Policy Update

Site Neutral Payment: Top 10 Services Likely to Be Impacted By Proposed Legislation

The House Energy and Commerce Committee has put on the table several site neutral Medicare payment policies in the 118th Congress, the largest of which is built on prior research from the Medicare Payment Advisory Commission (MedPAC). This article reviews that proposal and estimates the top 10 high volume services for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that could be subject to reduced site neutral payment rates.

Background

On April 26, 2023, the House Energy and Commerce Committee Health Subcommittee held a legislative hearing on 17 healthcare bills, including one that would direct the Centers for Medicare & Medicaid Services (CMS) to implement site neutral payments based on where services are most commonly provided. The draft bill is similar to potential policies recently studied by MedPAC. MedPAC's proposal was estimated to reduce Medicare fee-for-service (FFS) outpatient hospital spending by $7.5 billion for the first year for ambulatory payment classifications (APCs) aligned to site neutral payment rates, using 2021 Medicare claims data and assuming no change in provider behavior.

Generally, the draft bill would direct CMS to identify whether items and services within an APC are more commonly performed in the HOPD, ASC or physician office setting.

- Where items and services within an APC are most commonly performed in the ASC setting, the generally higher HOPD payment rates would be aligned to ASC payment rates. Services furnished in a physician's office would continue to be paid at the prevailing Medicare Physician Fee Schedule payment amount.
- Where items and services within an APC are most commonly performed in the physician office, HOPD and ASC payment rates would be aligned with the typically lower Medicare Physician Fee Schedule non-facility rates.
- Certain hospitals would be eligible for a 4.1% stop-loss on their payment reductions during the first two years if their disproportionate share patient percentage (DPP) is greater than the median for all hospitals nationally. The DPP formula benefits hospitals with a high share of Medicaid inpatients that are not eligible through Medicare, which may disadvantage Medicare dependent hospitals that are required to serve a high share of Medicare beneficiaries.

Implementing these payment policies could significantly affect Medicare payments to HOPDs and ASCs and incentivize new site of service behavior.

When the full Energy and Commerce Committee considered the Health Subcommittee's actions, it did not advance this broad Medicare site neutral policy. Instead, the Energy and Commerce Committee included a smaller site neutral payment policy for Medicare drug administration services.[1]

However, when Energy and Commerce Chair Cathy McMorris Rodgers (R-WA) offered and then withdrew the larger site neutral policy as an amendment at the full committee markup on May 24, 2023, she noted that Medicare should not subsidize hospital services that are "loss leaders by making patients and Medicare overpay on certain services," and noted that more work is needed to ensure that these site neutral policies do not jeopardize access.[2] That clearly leaves open the door for Congress to return to broader Medicare site neutral policy proposals. Congress also likely will want to pay for any healthcare proposal that advances, increasing the likelihood that additional site neutral policy proposals re-emerge this year.

Top Services Impacted

McDermottPlus analyzed Medicare claims data to identify APCs that would likely be impacted and found the following:

- High volume services performed in the HOPD likely to see payment rates reduced to the ASC payment rate include the following:
    - APC 5312 for **Level 2 Lower GI procedures**, which include HCPCS commonly performed by gastroenterologists including **colonoscopy with biopsy** (HCPCS 45380 and 44389), and **colonoscopy with lesion removal** (45385 and 45384)
    - APCs 5491 and 5492 for **Level 1 and 2 Intraocular Procedures**, which are performed by ophthalmologists, and which include HCPCS for **extracapsular cataract removal with insertion of intraocular lens** (HCPCS 66984 and 66982), **glaucoma surgery** (66170) and **vitrectomy codes** (67042, 67108 and 67041)
    - APC 5431 for **Level 1 Nerve Procedures**, which include HCPCS 64635 for **destruction by neurolytic agent lumbar or sacral, single facet joint**, and which are often performed by pain management specialists, and HCPCS 64721 for **carpal tunnel surgery**, which is commonly performed by orthopedic surgeons.

- High volume services performed in the HOPD and/or ASC likely to see payment rates reduced to the physician office payment rate include the following:
    - Radiology APCs Levels 1, 3 and 4 **Imaging without Contrast** (APCs 5521, 5523 and 5524, respectively), which includes **echocardiography** codes commonly performed by cardiologists (HCPCS 93306, 93312 and 93351), certain **x-ray codes** commonly performed by diagnostic radiologists (76080, 71045 and 71046), and **computed tomography of the abdomen and pelvis** (74176)
    - Levels 3 and 4 **Nuclear Medicine and Related Services** (APCs 5593 and 5594, respectively), which include high volume codes performed by cardiologists for **myocardial perfusion imaging** (78452 and 78451), codes commonly performed by diagnostic radiologists for **tomographic (SPECT)** (78803 and 78830), and **positron emission tomography** codes (78815, 78816, 78812 and 78811)

[1] It should be noted that two of the top 10 APCs (APC 5691 for Level 1 Drug Administration and APC 5694 Level 4 Drug Administration) that would be impacted by the broader site neutral policy would also be directly impacted by this smaller drug administration provision included in H.R. 3561 (PATIENT Act).

[2] Michelle M. Stein, "E&C Panel Passes Site-Neutral Pay for Rx Administration, McMorris Rodgers Says More Coming." Inside Health Policy, May 17 2023. https://insidehealthpolicy.com/daily-news/ec-panel-passes-site-neutral-pay-rx-administration-mcmorris-rodgers-says-more-coming?utm_medium=mh

- Levels 1, 2 and 3 **Nerve Injections** (APCs 5441, 5442 and 5443, respectively), which include high volume codes performed by physical medicine and rehabilitation specialists for **transforaminal epidural with imaging guidance** (64483 and 64479)
- Levels 1, 2, 3 and 4 **Skin Procedures** (APCs 5051, 5052, 5053 and 5054, respectively) which include codes commonly billed by podiatrists for **debridement of subcutaneous tissue** (11042); **punch biopsy of skin** (11104), which is commonly billed by family medicine doctors; and **application of skin substitute graft** (15271 and 15275), commonly billed by podiatrists and nurse practitioners.

Methodology

McDermottPlus identified the dominant setting for each APC by estimating, for every HCPCS code that maps to an APC, total volume billed by HOPDs, ASCs and physicians with a place of service code for office, using the 2018–2021 5% carrier and 100% outpatient Medicare standard analytic files. Results from the 5% carrier file were extrapolated to represent the full Medicare FFS population.

A dominant setting was defined for each HCPCS code based on the setting (HOPD, ASC or office) with the most volume in the 2018–2021 period. The legislation would exempt APCs that are specific to emergency department, critical care and trauma care. The legislation would also allow CMS to make exceptions to the site neutral payment rate for items and services because of extenuating circumstances through notice and comment rulemaking.

Table 1 provides the top 10 APCs with the most outpatient hospital spending where the dominant setting is ASC or office, and table 2 provides the top 10 APCs with the most ASC spending where the dominant setting is office. The most dominant setting may change between 2018–2021 and the first four-year period (2021–2024) that CMS would use under the legislation to identify the dominant setting for each APC.

Table 1: Top 10 procedures commonly performed by outpatient hospitals that would likely be subject to site neutral payment cuts

			Total and % of Medicare FFS Units from 2018–2021 Across All HCPCS That Map to the APC by Setting				
Rank by HOPD Payments	APC	APC Name	Outpatient Prospective Payment System	Ambulatory Surgical Center	Medicare Physician Fee Schedule: Physician Office	Dominant Setting	Providers Impacted by Reduced Payment Rates
1	5524	**Level 4 Imaging without Contrast**	8,800,074 **(43%)**	1,400 **(0%)**	11,689,640 **(57%)**	Office	**HOPD, ASC**
2	5523	**Level 3 Imaging without Contrast**	17,406,088 **(43%)**	31,180 **(0%)**	23,046,080 **(57%)**	Office	**HOPD, ASC**
3	5312	**Level 2 Lower GI Procedures**	3,805,854 **(47%)**	3,873,780 **(48%)**	385,720 **(5%)**	ASC	**HOPD**
4	5593	**Level 3 Nuclear Medicine and Related Services**	3,156,000 **(47%)**	-	3,590,140 **(53%)**	Office	**HOPD, ASC**
5	5694	**Level 4 Drug Administration**	10,140,411 **(33%)**	51,900 **(0%)**	20,918,400 **(67%)**	Office	**HOPD, ASC**
6	5491	**Level 1 Intraocular Procedures**	1,683,215 **(23%)**	5,397,560 **(75%)**	122,000 **(2%)**	ASC	**HOPD**
7	5594	**Level 4 Nuclear Medicine and Related Services**	1,836,760 **(48%)**	-	2,016,800 **(52%)**	Office	**HOPD, ASC**
8	5521	**Level 1 Imaging without Contrast**	57,847,964 **(48%)**	7,140 **(0%)**	63,164,580 **(52%)**	Office	**HOPD, ASC**
9	5194	**Level 4 Endovascular Procedures**	144,236 **(39%)**	8,360 **(2%)**	220,280 **(59%)**	Office	**HOPD, ASC**
10	5691	**Level 1 Drug Administration**	59,553,955 **(40%)**	9,500 **(0%)**	88,888,192 **(60%)**	Office	**HOPD, ASC**

Source: McDermottPlus analysis of Medicare limited data set 5% carrier and 100% outpatient files from 2018–2021. Carrier results extrapolated for full FFS population. HCPCS mapped to APC using addendum B of the 2023 Outpatient Prospective Payment System final rule. Percentages may not sum to 100% because of rounding. Units represent the count of services performed and billed by providers.

Table 2: Procedures commonly performed by ASCs that would likely be subject to site neutral payment cuts

			Total and % of Medicare FFS Units from 2018–2021 Across All HCPCS That Map to the APC by Setting				
Rank by ASC Payments	APC	APC Name	Outpatient Prospective Payment System	Ambulatory Surgical Center	Medicare Physician Fee Schedule: Physician Office	Dominant Setting	Providers Impacted by Reduced Payment Rates
1	5443	**Level 3 Nerve Injections**	1,824,162 **(23%)**	2,756,420 **(35%)**	3,329,980 **(42%)**	Office	**HOPD, ASC**
2	5442	**Level 2 Nerve Injections**	2,158,249 **(31%)**	1,515,400 **(22%)**	3,361,300 **(48%)**	Office	**HOPD, ASC**
3	5054	**Level 4 Skin Procedures**	864,356 **(27%)**	496,640 **(16%)**	1,804,540 **(57%)**	Office	**HOPD, ASC**
4	5192	**Level 2 Endovascular Procedures**	383,885 **(39%)**	142,040 **(15%)**	452,200 **(46%)**	Office	**HOPD, ASC**
5	5481	**Laser Eye Procedures**	230,901 **(4%)**	1,296,500 **(20%)**	4,912,900 **(76%)**	Office	**HOPD, ASC**
6	5373	**Level 3 Urology and Related Services**	832,427 **(41%)**	276,840 **(14%)**	908,820 **(45%)**	Office	**HOPD, ASC**
7	5372	**Level 2 Urology and Related Services**	919,005 **(18%)**	342,400 **(7%)**	3,745,700 **(75%)**	Office	**HOPD, ASC**
8	5194	**Level 4 Endovascular Procedures**	144,236 **(39%)**	8,360 **(2%)**	220,280 **(59%)**	Office	**HOPD, ASC**
9	5053	**Level 3 Skin Procedures**	893,019 **(12%)**	195,660 **(3%)**	6,587,340 **(86%)**	Office	**HOPD, ASC**
10	5052	**Level 2 Skin Procedures**	4,626,527 **(25%)**	114,140 **(1%)**	13,641,500 **(74%)**	Office	**HOPD, ASC**

Source: McDermottPlus analysis of Medicare limited data set 5% carrier and 100% outpatient files from 2018–2021. Carrier results extrapolated for full FFS population. HCPCS mapped to APC using addendum B of the 2023 Outpatient Prospective Payment System final rule. Percentages may not sum to 100% because of rounding. Units represent the count of services performed and billed by providers.

Hospitals with a High Disproportionate Share Patient Percentage Would Have Their Payment Reductions Capped

The draft legislation would create a stop-loss provision for hospitals with a disproportionate share patient percentage (DPP) that exceeds the median among all hospitals nationally.

Hospitals that qualify for the stop-loss provision would have their decreases in Medicare revenue capped at 4.1% of total payments. Starting in year three of implementation, CMS could choose to weaken the stop-loss policy by increasing the cap to a percentage greater than 4.1% of total payments.

Table 3: Total hospitals by DPP

Type of Hospital	Count of Hospitals	Median DPP	Count of Hospitals at or Above National Median DPP	Count of Hospitals Below National Median DPP
All Hospital Types	**3,199**	**0.2775**	**1,601**	**1,598**

Source: McDermottPlus analysis of 2024 Inpatient Prospective Payment System Proposed Rule impacts file. Table limited to hospitals listed in the 2024 Inpatient Prospective Payment System Proposed Rule impacts file. National median DPP represents the DPP across all 3,199 hospitals nationally.

The DPP formula (as shown below) benefits hospitals with a large share of Medicaid inpatients that are not dually eligible for Medicare. Conversely, the Medicare DPP formula disadvantages Medicare dependent hospitals, which are required to have at least 60% of their inpatient days or discharges attributable to Medicare beneficiaries.[3]

Medicare DPP Formula[4]

$$Medicare\ DPP = \frac{Medicare\ Supplemental\ Security\ Income\ Days}{Total\ Medicare\ Days} + \frac{Medicaid,\ Non\ Medicare\ Days}{Total\ Patient\ Days}$$

Based on this formula, the greater the share of inpatient days attributable to Medicare beneficiaries, the lower the possible share of inpatient days that can be attributed to Medicaid beneficiaries who are not also covered through Medicare. As a result, use of the Medicare DPP formula to identify hospitals eligible for the stop-loss policy may disadvantage hospitals with a large share of Medicare inpatients, including Medicare dependent hospitals, which are more likely to have a DPP that is below the national median.

Conclusion

Site neutral payment policies have the potential to greatly reduce Medicare prices for ambulatory services, which may negatively impact certain HOPD and ASC providers, impact beneficiary access or incentivize changes in provider behavior. Hospitals and ASCs should continue to be on the lookout for future legislative action, as Congress may return to consider site neutral payment policies in the near future.

[3] 42 CFR 412.108(a)(1)(iv).
[4] CMS Medicare Learning Network Factsheet. "Medicare Disproportionate Share Hospital." January 2023.