

## Potential Impacts of Medicare Site Neutrality on Off-Campus Drug Administration Costs

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### Background

Many types of healthcare services can be performed in multiple settings. Even when there is little variation in the service provided, the Medicare program and Medicare beneficiaries typically pay more when that service is performed in a hospital outpatient department (HOPD) than when the same service is performed in a physician office or ambulatory surgical center (ASC).

Over the past several years, limited policies to promote site neutral payments have been implemented. These policies have consisted of a combination of legislation for services performed at new (non-excepted) off-campus HOPDs and payment system rules for clinical evaluation services at all off-campus HOPDs.<sup>1</sup> However, these policies impact only 0.8% of outpatient spending.<sup>2</sup>

At the same time, many relevant stakeholders have been pushing for broader approaches to achieving site neutrality, where appropriate. MedPAC included chapters in each of their last two years' Reports to Congress dedicated to broadening site neutrality to all services which can safely be performed in multiple settings.<sup>3</sup> This year, legislative proposals from both parties in both chambers of Congress have included site neutrality provisions specific to off-campus HOPDs.<sup>4</sup>

Actuarial Research Corporation (ARC) has developed a simulation model to illustrate the current state of billing practices, payment rates, and the hypothetical impacts of site neutrality across a variety of inputs which define the scope of services and approach to payment neutrality. In this brief, we explore site neutrality related to drug administration services, which are specifically targeted in the bills under consideration in the House of Representatives. Drug administration includes the intravenous or intramuscular administration of a range of medicines. Considering these services in the context of site neutrality is particularly insightful given their high volume, the magnitude of rate differences between settings, and billing practices which make comparisons across settings relatively straightforward.

### Current State

Drug administration can be performed in either physician offices or HOPDs. In Medicare outpatient payment methodologies, drug administration is categorized into four levels of complexity. Payments are set at a category level, called the Ambulatory Payment Classification (APC). Within a category of complexity, the effort to administer a drug does not meaningfully differ between settings. The fact that 68% of these services currently take place in physician offices provides evidence that they can be safely performed in multiple settings. These considerations led MedPAC to include drug administration on their list of recommended services for site neutrality. As Table 1 shows, **the rate Medicare and beneficiaries pay in most HOPDs is currently 200-300% of the rate paid for the same services in physician offices.**

**TABLE 1: ALLOWED COSTS AND FREQUENCIES FOR DRUG ADMINISTRATION IN PHYSICIAN OFFICES AND HOPDs (2021)<sup>2</sup>**

APC	Average Allowed Cost (per Service)				Relativity to Office	
	Physician Office	Off-Campus HOPD Non-Excepted	Off-Campus HOPD Excepted	On-Campus HOPD <sup>5</sup>	Off-Campus HOPD Excepted	On-Campus HOPD
5691 Level 1 Drug Admin	\$24.92	\$31.16	\$57.12	\$73.10	229%	293%
5692 Level 2 Drug Admin	\$29.25	\$29.15	\$74.47	\$83.36	255%	285%
5693 Level 3 Drug Admin	\$68.85	\$81.51	\$209.58	\$213.94	304%	311%
5694 Level 4 Drug Admin	\$132.62	\$124.55	\$323.22	\$341.68	244%	258%
Frequency (%)	67.8%	1.5%	5.6%	25.1%		

Note: Average allowed costs are for the drug administration service only, and do not include separately paid drug costs.

Table 1 also shows that neutrality has largely been achieved at non-excepted off-campus HOPDs, but that only covers 1.5% of drug administration services. Expanding neutrality to excepted off-campus HOPDs would increase the number of drug administration services subject to site-neutral payments five-fold.

The billing and payment for drug administration is relatively straightforward. There is usually only one bill for the administration service: when performed at an HOPD, an institutional payment is determined by the Outpatient Prospective Payment System (OPPS); and when performed in a physician office, a professional payment is determined by the Physician Fee Schedule (PFS). This contrasts with other services which can result in both a professional bill and an institutional bill (“facility fee”) for the same service.<sup>6</sup> For the drug itself, payment is usually separate from the administration. The exception to separately paid drugs is low-cost drugs within OPPS, where the APC payment for administration is intended to also cover the drug costs. However, the impact of this low-cost drug bundling is insignificant relative to the magnitude of the rate differences across settings.<sup>7</sup> Therefore, Table 1 simply compares the average PFS rate when the drug administration takes place in an office to the average OPPS rate when the service takes place in an HOPD.

In all ambulatory places of service, Medicare covers drug administration under Part B. Therefore, the beneficiary is usually responsible for 20% of the rate as cost sharing.<sup>8</sup> As an example, for Level 4 Drug Administration, there is an average per-service allowed cost difference of approximately \$200. Therefore, **the beneficiary cost sharing is \$40 higher if they receive the drug in an HOPD rather than in a physician office.**

## Aggregate Site Neutrality Impacts

Site neutrality has largely been achieved at non-excepted off-campus HOPDs, as discussed above. Neutrality at non-excepted off-campus HOPDs was required in 2015 legislation and first implemented in the 2017 OPPS and PFS rules. Within these payment systems, neutrality is implemented by applying a uniform 40% multiplier (“Relativity Adjuster”) to the OPPS rates.<sup>1</sup>

Table 2 shows the impact of expanding neutrality for drug administration to include excepted off-campus HOPDs. Had this expanded neutrality been in effect in 2021, **aggregate allowed costs would have been \$201 million lower.**<sup>9</sup> For beneficiaries utilizing these services in excepted off-campus HOPDs, annual cost sharing would have been \$55.94 lower. Across all of Medicare, the annual cost sharing reduction per beneficiary would have been \$1.12.<sup>8</sup> The standard Part B premium would have been \$1.14 per year lower.

**TABLE 2: SAVINGS HAD DRUG ADMINISTRATION BEEN SITE NEUTRAL AT ALL OFF-CAMPUS HOPDs IN 2021<sup>2</sup>**

APC	Aggregate Savings	Medicare Program Savings <sup>9</sup>	Beneficiary Cost Share Savings	Standard Part B Premium Savings
5691 Level 1 Drug Admin	\$26m	\$21m	\$5m	
5692 Level 2 Drug Admin	\$31m	\$25m	\$6m	
5693 Level 3 Drug Admin	\$45m	\$36m	\$9m	
5694 Level 4 Drug Admin	\$99m	\$79m	\$20m	
Total (\$ millions, 2021)	\$201m	\$161m	\$40m	
Total (Per-Beneficiary-Per-Year)	\$5.59	\$4.48	\$1.12 (all) \$55.94 (impacted)	\$1.14

Note: Cost Share Savings per Impacted Beneficiary (\$55.94) includes all beneficiaries with at least one drug administration service at an excepted off-campus HOPD. Beneficiaries who receive regular drug administration services would have realized greater savings (see Table 3).

We estimated the impact of expanding site neutrality for drug administration to excepted off-campus HOPDs using two methods. First, we assumed the 40% Relativity Adjuster was simply expanded to excepted off-campus HOPDs. Second, we estimated a more precise neutrality implementation where the OPPS rate would be set for each APC at the average rate paid for the same mix of services under the PFS. The table above reflects the first method, for consistency with existing site-neutral policy implementation. However, utilizing the second, more precise, method would have yielded savings which were only \$6 million higher in aggregate, indicating the 40% multiplier is a potentially accurate simplification for implementing neutrality.

Savings estimates presented in this brief consider only fee-for-service (FFS) Medicare. There would be additional impacts to Medicare Advantage, where roughly half of Medicare beneficiaries receive their care, given benchmarks are tied to FFS experience. Savings would likely materialize in the commercial segments as well, given contracting practices often mirror Medicare.

It is worth noting that a significantly larger share of drug administration takes place in on-campus HOPDs than off-campus. Were neutrality applicable to all HOPDs, as MedPAC proposed, aggregate savings associated with drug administration would have been over \$1 billion in 2021 (not shown in exhibit).

## Chemotherapy Patients' Out of Pocket Costs

Drug administration services are skewed toward a small portion of the population with high utilization. Cancer patients receiving chemotherapy are among the highest utilizers of these services. Focusing on the cost sharing of chemotherapy patients demonstrates how this cohort is disproportionately impacted by the current payment structure and is uniquely positioned to benefit from site neutrality expansion.

Table 3 shows relevant statistics related to utilization and cost sharing per impacted chemotherapy patient. In 2021, approximately 74,000 Medicare FFS chemotherapy patients utilized excepted off-campus HOPDs and would have had cost sharing expenses that were \$292 lower per patient had site neutrality applied. For the highest utilizing 5,000 patients who received chemotherapy most frequently at excepted off-campus HOPDs, **cost sharing would have been \$1,055 lower per patient if payments had been site neutral.**

**TABLE 3: CHEMOTHERAPY UTILIZATION AND COST SHARING AT EXCEPTED OFF-CAMPUS HOPDs IN 2021<sup>2</sup>**

	<b>All Chemotherapy Utilizers</b>	<b>High-Frequency Chemotherapy Utilizers</b>
% of Medicare Population	2.4%	0.14%
Number of Services per Patient	9.5	44.4
<b>Using Excepted Off-Campus HOPDs:</b>		
Approx. Number of Patients	74,000	5,000
Current State – Avg. Annual Cost Sharing	\$486	\$1,759
Site Neutral – Avg. Annual Cost Sharing	\$194	\$704
<b>Avg. Cost Sharing Savings if Site Neutral</b>	<b>\$292</b>	<b>\$1,055</b>

Note: Number of Patients includes only patients with FFS Medicare using Excepted Off-Campus HOPDs.

The 74,000 patients who used excepted off-campus HOPDs for chemotherapy administration corresponds to 8.5% of all chemotherapy patients, which is higher than the 5.6% off all drug administration which takes place at excepted off-campus HOPDs (as shown in Table 1). This means that off-campus site neutrality legislation would impact a greater share of chemotherapy patients than beneficiaries receiving other types of drug administration. Still further, if neutrality were applied to on-campus HOPDs, the number of impacted patients would have increased from 74,000 to over 320,000 (not shown in table).

## Conclusions

In discussions of site neutrality reform, drug administration services have received particular focus given their relatively straightforward payment methodologies, intuitive arguments for neutrality, and sizable share of Part B spending.

Drug administration is already site neutral at non-excepted off-campus HOPDs. However, these non-excepted locations make up less than 2% of service volume. At excepted off-campus HOPDs, payment rates are more than double rates at non-excepted HOPDs and office locations. Expanding neutrality to all off-campus HOPDs, as recent legislative bills have proposed, would cover an additional 6% of drug administration service volume, with annual savings which would have been \$161 million to Medicare and \$40 million to beneficiaries in 2021.

The administration of chemotherapy highlights that a small portion of the population is disproportionately harmed by the current state of drug administration payment. A meaningful number of beneficiaries in this cohort are paying hundreds (and occasionally thousands) of dollars more per year in cost sharing than had they received treatments at offices or non-excepted off-campus HOPDs. The recent legislative bills would significantly benefit this population.

Expanding site neutrality for drug administration services at off-campus HOPDs would reflect incremental progress toward the recommendation in MedPAC's June 2023 Report to the Congress. MedPAC's recommendation includes expansion of site neutrality to a broader set of services, of which we estimate drug administration to be approximately 20% of the opportunity, at both on- and off-campus HOPDs.

## Disclosures

This work was supported by Arnold Ventures. ARC maintains full editorial control over the written policy analysis and savings estimates.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all communications with respect to actuarial services. Tim Bulat is a member in good standing of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this brief.

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## Notes

<sup>1</sup> The 2015 Bipartisan Budget Act introduced site neutrality for non-excepted off-campus HOPDs. This bill also defined excepted off-campus HOPDs as those grandfathered from site neutrality because they were already operating as off-campus HOPDs prior to the bill's passage. In 2019, site neutrality specific to clinical evaluation and management was expanded in the OPPS and PFS payment rules to excepted off-campus HOPDs.

<sup>2</sup> Analytical results throughout this brief are based on ARC analysis of carrier and outpatient claims in the 2021 Medicare 5% sample Limited Data Set (LDS). Results exclude services performed in: Emergency Departments, Federally Qualified Health Centers, Community Access Hospitals, Rural Health Clinics, End Stage Renal Disease facilities, and other specialty facilities. When results are shown at the APC level, office rates reflect a weighted average of actual allowed costs for all HCPCS which map to the designated APC under OPPS. Site neutrality impacts are based on ARC's site neutrality scenario model, populated with 2021 Medicare 5% sample LDS claims.

<sup>3</sup> MedPAC. June 2022. Chapter 6: Aligning fee-for-service payment rates across ambulatory settings.  
[https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-default-document-library-jun21\\_ch6\\_medpac\\_report\\_to\\_congress\\_sec-pdf-copy/](https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-default-document-library-jun21_ch6_medpac_report_to_congress_sec-pdf-copy/) and

MedPAC. June 2023. Chapter 8: Aligning fee-for-service payment rates across ambulatory settings.  
<https://www.medpac.gov/document/chapter-8-aligning-fee-for-service-payment-rates-across-ambulatory-settings-june-2023-report/>

<sup>4</sup> In the House, see the PATIENT Act of 2023 (HR5361) and the Lower Costs, More Transparency Act (HR5378). In the Senate, see the SITE Act (S1869) and the Primary Care and Health Workforce Expansion Act.

- <https://www.congress.gov/bill/118th-congress/house-bill/3561/text>
- <https://www.congress.gov/bill/118th-congress/house-bill/5378/text>
- <https://www.congress.gov/118/bills/s1869/BILLS-118s1869is.pdf>
- [https://www.sanders.senate.gov/wp-content/uploads/TAM23D25\\_07.19.2023.pdf](https://www.sanders.senate.gov/wp-content/uploads/TAM23D25_07.19.2023.pdf)

<sup>5</sup> While both on-campus HOPD and excepted off-campus HOPD payment rates are determined by the OPPS, the average allowed costs are not identical due to outlier payments, geographic mix, and other components of the OPPS methodology.

<sup>6</sup> Less than 1% of drug administration services in HOPDs are billed on both the professional (CMS-1500) and institutional (UB-04) bill. This contrasts to many other services which typically include a matching (same day & service) professional and institutional bill (sometimes referred to as the "Facility Fee") for the same service.

<sup>7</sup> Under OPPS, high-cost drugs are paid separately, while low-cost drugs are often bundled into the APC payment. We estimated the impact of bundling using the average allowed costs for the same drugs when administered in physician offices, where payment for the drug is always separate and a function of average sale price (ASP). Using this methodology, the cost of bundled drugs was approximately 5% of excepted off-campus HOPD rates.

<sup>8</sup> In Medicare Part B, a 20% coinsurance is required after a nominal deductible is met (\$203 in 2021). While many beneficiaries have a Medicare Supplement plan which directly pays the Part B coinsurance, pricing in the Medicare Supplement market is extremely competitive, and we implicitly assume savings would be passed to beneficiaries in terms of lower Medicare Supplement premiums.

<sup>9</sup> The savings estimates do not consider OPPS budget-neutrality requirements. Under current law, any decreases in payments for certain services would be offset by increases in services not made site neutral. To fully realize the savings, legislation would have to exempt site neutrality savings from budget neutrality calculations, as the recent House of Representatives bills propose.