ALLIANCE FOR
SITE NEUTRAL
PAYMENT REFORM

February 4, 2022

The Honorable Kevin Hern
U.S. House of Representatives
1019 Longworth House Office Building
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The Honorable Rick Allen
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The Honorable Victoria Spartz
U.S. House of Representatives
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Dear Heathy Future Task Force Affordability Subcommittee Members:

As members of the Alliance for Site Neutral Payment Reform, we appreciate the opportunity to comment on the Subcommittee's Request For Information (RFI) on ways to increase price transparency, lower barriers to competition, and empower consumers to have more choice in their healthcare providers.

The Alliance for Site Neutral Payment Reform is a coalition of patient advocates, providers, employers and payers advocating for payment parity across sites of service in order to decrease Medicare and commercial spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs and increase patient access and choice. Since our inception, the Alliance has worked collectively to urge Congress and regulators to advance site neutral payment policies to equalize payments across sites of service for all clinically appropriate outpatient services.

The need for site neutral payment reforms is evident— payment policies supporting higher reimbursement in the hospital outpatient department (HOPD) setting have resulted in increased costs to patients, employers, and taxpayers. Services provided in the physician office setting are reimbursed according to the Medicare Physician Fee Schedule (PFS) and services provided in the HOPD setting are reimbursed according to the hospital outpatient prospective payment system (OPPS) and include a facility fee. As a result, patients and Medicare pay more for the exact same service when it is delivered in the HOPD setting instead of an independent physician practice.

A multitude of studies have verified that care delivered in the HOPD setting costs significantly more than in the physician office setting without providing any meaningful improvement in quality of care or

outcomes. This is true for a wide variety of services; for example**:** chemotherapy: $326[1] vs. $140[2]; cardiac imaging: $5,148 vs. $2,862; colonoscopy: $1,784 vs. 1,322[3]. The increased cost to both patients and Medicare is substantial. Over a three-year period, Medicare paid an additional $2.7 billion on services and patients spent $411 million more in out-of-pocket costs when four specific cardiology, orthopedic, and gastroenterology services were delivered in a hospital-owned setting[4].

This trend is exacerbated in the commercial setting. A 2019 analysis by the Health Care Cost Institute[5] determined that the average price for a given service was always higher when performed in the HOPD setting and average prices rose faster in the outpatient setting compared to the physician office setting. For example:

- The average price for a level 3 diagnostic and screening ultrasound visit increased 4% in office settings from 2009 to 2017, from $233 to $241, and 14% in outpatient settings, from $568 to $650.
- The average price for a level 5 drug administration visit increased 15% in office settings from 2009 to 2017, from $220 to $254, and 57% in outpatient settings, from $423 to $664.
- The average price for a level 4 endoscopy upper airway visit increased 14% in office settings from 2009 to 2017, from $463 to $527, and 73% in outpatient settings, from $1,552 to $2,679.

In addition to increasing costs for patients and for the health care system overall, this payment disparity is also encouraging consolidation across the health care marketplace. A 2019 Avalere analysis[6] for the Physicians Advocacy Institute (PAI) found that the share of physician practices owned by hospitals more than doubled from 2012 to 2018. The COVID-19 pandemic only worsened this trend as hospital systems and other corporate entities continued to drive consolidation by aggressively acquiring physician practices. In a subsequent study[7] for PAI, Avalere examined the impact of the COVID-19 pandemic on physician practice acquisition in 2019 and 2020 found 48,400 additional physicians left independent practice during the two-year study, and, by the beginning of 2021, only 30% of physicians in the United States were practicing medicine independently.

As this payment disparity grows and hospitals acquire more physician practices, care is actually shifting into the more expensive HOPD setting, reversing previous trends. This has a drastic impact on overall Medicare program growth. The Medicare Payment Advisory Commission (MedPAC) March 2018 report stated the hospital outpatient setting has had higher growth in program spending than any other sector in Medicare, and a large source of that growth "appears to have been the shift of services from (lower cost) physician offices to (higher cost) HOPDs." According to MedPAC, from 2011-2016, chemotherapy administration in the HOPD setting rose by 56.1% while chemotherapy administration in the physician office setting declined by 13.4%.

According to the Congressional Budget Office (CBO), this trend will only grow. In its March 2020 baseline, CBO projected OPPS payments would grow by 100%[8] over the next decade; by comparison, PFS payments are only expected to grow by 28%. In fact, physician payments are frozen under current law and subject to the 2% Medicare sequester, which is set to be phased back in later this year and continued through 2031. According to the American Medical Association, when adjusted for inflation in practice costs,

[1] Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems for CY 2022 (CMS-1753-FC)
[2] Revisions to Payment Policies under the Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2022 (CMS-1751-F)
[3] Avalere, PAI Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018, February 2019
[4] Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017
[5] Health Care Cost Institute: Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices, April 2019
[6] Avalere, PAI: Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018, February 2019
[7] Avalere-PAI, COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020, June 2021
[8] Medicare- CBO's Baseline as of March 6, 2020

Medicare physician payment has actually declined 20% from 2001 to 2020[9]. This payment disparity is simply unsustainable and will only encourage further consolidation into the more expensive HOPD setting.

Congress previously recognized the negative consequences this payment disparity has on patients, taxpayers, and businesses by directing CMS to institute site neutral payments for newly-built or newly-acquired off-campus provider-based HOPDs in the Bipartisan Budget Act of 2015. However, the majority of off-campus HOPDs are still able to bill Medicare at the much higher rate for the same services and still have a strong incentive to purchase physician practices and move them into existing HOPDs.

The Alliance applauded the Centers for Medicare and Medicaid Services (CMS) for making further reforms in the 2019 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rule, which instituted site neutral payments for clinic visit services performed at excepted off-campus HOPDs. The Alliance urges Congress to build on these important reforms and examine other opportunities to further payment parity in the outpatient setting, including:

- *Expand site neutral payments to all clinically appropriate outpatient services.* The FY2020 President's Budget called for expanding site neutral payments for all off-campus hospital-owned physician practices. This policy was projected to save approximately $28.7 billion over 10 years.

- *Extend site neutral payments to Part B drug administration.* More narrowly targeted than the above provision, this policy would immediately reduce out-of-pocket prescription drug costs for seniors because Medicare beneficiary cost-sharing is directly related to the Medicare payment rate for the drug and the administration of the drug. This policy is included in H.R. 19, the Lower Costs, More Cures Act of 2021.

- *Improve Medicare site-of-service transparency*. Modify the Medicare Outpatient Procedure Price Lookup tool to include information for services furnished in a physician office. This will empower patients to better understand the variations in cost by site of care and the impact on their out-of-pocket costs. This policy is also included in H.R. 19, the Lower Costs, More Cures Act of 2021.

On behalf of the Alliance for Site Neutral Payment Reform, thank you for your consideration of our comments on the Heathy Future Task Force Affordability Subcommittee RFI. We look forward to working with you and your colleagues to improve health care for all Americans and protect access to high quality, cost-effective, community-based care. We are happy to serve as a resource and welcome any questions about the issues, concerns, and suggestions discussed above.

Sincerely,

The Alliance for Site Neutral Payment Reform
www.siteneutral.org

[9] American Medical Association, Medicare Updates Compared to Inflation (2001-2021), October 2021