ALLIANCE FOR
SITE NEUTRAL
PAYMENT REFORM

Statement for the Record

Senate Finance Committee
Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs
June 8, 2023

The Alliance for Site Neutral Payment Reform thanks Chairman Wyden, Ranking Member Crapo, and members of the Committee for the opportunity to submit this statement for the record of the Senate Finance Committee hearing on "Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs."

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 Alliance commends lawmakers on the Senate Finance Committee for exploring the impacts of consolidation on America's health care system and its contribution to rising costs and decreased access for patients. As the committee considers opportunities to empower patients and lower health care costs, the Alliance encourages lawmakers to consider site neutral payment reforms.

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, taxpayers, and Medicare pay more for the exact same service when it is delivered in the HOPD setting instead of an independent physician practice.

Multiple studies have shown 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.[1] This is true for a wide variety of services; for example**:** chemotherapy: $326[2] vs. $140[3]; cardiac imaging: $5,148 vs. $2,862; colonoscopy: $1,784 vs. 1,322.[4] 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.[5]

[1] JAMA: Organization and Performance of US Health Systems, January 2023
[2] Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems for CY 2022 (CMS-1753-FC)
[3] Revisions to Payment Policies under the Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2022 (CMS-1751-F)
[4] Avalere, PAI Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018, February 2019
[5] Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017

This trend is exacerbated in the commercial setting. A 2019 analysis by the Health Care Cost Institute[6] 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 higher costs to the healthcare system, higher reimbursement in the HOPD setting encourages the acquisition of office-based physician practices, reducing access to care in the lower cost community setting. The Medicare Payment Advisory Commission (MedPAC) June 2022 report concluded that Medicare's payment rates often vary for the same services provided to similar patients in different settings and "encourage arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care."

A 2019 Avalere analysis[7] 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[8] for PAI, Avalere examined the impact of the COVID-19 pandemic on physician practice acquisition in 2019 and 2020. The study 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. Fully 70% of physicians are now employed by hospital systems or other corporate entities such as private equity firms and health insurers. This consolidation impacts other aspects of patient care as physicians in integrated systems are also more likely to refer patients to the owning hospital, which can drive patients to lower quality, high-cost facilities.[9]

As this payment disparity grows and hospitals acquire more physician practices, care is actually shifting into the more expensive HOPD setting, reversing previous trends. The MedPAC June 2022 report also found that as hospitals acquire more physician practices and more physicians become employed by hospitals, large shifts in billing are seen in chemotherapy administration, echocardiography, cardiac imaging, and office visits. According to MedPAC, in 2012, only 35% of chemotherapy administration services were provided in HOPDs; by 2019, this figure rose to 51%.

The physician and the patient should be at the center of the decision on setting of care. Instead, this anti-competitive behavior limits patients' ability to choose where they receive their healthcare and drives up unnecessary health care spending for patients, taxpayers, and the Medicare program. According to the Congressional Budget Office (CBO), this trend will only grow. In its May 2022 baseline, CBO projected OPPS payments would grow by over 100%[10] over the next decade; by

---

[6] Health Care Cost Institute: Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices, April 2019
[7] Avalere, PAI: Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018, February 2019
[8] Avalere-PAI, COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020, June 2021
[9] Journal of Health Economics: The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending, May 2018
[10] Medicare- CBO's Baseline as of May 2022

comparison, PFS payments are only expected to grow by 20%. In comparison, according to the American Medical Association, when adjusted for inflation in practice costs, Medicare physician payment has actually declined 26% from 2001 to 2023.[11] This payment disparity is 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 employers 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 (BBA 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.

Republican and Democrat administrations have also recognized that expanding site neutral payment policies would reduce Medicare spending and premiums and cost-sharing for Medicare beneficiaries and included such proposals in their annual budget requests. The Alliance applauded the Centers for Medicare and Medicaid Services (CMS) for the reforms included 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 off-campus HOPDs that were excepted from the site neutral requirements in BBA 2015.

The Alliance urges the Committee to build on these important reforms and advance payment parity in the outpatient setting by:

- *Eliminating the grandfathering provisions from BBA 2015 and expanding site neutral payments to all clinically appropriate outpatient services provided by off-campus HOPDs.* According to the MedPAC June 2022 report, only 0.8% of total OPPS spending is for services provided in off-campus HOPDs covered by BBA 2015 requirements. Clearly, this law is not fulfilling its goal of reducing consolidation. Congress should eliminate the grandfathering provisions and ensure site neutral payments apply to all off-campus HOPDs.

- *Extending 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. 3561, the PATIENT Act of 2023, which recently passed the House Energy & Commerce Committee by a bipartisan vote of 49-0.

On behalf of the Alliance for Site Neutral Payment Reform, thank you for the opportunity to submit comment. 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

[11] American Medical Association, Medicare Updates Compared to Inflation (2001-2023), April 2023