Every year, the healthcare community braces itself for new proposals seeking to cut healthcare spending. Imaging services often are on the receiving end of these payment cuts. One proposal that has captured the attention of the imaging community, as well as the wider healthcare community and hospitals in particular, involves site neutral payments.

Currently, the Centers for Medicare & Medicaid Services (CMS) pays different rates for the same healthcare service depending on the location where the service is provided (e.g., hospital vs. physician’s office). For example, payment rates for services provided in a hospital outpatient department are typically much higher than rates for the same service provided in a physician-owned medical practice. In its purest form, a site neutral payment policy would entail CMS paying the same rate for the same healthcare service regardless of the location in which the service is provided. From the government’s perspective, the reason behind this policy is potentially billions of dollars in savings.

Payment Systems and Rates

In order to understand site neutral payment policies, one must understand how payment rates are determined for particular services. CMS established different payment systems for different healthcare settings. For example, payment rates for healthcare services provided in a physician-owned medical practice are determined by the Medicare Physician Fee Schedule (MPFS). On the other hand, payment rates for services provided in a hospital outpatient department are determined by the Hospital Outpatient Prospective Payment System (HOPPS). Similarly, ambulatory surgical centers (ASC), inpatient hospital departments, skilled nursing facilities, etc., each have their own payment systems, which determine rates for the services provided at each location. The payment rate for a particular service is based on the location where the service was provided. As a result, payment rates may vary widely across locations—even when the same exact service is provided.

The rationale for using various payment systems is that there are different costs associated with providing healthcare services in different locations. Each payment system has a separate methodology for determining rates for services based on these costs. Hospitals may choose to prepare early for the inevitable through accurate cost reporting, shifting certain ancillary services to more appropriate outpatient, off-site locations, and participating in the Medicare Shared Savings Program.

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The rationale for using various payment systems is that there are different costs associated with providing healthcare services in different locations. Each payment system has a separate methodology for determining rates for services based on these costs. Typically, payment rates are meant to reflect the costs (both operation and capital) of providing the service, costs of operating the site, and the demographic of patients served at the site (e.g., economic status). Rates usually
Due to the different methodologies used by the HOPPS and the MPFS, the payment rates vary dramatically across these two payment systems.

Do not take into account the rates paid at other locations, and each location’s payment system is often entirely independent from another payment system. However, the rates across payment systems for some advanced imaging services are interrelated. For example, with the enactment of the Deficit Reduction Act of 2005, Congress reduced rates for certain imaging services provided in the physician office location to the lower rates for the same services provided in the hospital outpatient location.

So, if payment rates are based on the costs associated with providing a particular service at a particular location, then how are these “costs” determined? In the hospital outpatient setting, the HOPPS uses a number of factors to estimate costs. Facilities such as hospitals are required to submit annual cost reports as a condition of participation in Medicare, and the cost reports are intended to show the actual costs incurred by the hospital. Simplified, the HOPPS methodology uses hospital claims data and annual hospital costs reports to determine estimated costs. More specifically, under the HOPPS methodology, costs are estimated by calculating the median costs (operational and capital) of the services within an ambulatory payment classification (APC) group using the most recently filed cost reports and claims data across similar providers. Next, hospital specific and department specific “cost-to-charge ratios are used to convert billed charges to costs for each HCPCS code.”

On the other hand, the MPFS has its own methodology for determining payment rates for services provided by physicians in, for example, a physician owned medical practice. Each MPFS rate takes into account the physician’s work, the practice expense, and the malpractice expense associated with a particular service, which is then adjusted for geographical differences. The practice expense component is similar to the “facility fee” a hospital would receive for a particular service in that it is intended to reflect the individualized costs the physician incurs for staff, productivity enhancing technology, and materials. Unlike hospitals, physicians do not submit annual cost reports to CMS. Instead, CMS estimates the costs associated with the practice expense component of a particular service.

Due to the different methodologies used by the HOPPS and the MPFS, the payment rates vary dramatically across these two payment systems. In June 2014, the National Institute for Health Care Reform reported on a study conducted by the Center for Studying Health System Change. In the article, the authors discussed a number of common procedures for which the price differential based on location is significant. One example cited was the 2014 payment rates for an MRI of the knee with contrast (CPT code 73721), which, on average, paid out at a rate of $919 in the outpatient department setting versus $606 in the community based setting (eg, physician office). This is just one example of payment discrepancies that have brought the issue to the forefront. Not surprisingly, in an effort to cut costs, the site neutral payment policies proposed by the government often involve neutralizing payments to whichever rate is lowest.

Because rates are calculated based on costs, then isn’t the payment differential justified if different locations incur higher costs when providing the same service? The answer to this question often depends on who you ask (ie, the government, hospital providers, or other providers). Additionally, this question is complicated by the fact that many physician practices are now owned by hospitals. If these practices meet certain requirements, then they are reimbursed at the (typically) higher HOPPS rate rather than the lower MPFS rate—simply because they are hospital owned. Hospitals argue that it costs more for a hospital to run a medical practice than it does for a physician. In any event, the recent prevalence of hospital owned physician practices has caused the most recent push for site neutral payment policies.

The Move to Site Neutrality

Site neutral payment proposals are not new. The Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policies, has advocated for site neutrality for years. In a June 2013 “Report to Congress,” MedPAC advocated for site neutral payments and stated that:

[T]hese payment differences between settings may cause Medicare and beneficiaries to pay more than necessary and may encourage arrangements among providers that result in more care being provided in higher paid settings. Therefore, in its fee-for-service payment systems, Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (ie, highest quality, lowest cost) setting, adjusting for differences in patient severity to the extent that severity differences affect costs. In the absence of comparable data on providers’ costs and quality across settings, Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries.

MedPAC recommended site neutral payments for certain services, including imaging services, that:

1. are safe and appropriate to provide in physician offices and where the MPFS payment rate is sufficient to ensure access to care;
2. involve payment rates across payment systems (ie, HOPPS and MPFS) that include a similar set of services (ie, similar packaging);
3. are unlikely to incur costs associated with emergency room department visits;
4. have patient severity that would be no greater in outpatient departments than in physician offices; and
5. are not 90-day global codes, which are associated with higher costs when performed in the hospital setting.

Using these factors, MedPAC identified 66 categories of services organized by APC code and placed them into two groups. Group 1 included 24 services that met all five of the above mentioned criteria, and for which MedPAC recommended equalizing payment rates across all locations. Group 2 included 42 services that met four of the five criteria, and for which MedPAC recommended reducing the difference (albeit not completely) between the HOPPS and MPFS rates. Imaging services in group 1 included: level I and level III diagnostic and screening ultrasounds; level II echocardiograms without contrast; MRI and magnetic resonance angiography without contrast; and axial skeleton bone density tests. Imaging services in group 2 included: level I radiation therapy and cardiac CT imaging. MedPAC estimated that the site neutral payment policies referenced in its June 2013 Report, coupled with its previous recommendations for site neutrality to be applied to evaluation and management services across locations, will result in Medicare program and beneficiary cost-sharing savings of approximately $1.8 billion per year.

However, the American Hospital Association (AHA) vehemently objected to MedPAC’s proposals and argued that HOPPS payment rates have already been reduced to unsustainable levels in the MPFS and that lowering hospital payments to such a rate would be devastating for hospitals. The AHA argues, and MedPAC acknowledges, that hospitals incur costs that justify the higher payment rates. For example, hospitals are open 24 hours a day and are required “to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay.” Additionally, patients treated in hospitals may have more severe conditions than patients in a physician’s office. Hospitals also incur additional costs in the form of having to comply with more stringent licensing, accreditation, and regulatory laws. Hospitals also argue that the HOPPS payment rates include more “packaging” of items and services into a single payment than under the MPFS, and that the higher payment rates under the HOPPS reflect this increased packaging. In all, MedPAC estimates that hospitals would lose $1.44 billion in revenue in one year under the proposed site neutrality policies.

MedPAC addressed some of these concerns directly in the five criteria used to determine which services should be subject to site neutrality policies (eg, choosing services with similar packaging and patient severity across locations). To address other concerns, MedPAC recommended that policymakers consider: (i) “a stop-loss policy that would limit the loss of Medicare revenue for hospitals that serve a large share of low-income patients;” and (ii) “a mitigation policy…to prevent access problems for rural beneficiaries.” These recommendations may not do much to alleviate hospitals’ concerns. However, MedPAC is not backing down on its recommendations. In fact, MedPAC recommended similar policies across hospital outpatient department and ambulatory surgical center settings. And, most recently, MedPAC expanded its recommendation of site neutral payments to locations such as skilled nursing facilities and inpatient rehabilitation facilities.

CMS has also considered how to best implement site neutrality. However, CMS’s approach often differs from that of MedPAC, and CMS is not obligated to adopt MedPAC’s recommendations. Rather than targeting high HOPPS payment rates, CMS first targeted payments under the MPFS. By way of brief background, there are a number of services paid at a higher rate under the MPFS than the HOPPS due to what CMS believes is the use of flawed data. CMS maintained that the higher HOPPS rates were necessary due to the higher costs of operating a hospital, but sought to reduce certain payment rates under the MPFS that exceeded the rates paid under the HOPPS. Ultimately, CMS did not adopt this proposal.

In its 2015 HOPPS and ASC Payment System Proposed Rule, CMS sought public comments on how to collect data to analyze payment rates for services provided in the off campus, provider based outpatient departments (eg, physician’s office) in light of the increase in hospital acquisition of physician practices. In finalizing this rule, CMS created the HCPCS modifier “PO” to be attached to every code for outpatient hospital services furnished in an off campus, provider based department of a hospital. It is yet to be seen what the data will reveal and how CMS will react during the rulemaking process. But the signs point to CMS adopting some form of site neutrality.

This is made all the more likely by the release of President Obama’s 2016 Fiscal Year Budget. The 2016 budget includes a provision to reduce payment for services provided in provider based, off campus hospital outpatient departments to either the lower MPFS rate or the ASC payment system rate. If the MPFS rate is used, this would essentially equalize payments for the same services whether provided in a physician owned medical practice or in an off campus, hospital owned physician office. The estimated savings could equal $30 billion over the next decade.

**Patient Benefits**

Closing the payment differential will not only result in savings for the federal government, but patients will experience savings as well. Patients often have options as to where to receive a particular service. For example, many surgeries can be performed either in a hospital or an ASC, and sometimes even in a physician’s office. Similarly, patients often have the choice of whether to receive imaging services at a hospital or physician’s office. Many patients have copayment obligations of 20% of the cost of the service (eg, Medicare pays 80% of the allowable
charge for physician services after the patient’s deductible is met). Because the cost of the service is determined by the location in which the service is provided, a patient’s copayment may vary widely for the same exact service depending on the location the patient chooses.

As the healthcare benefit landscape continues to change (eg, many patients find themselves with high deductible insurance plans), patients are becoming well informed consumers of healthcare services and seek the best care for the lowest price. While site neutrality would certainly lower patients’ copayment obligations for many services, the question many are asking is, at what price? Many healthcare providers argue that the real challenge in implementing site neutrality will be in maintaining a high level of quality care in light of the decrease in revenue hospitals will experience.

**Preparing for Site Neutrality**

In April 2015, The Advisory Board Company published an article which projected that it is a matter of “when, not if” site neutrality will be implemented. So, what can hospitals and their departments do to prepare? First, accurate hospital cost reporting and claims data submission are essential to ensuring hospitals are properly reimbursed for costs incurred. For many hospital departments, including imaging departments, preparing the annual departmental cost reports is a huge undertaking. It is imperative that hospitals dedicate the time and resources necessary to ensure accurate cost reports and claims data so that the payment rates—which are calculated based on this data—accurately reflect the cost of providing the services.

Second, the Advisory Board recommends that hospitals prepare for the shift to site neutrality by redesigning their healthcare delivery models and shifting certain ancillary services to more appropriate outpatient, off site locations. According to the Advisory Board, returning certain outpatient services to the practice setting will lower costs, provide greater access to care, reduce duplication of equipment and labor, and allow hospitals to backfill hospital outpatient space with services that are truly needed in that setting. But hospitals should take care to transition slowly by reevaluating operational activities such as current management of outpatient services, revenue cycle operations, physician compensation, and patient access.

Third, the Advisory Board recommends that hospitals seek to regain some of the lost revenue by participating in the Medicare Shared Savings Program or Medicare Advantage. These programs incentivize providers by providing rewards for reducing utilization and increasing Medicare savings. The Advisory Board recognizes that participation in these programs will not entirely offset the losses incurred from site neutrality policies, but they can help tremendously. The Advisory Board also recommends exploring entering into meaningful risk sharing arrangement for greater impact.

**Conclusion**

Some hospitals and imaging departments may be asking not what they can do to prepare for site neutrality, but how they can fight against it. With the government inevitably focused on the cost savings associated with site neutrality, those wishing to shift the focus to the negative effects site neutrality may have on healthcare can advocate their position—whether it be for, against, or somewhere in the middle—through the rulemaking and commentary process. When CMS issues proposed regulations, there is a comment period for interested parties in the community to submit comments to the drafters. For example, the comment period for the 2016 HOPPS and ASC Payment Proposed Rule ended on August 31, 2015, and the comment period for the 2016 Proposed MPFS ended on September 8, 2015. Interested providers can expect the 2017 HOPPS and ASC Payment Proposed Rule and the 2017 MPFS Proposed Rule, both of which will likely discuss site neutrality, to be released in or around July 2016 with a comment period of about 60 days. Providers may also consider appealing to their professional organizations to advocate on behalf of them and fellow members.

The real challenge lies in determining which payment system most accurately reflects the cost of providing a particular service. It is difficult to compare payment rates across locations due to different methods for calculating costs and different policies on packaging items and services into one service code (ie, CPT or HCPCS code). For now, the healthcare community will wait to see how CMS will tackle these issues, and hospitals may choose to prepare early for the inevitable.

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Questions

Instructions: Choose the answer that is most correct.

1. Currently, the Centers for Medicare and Medicaid Services (CMS) pays different rates for the same healthcare service depending on the:
   a. Frequency of the service provided
   b. Time the service was provided
   c. Location where the service was provided
   d. Provider of the service

2. From the government’s perspective, the reason behind a site neutral payment policy is potentially saving:
   a. Trillions of dollars
   b. Billions of dollars
   c. Millions of dollars
   d. Hundreds of dollars

3. Payment rates for healthcare services provided in a physician owned medical practice are determined by the:
   a. Medicare Physician Fee Schedule (MPFS)
   b. Medical Payment Plan (MPP)
   c. Private Physician Fee Association (PPFA)
   d. Healthcare Coverage Payment Division (HCPD)

4. Payment rates may vary widely across locations, even when the same exact service is provided.
   a. True
   b. False

5. Congress reduced rates for certain imaging services provided in the physician office location to the lower rates for the same services provided in the hospital outpatient location with enacting the Deficit Reduction Act of:
   a. 2011
   b. 2009
   c. 2007
   d. 2005

6. Under the Hospital Outpatient Prospective Payment System (HOPPS) methodology, costs are estimated by calculating the:
   a. Highest costs of the services
   b. Lowest costs of the services
   c. Median costs of the services
   d. Have not been determined yet
7. For determining payment rates for services provided by physicians, each Medicare Physician Fee Schedule (MPFS) takes into account the physician’s:
   a. Work
   b. Practice expense
   c. Malpractice expense associated with a particular service
   d. All of the above

8. Due to the different methodologies used by the HOPPS and the MPFS, the payment rates across these two payment systems:
   a. Are the same
   b. Vary dramatically
   c. Differ slightly
   d. Are unknown

9. In a “Report to Congress,” MedPAC advocated for site neutral payments in:
   a. October 2014
   b. April 2015
   c. December 2012
   d. June 2013

10. MedPAC recommended site neutral payments for certain services, including imaging services, that:
    a. Are likely to incur costs associated with emergency room department visits
    b. Involve payment rates across payment systems that do not include a similar set of services
    c. Are 90-day global codes, which are associated with lower costs when performed in the hospital setting
    d. Have patient severity that would not be greater in outpatient departments than in physician offices

11. How many categories of services did MedPAC identify that are organized by APC code and placed into two groups?
    a. 87
    b. 66
    c. 45
    d. 31

12. MedPAC estimated the site neutral payment policies coupled with its previous recommendations for site neutrality will result in Medicare program and beneficiary cost-sharing savings of approximately:
    a. $1.8 billion per year
    b. $3.2 billion per year
    c. $5 billion per year
    d. $6 billion per year

13. Hospitals also incur additional costs in the form of having to comply with:
    a. More stringent licensing
    b. Accreditation
    c. Regulatory laws
    d. All of the above

14. CMS sought public comments on how to collect data to analyze payment rates for services provided in the off campus, provider based outpatient departments in the:
    a. 2015 HOPPS and ASC Payment System Proposed Rule
    b. 2014 Increased Cost Adoption
    c. 2013 Decrease the Cost Questionnaire
    d. 2012 Data Implementation Survey

15. Many patients have copayment obligations of:
    a. 20% of the cost of the service
    b. 40% of the cost of the service
    c. 50% of the cost of the service
    d. 65% of the cost of the service

16. Many healthcare providers argue that the real challenge in implementing site neutrality will be in maintaining a high level of quality in light of the increase in revenue hospitals will experience.
    a. True
    b. False

17. In April 2015, The Advisory Board Company published an article which projected that it is a matter of “when, not if” site neutrality will be:
    a. Reviewed
    b. Completed
    c. Implemented
    d. Terminated

18. According to The Advisory Board, returning certain outpatient services to the practice setting will:
    a. Lower costs
    b. Provide greater access to care
    c. Reduce duplication of equipment and labor
    d. All of the above

19. The Advisory Board recommends that hospitals seek to regain some of the lost revenue by participating in the:
    a. Medicare Plus Programs
    b. Medicare Shared Saving Program or Medicare Advantage
    c. Medicaid Funding Plan
    d. Medicaid Revenue

20. Interested providers can expect the 2017 HOPPS and ASC Payment Proposed Rule and the 2017 MPFS Proposed Rule to be released in or around July 2017 with a comment period of about:
    a. 30 days
    b. 45 days
    c. 60 days
    d. 90 days