found that the share of doctor visits (referred to as evaluation and management services) and certain diagnostic cardiology procedures performed in hospital outpatient departments increased markedly between 2010 and 2011 (8 percent) and again between 2011 and 2012 (9 percent).

At the same time, the share of those services performed in free-standing physicians’ offices decreased by 1 percent each year. [MedPAC identifies several factors that may be contributing to this shift](#), including incentives for hospitals and physicians to form integrated delivery networks in order to function as accountable care organizations, an increasing preference among physicians for predictable work hours that may be difficult to achieve in an independent practice, and the rising costs of maintaining a private physician practice.

Because of the higher payment rates for outpatient department services, this shift in site of service means that Medicare spending on these services is increasing even though there may be no difference in the care the patient receives. Out-of-pocket costs to the beneficiary are also higher since beneficiaries are responsible for roughly 20 percent of the payment amount for outpatient services.

### WHAT’S THE DEBATE?

Both MedPAC and CMS have made proposals or recommendations to eliminate differential payments for certain services. While MedPAC first concentrated its analysis and recommendations on differences in payments between hospital outpatient departments and physicians’ offices, it noted that this effort was part of a broader push toward having “the same payment for the same service provided to similar patients across sites of care.”

One of the primary issues in pursuing these proposals is determining which services and payments should be addressed. CMS and MedPAC took divergent approaches.

**CMS proposes cap on physician office payment rates.** As noted above, Medicare typically pays more for the same service when it is provided in a hospital outpatient department than in a physician’s office. CMS notes that this general relationship between payment rates is appropriate because hospitals incur higher costs to maintain operations around the clock and to meet legal obligations to provide care to people needing emergency medical treatment.

However, the separate methodologies of the payment systems for these two settings have produced rates for some 200 procedure billing codes where the physician fee schedule rate is higher than the outpatient prospective payment system rate for the same service. CMS believes that these anomalous rates are the result of inaccurate data used to determine costs under the physician fee schedule.

[In updating the physician fee schedule for 2014](#), CMS proposed to limit the amount paid for a service in the physician office setting to the amount paid for the same service when provided in a hospital outpatient department or ambulatory surgical center (for surgical services) but ultimately did not adopt the limit.

**MedPAC recommends limiting payments to hospital outpatient departments.** In contrast to the CMS proposal that targeted physician payments, MedPAC has focused on limiting Medicare payments to hospital outpatient departments. MedPAC states as its general position that “Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries.”

In 2012 [MedPAC recommended that Congress should set payment rates](#) for evaluation and management services provided in hospital outpatient departments at the same rate that is paid under the physician fee schedule. In 2013 [MedPAC developed additional options](#) for aligning payments for ambulatory care, including expanding the number and types of services that could be paid at the physician office rate or for which the gap between the outpatient department and the physician office payment could be reduced. MedPAC also evaluated an alternative approach of equalizing payment rates between hospital outpatient departments and ambulatory surgical centers for certain services.

The contrast between the CMS and MedPAC approaches highlights one of the key ques-

**“Services that can be provided in a variety of clinical settings may sometimes be paid for at dramatically different payment rates.”**

tions in developing site-neutral payments: Which payment system has the most appropriate payment rate? Each of the payment systems has limitations with its methodology, such as the concerns regarding accuracy of the cost data used to set rates under the physician fee schedule that are at the heart of the CMS proposal to cap physician office payments. Applying payment rates from one setting to services furnished in another setting can extend the impact of the concerns with payments in one setting into another setting.

For example, ASC payment rates are currently based primarily on the rates set under the outpatient prospective payment system. Because of different inflation updates and other features of the ambulatory surgical center payment system, ASC rates are well below outpatient PPS rates. The ambulatory surgical center industry has raised concerns about the marked difference in payment rates for the same services in the two settings, especially for services that include significant fixed costs such as for expensive devices. Despite these concerns, the Office of Inspector General recently estimated that Medicare could save \$15 billion over the period 2012–17 if it applied the ambulatory surgical center payment rates to hospital outpatient services with low or no clinical risks. CMS did not concur with the OIG recommendations.

**Making cost comparisons.** Hospitals submit yearly data reports to Medicare that allow CMS and others to compare actual costs incurred by the hospital to the amount paid for the services provided. There are no similar centralized sources of data on the cost of performing services in other settings such as ambulatory surgical centers or physicians’ offices to help determine which payment system most accurately reflects the cost of providing services.

In addition, differences between payment systems and which items are covered by a single payment complicate the application of rates from one system to another. For example, physician office payments are typically based on the cost of providing a single service with only modest bundling of the specific supplies and equipment needed to perform the service.

Additional services provided at the same time are priced separately. Under the outpatient prospective payment system, CMS is increasingly packaging related items and services into the payment for the base procedure, making an apples-to-apples comparison

across those two payment systems more difficult. Packaging policies are generally the same under the outpatient PPS and the ASC payment system, allowing those rates to be compared more easily.

In its broad description of its preference for site-neutral payments, MedPAC defaults to the lowest payment rate across settings, after taking into consideration differences in patients’ severity of illness. As noted, this approach would likely reduce payments to hospitals for outpatient department services.

But hospital advocates emphasize differences between the role played by hospitals in health care delivery and those of physicians’ offices and ambulatory surgical centers. They argue that higher payments for hospitals are justified by the requirements to provide around-the-clock care, to act as safety-net providers for the uninsured and underinsured, and to provide care during disasters that physicians’ offices and ambulatory surgical centers do not face. [A technical paper](#) by Barbara O. Wynn, Peter S. Hussey, and Teague Ruder found that the difference in payments to hospitals compared to physicians’ offices exceeded the differences in costs between the two settings and are generally a result of how the payment systems have evolved.

**General appropriateness of cost-based rates.** When Medicare was originally established, the program paid providers their specific individual costs, subject to certain limitations. Over time, Medicare payment has shifted away from this retrospective cost accounting approach to prospectively set rates that are based on the average cost across similar providers as described above.

Nevertheless, even with the shift to prospective payment, Medicare was still paying in all systems according to the volume of care provided instead of its value. The issue of determining which of the different estimates of the cost of providing the same service is most appropriate raises the question of whether and how Medicare payments should be revised to reflect the value, not just the cost, of the service.

**Operational complexity.** Medicare’s payment systems are complicated machinery with numerous parts. The payment systems that account for the largest volume of services and spending, including the inpatient prospective payment system, the outpatient prospective payment system, and the physician fee sched-

**“Medicare typically pays more for care provided by specialized facilities than it does when care is provided by a general acute care hospital.”**

ule, are updated annually to reflect the most current data and to refine payment policies. Proposed refinements and payment rates are then put out for public comment before being finalized. Inpatient payment systems are updated with the start of the fiscal year on October 1, and outpatient payment systems are updated on a calendar-year basis effective January 1.

The final step in the rate-setting process is the budget-neutrality calculation during which CMS adjusts rates to keep expected total payments under the payment system at a certain level after adjusting for inflation and payment policy changes. The budget-neutrality adjustment is applied across the board to all of the rates under the payment system. If policy changes or updated data reduce individual rates from the previous year’s level, then the budget-neutrality adjustment might increase rates across the board. Similarly, if rates increase from the previous year, then the budget-neutrality adjustment might reduce rates.

This cycle means that CMS is often working simultaneously to update systems that would pay for the same items in different settings. For example, the outpatient prospective payment system and the physician fee schedule proposed and final rules are often released on the same day following a comprehensive process of data analysis and review within the Department of Health and Human Services and by the Office of Management and Budget.

Cross-referencing rates set under other payment systems further complicates the rate-setting process since it could require CMS to complete its rate setting under the reference system before being able to calculate rates, particularly the budget-neutrality adjustment, for the setting in which payments are being adjusted. In its proposal last year to cap physician’s office payments to be the same as payments for the same service in a hospital outpatient department or ambulatory surgical center, CMS tried to solve this problem by using as the reference point the rates set in the prior year. Commenters were generally unhappy with the proposal and particularly disparaged the use of prior-year, rather than current-year, rates in setting the cap.

#### WHAT’S NEXT?

Both CMS and MedPAC have indicated continued interest in identifying and addressing situations where differences in payment are not considered appropriate or supported by

differences in cost or the needs of the patient. CMS did not finalize its proposal to limit physician office payments to the amount paid for the service in a hospital outpatient department or ambulatory surgical center, but the agency indicated it continues to be concerned that the physician office rates exceed rates in other settings for those services.

Recently enacted legislation may provide CMS with additional opportunity and authority to revisit this issue. As part of the Protecting Access to Medicare Act of 2014 that President Barack Obama signed into law on April 1, Congress expanded the types of information CMS can use to determine costs under the physician fee schedule and encouraged CMS to take action on potentially misvalued codes.

The law includes numerous criteria that can be used to identify potentially misvalued codes, including a “significant difference in payment for the same service between different sites of service.” In the proposed rule updating physician payments for 2015, CMS asked for public comments on the use of hospital cost data (not outpatient prospective payment system payment rates) in determining or validating physician payments.

As noted, MedPAC has continued to provide Congress with alternative options for creating site-neutral payments for ambulatory procedures provided in an outpatient setting. MedPAC is exploring proposals to reduce differences in payments between inpatient rehabilitation facilities and skilled nursing facilities for certain conditions as well as possible approaches to synchronizing policies across broad payment models such as fee-for-service Medicare and Medicare Advantage. Hospitals are geared up to fight the proposals, while other providers, such as nursing home associations that compete for patients with currently higher-paid rehabilitation facilities, are more supportive.

Congress has taken its first steps on site-neutral payments by requiring that long-term care hospitals be paid a rate comparable to the inpatient prospective payment system rate for patients that do not meet certain criteria. This payment adjustment does not take effect until fiscal year 2016. CMS is expected to include details about how the adjustment will be applied in its rulemaking next year. ■

**About Health Policy Briefs**

Written by

**Amanda Cassidy**

Health Policy Consultant

Editorial review by

**Kelly Hall**

Founder and Principal

Pembroke Policy Consulting

**Barbara O. Wynn**

Senior Policy Analyst

RAND Corporation

**Rob Lott**

Deputy Editor

Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:

"Health Policy Brief: Site-Neutral Payments," *Health Affairs*, July 24, 2014.

Sign up for free policy briefs at:

[www.healthaffairs.org/  
healthpolicybriefs](http://www.healthaffairs.org/healthpolicybriefs)

**RESOURCES**

Centers for Medicare and Medicaid Services, "[Revisions to Payment Policies under the Fee Schedule and Other Revisions to Medicare Part B for CY 2014.](#)" *Federal Register* 78, no. 139 (July 19, 2013).

Medicare Payment Advisory Commission, "[Hospital Inpatient and Outpatient Services.](#)" In *Report to the Congress: Medicare Payment Policy*. Washington (DC): MedPAC, March 2012. pp. 45–82.

Medicare Payment Advisory Commission, "[Medicare Payment Differences Across Ambulatory Settings.](#)" In *Report to the Congress: Medicare and the Health Care Delivery System*. Washington (DC): MedPAC, June 2013. pp. 27–56.

Office of Inspector General, "[Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical-Center Approved Procedures to Ambulatory Surgical Center Payment Rates.](#)" Washington (DC): OIG, April 2014.

Barbara O. Wynn, Peter S. Hussey, and Teague Ruder, "[Policy Options for Addressing Medicare Payment Differentials across Ambulatory Settings.](#)" Santa Monica, CA: RAND Corp., 2011.