To achieve the goal of paying the same price for the same service, many have proposed making Medicare’s payments for certain services site-neutral. Under site-neutral payment, services provided to patients with similar conditions and characteristics would be reimbursed the same amount no matter where the service is delivered. Site-neutral payment has been discussed by the Medicare Payment Advisory Commission (MedPAC), the current and prior administrations, and others, most frequently in the context of paying for post-acute care (PAC) services provided by skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). Currently, Medicare pays these PAC providers different amounts, even though the types of patients served, services received, and outcomes of care are often very similar.¹

In its March 2015 Report to the Congress, MedPAC reiterated concerns about the shortcomings of Medicare’s PAC payment systems and called on the U.S. Department of Health and Human Services (HHS) to begin moving toward site-neutral payment. Specifically, MedPAC recommended a phased-in elimination of differences in payment rates between IRFs and SNFs for selected conditions.² More broadly, MedPAC has called for developing a unified PAC payment system that would pay providers on the basis of patient characteristics rather than the site of care.

Calls for site-neutral payment have also surfaced in conjunction with ambulatory outpatient services provided in stand-alone physicians’ offices and hospital outpatient departments (OPDs). A service provided in a hospital OPD is typically more expensive than the same service furnished in a stand-alone physician’s office. For instance, the OPD collects a fee
for the physician’s time as well as a facility fee that is intended to compensate the hospital for its higher overhead costs. To complicate matters, some hospitals have purchased physician practices and are charging the outpatient facility fee for services provided in a physician’s office even if it is located miles from the hospital.3

Considerable money is at stake for the Medicare program, private insurers, and beneficiaries, all of whom pay more when services are provided in sites of care with higher payment rates. For example, both SNFs and IRFs provide care to patients who have had a stroke or a hip replacement, but per-stay payments are 25 to 40 percent higher in IRFs than SNFs.4 Similarly, a level II echocardiogram provided in a hospital OPD costs Medicare and beneficiaries 116 percent more than if it had been provided in a freestanding physician’s office.5 MedPAC estimates that, for 66 ambulatory services, the shift of care from stand-alone physician’s offices to hospital OPDs cost Medicare $1.2 billion in additional payments in 2013; beneficiaries paid an additional $240 million in coinsurance.6 MedPAC has called for aligning OPD rates with freestanding office rates to limit the incentives to shift cases to higher-cost settings.7

Both IRFs and hospital OPDs argue that their higher payment rates are justified because of differences in their underlying cost structures. Unlike SNFs, IRFs must meet Medicare’s conditions of participation for acute care hospitals. As a result, they are required to have more nursing resources available than SNFs, and care must be supervised by a rehabilitation physician.8

Hospitals cite the “unfunded” costs of providing 24/7 access to emergency services, serving vulnerable populations including the un- and underinsured, maintaining emergency standby capacity, and responding to disasters. They say these services can only be provided because their costs are supported by “revenues received from providing direct patient care across various settings.”9

Hospitals also argue that they treat high-severity patients.10 Finally, it has been suggested that if site-neutral payment policies were adopted, they might be short-lived because of the evolving nature of payment and delivery systems which may become more episode-based.11 A bundled payment for PAC services, for example, could create incentives to use the most appropriate and efficient site of care based on a more refined assessment of patient needs.

Of course, formulating a sound site-neutral payment policy is easier said than done. Patients differ, and not all conditions may be suitable for site-neutral payment. Even when site-neutral payments
are deemed appropriate, the lack of comparable patient assessment data from across the various settings is a major stumbling block to implementation. Uniform data are needed to risk adjust outcomes and provider payments. To address this problem, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires PAC providers to begin collecting uniform assessment data in 2018; in 2020 the Secretary of HHS is required to report to Congress on recommendations for a uniform payment system for PAC. The Act also charges MedPAC with developing a prototype prospective payment system that would apply to all PAC settings. The goal is to use common assessment data to “set a single payment rate based on a patient’s conditions and characteristics” that would follow the patient regardless of setting.12

SESSION

This Forum session reviewed the issues that have prompted calls for site-neutral payment for certain post-acute and ambulatory care services. It also highlighted some of the concerns and cautions that have been raised with regard to adopting site-neutral payment policies in Medicare and private insurance. Mark E. Miller, PhD, executive director of the Medicare Payment Advisory Commission, described the Commission’s findings and recommendations focusing on post-acute care provided in skilled nursing facilities and inpatient rehabilitation hospitals, as well as ambulatory care provided in hospital outpatient departments and stand-alone physicians’ offices. Donald Fischer, MD, senior vice president and chief medical officer at Highmark Inc., discussed site-neutral payment from the perspective of an insurer. Gerben DeJong, PhD, FACRM, senior fellow for health policy and post-acute care at the MedStar National Rehabilitation Hospital, and Michael Sack, MSPH, FACHE, former president and chief executive officer of Hallmark Health System (Massachusetts), offered their perspectives as providers and discuss some of the risks and challenges of developing site-neutral payment policies.

KEY QUESTIONS

• What evidence did MedPAC consider in recommending site-neutral payment policies for Medicare? Why are some insurers calling for site-neutral payments?
• What are the primary obstacles to implementing site-neutral payments?

• What are the downsides of site-neutral payment for payers? For providers? For patients?

• How does site-neutral payment fit within a rapidly evolving health delivery system that is experimenting with bundling and other forms of payment for episodes of care or for populations?

• How do we reconcile site-neutral payment with our expectations that hospitals will continue to provide standby capacity and other “unfunded” services? Are there other ways to finance these hospital services?

ENDNOTES


2. Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, March 2015, p. 161, www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf. The Pathway to SGR Reform Act of 2013 phased in site-neutral payment for long-term care hospitals (LTCHs) beginning in fiscal year 2016. LTCH-level payments will be restricted to certain chronically critically ill patients discharged from an acute care hospital to an LTCH. These patients’ acute hospital stays must have included at least three days in an intensive care unit or they must have received at least 96 hours of mechanical ventilation while in the LTCH. Payment for all other discharges from the LTCH will be site-neutral. These discharges will be paid at a rate comparable to an acute care hospital or 100 percent of the cost of the care, whichever is less.


4. Miller, “Medicare Fee-For-Service Payment Across Sites of Care,” p. 5.


7. Miller, “Medicare Fee-For-Service Payment Across Sites of Care,” p. 15.


10. Coopwood, “Keeping the Promise,” AHA testimony, p. 3.
