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The Health Wonk Shop: What's Behind the Buzz about Site-Neutral Payments?

Larry Levitt: Hello. I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. About once a month we dive into timely and complex health policy topics with experts from a variety of perspectives. Today's topic is about as wonky as they come, site neutral payments for hospitals. Right now, in many circumstances, what appears to be the same service might cost much more in a hospital outpatient department than in a freestanding physician's office. It's become a much bigger issue as hospitals have acquired physician practices and started charging facility fees at these off-campus clinics. This has led to calls, especially in Medicare for so-called site neutral payments, that is the same price for a service no matter where it's delivered. There's potential to save Medicare and potentially private payers a lot of money that not surprisingly has hospitals quite concerned, especially those with low or negative margins.

There's bipartisan support in Congress to move further towards site neutral payments in Medicare, and a bill has passed the house, but it's anybody's guess what Congress might do in this divisive and chaotic political environment. We're joined as always by a smart panel of experts with different perspectives. Zack Cooper is an associate professor of public health and also economics at Yale. Ashley Thompson is Senior Vice President for Public Policy Analysis and Development at the American Hospital Association. And because you can apparently never have too many Zacks, we also have Zach Levinson, who is Director of the Project on Hospital Costs here at KFF.

A little bit of housekeeping before we jump in. If you have questions, submit them at any time through the Q&A button in Zoom. We'll get to as many of them as we can. Also note that the session is being recorded, and an archive version should be available later today. Zach Levinson, let me start with you. Medicare has actually taken some steps in recent years towards site neutral payments already. Explain how that works and what the effect has been of that change.

Zachary Levinson: Sure. So as you're mentioning, there's been a lot of policy interest and potentially aligning payments across different sites of care and Medicare. A lot of the interest is focused specifically on hospital outpatient departments that are not part of the main hospital campus. And these off-campus departments

can sometimes resemble physician offices. In many instances they may actually have been previously physician offices, freestanding offices that were acquired by a hospital and then converted into an outpatient department. And the government has made some progress over time in aligning payments across different settings. So in 2015, Congress passed a law that reduced payments for services at off-campus hospital outpatient departments. An important caveat of that law is that it did not apply to departments that had already existed when the law was passed. So it was really a forward-looking law that was primarily applying to relatively new outpatient departments. In 2019, CMS reduced payments for clinic visits that were at off-campus departments that were exempt under this previous law.

So what does that leave on the table? Well, first of all, neither of these changes apply to on campus departments. On campus departments account for most of Medicare spending on hospital outpatient services. And again, aside from clinic visits, these reforms exempt departments that had existed when the law was passed. So there's been a lot of policy interest in potentially expanding upon these reforms and proposals from members of Congress and from different policy groups very substantially in both their scope and their potential savings. So, for example, in December, 2023, the House of Representatives passed the Lower Cost More transparency Act, and this would reduce payments for off-campus departments, specifically for drug administration services such as for chemotherapy. There've been some who've said that this is a fairly narrow bill. So, for example, it only applies to a specific set of services. It again only applies to off-campus departments.

And there have been other proposals that would go further. Some proposals, for example, would extend to all services at off-campus departments. Others would apply to certain services at on-campus departments, which could potentially achieve much greater savings. Another important difference across these proposals is whether they would provide certain protections or support for vulnerable facilities. For example, whether they would include targeted subsidies for rural hospitals or for safety net hospitals. And the extent to which they include these protections will certainly have implications both for how much money they save the government, but also the impact on hospitals across the country.

Larry Levitt: Thanks, Zach. Zack Cooper, let me turn to you. So let's step back for a minute. I mean, how did we get here? Why all of a sudden do you think there is this flurry of proposals in Congress to address site neutral payments?

Zack Cooper: Yeah, and thanks Larry and Ashley and Zach for doing this with me and Kaiser for hosting. Forgive me, I'm a little under the weather, so if I sound a little croaky, it's just the occupational hazard. So, yeah, taking a step back, why are we here? Really high prices in the healthcare sector among providers. We've got a market that's changing a lot, so lots of vertical integration between hospitals and physicians and mergers between hospitals over the last two decades. And the net result is really, really high spending. That's putting tremendous pressure on the federal government. It's putting pressure on companies. I think most importantly it's putting pressure on American families. And so we now see that high costs are really an access issue where something like one in four individuals are reporting putting off care each year because they just can't afford it. There aren't silver bullets to fixing what's wrong with US healthcare system.

There's this incremental approach we've got to take. And in many ways the low hanging fruit is this differential payment that we see happening in a hospital owned doctor's practice versus an independent doctor's practice. And I think the metaphor to think about my local coffee shop Cilantros in Guilford, Connecticut gets bought by American Hospital Association Coffee. They keep selling the same beans, they've got the same baristas, they've got the same place, the only thing that changes is the badging, but the coffee becomes twice as expensive. And it creates three problems. So in the Medicare system, what it does is it shifts care to a more expensive setting. That's just inefficient. It's going to raise spending, it's going to raise out-of-pocket costs. So a person with cancer is going to end up paying about a thousand dollars more each year. Under a policy, we pay a different amount.

Second, it's going to incentivize vertical integration. We see that really, really clearly in the literature. And I think stepping back, it's going to embed these distortions in the system we worry about. I think it is worth, I think, taking some of the skepticism criticism about this head on, and then I'll wrap up. We've got to protect rural hospitals. We do. And I think the way to do that is really through targeted spending. It isn't an across the board payment bump for all hospitals. I think it is true that hospitals do different things than doctor's practices. We have to acknowledge that. But at the end of the day, an infusion is an infusion is an infusion. And the third is there are genuinely vulnerable hospitals out there. I think we saw that in the change healthcare hack. And the question is how to help them. And, again, it's targeted benefits. It isn't giving more money to the Yale New Havens, the Cleveland Clinics, the Mass Generals of the world. And so I think that's how we got to this in the first place.

Larry Levitt: So, I mean, Ashley, fortunately there's only one Ashley that makes it simple. Zack Cooper laid out this argument that it's intuitive that who owns your coffee

shop shouldn't matter, who owns the clinic shouldn't matter in terms of the payment. What in your view justifies these higher payments, these facility fees for these hospital owned facilities and clinics?

Ashley Thompson: Yeah, thanks for having me as well. And you can tell from my voice that we're all sick this morning. But I want to share that there's really nothing neutral about site neutral payments because the patients that are seen at hospital outpatient departments are typically much sicker and much more complex. And hospital outpatient departments are held by higher standards of rules and regulations and licensure. And to some extent it's based on a flawed sentiment that hospitals are perhaps overpaid, which is not true at all. And when you say, Zack, that an infusion is an infusion is an infusion, I guess I would beg to differ. I don't know if I would use that analogy, but I can come back to that one. I mean, to me, if you look at people who need perhaps an MRI and maybe an MRI of the shoulder, and you have this 67-year-old healthy individual who's playing tennis and their shoulder hurts, so they can go to a physician office for that MRI.

That's completely different than the 87-year-old person that's at a skilled nursing facility that might've fallen out bed in the morning. They might be obese, they might have dementia. They are a completely different patient that needs additional resources and additional care. And most of those are treated at hospital outpatient departments, and physicians send them there because they are aware of the differences. And when you get the same exact payment for that MRI, that means that hospitals are losing a ton of money and especially if you cut it further because the resources that we use to provide that care are so much greater.

Zack Cooper: Yeah, I mean, I think you're right that most of those complex cases do happen in hospitals, but it turns out most cases aren't those complex episodes. And it turns out most are services that could readily be provided elsewhere. And I think the way we know that is 70% of the infusions are happening in physician practices. And so I think if we're worried about complex cases, we should pay more for complex cases. What we don't have to do is pay across the board more money for the same stuff for everybody. I think MedPAC has pretty good work on this. I think the only real evidence out there on sicker patients being treated in HOPs and some of the work you've done, MedPAC says, "Okay, maybe they're a little sicker, but it doesn't justify the cost." There's actually a really good op-ed on this in The Times right now that came out a couple hours ago. They're saying, "Look, you can't justify the payment differences off the cost because the costs for the institution are largely the same."

Ashley Thompson: Well, I would suggest differently. Larry, you might have different questions, but if I could just quote some of that research that you were saying, it does show that hospitals treat patients that are sicker, likely to be non-white, likely to be low income or dual eligible, likely to have just come out of a hospital outpatient department or emergency room visit. They have more severe complications and comorbidities. They might have a disability. So all of that means that you're treating a much more frail patient. And in the infusion center, yes, many of these are being done in hospital outpatient departments and in physician offices. But when you get those really sick patients, those are the ones that you see in hospital outpatient departments. They're the ones that might have congestive heart failure or some other secondary comorbidity where that if something goes wrong during that infusion, you have a whole supply of backup services. You have the crash cart available,

Actually we're held to higher standards, so for the infusion area, we might make the materials on site. And that is actually more controlled in a reverse flow air room versus what you might have at the physician office because we just have tons more standards in order to hold us to a higher accreditation level, et cetera.

Larry Levitt: Ashley, can I ask you central to this question, particularly for these off campus offices/clinics, what is the infrastructure required to keep those going? And you talk about the higher standards. Just explain, do those higher standards apply both to on campus and off campus clinics? So if a hospital, for example, buys a freestanding physician practice, is there an upgrade in what's required in that practice?

Ashley Thompson: Yes, that is absolutely correct. For those off campus offices, hospital outpatient departments, they are held to higher life safety codes, fire safety codes. They have to make sure that the corridors or whatever measures they have to report quality measurements in certain manners. They have infection control standards that are much higher. And again, they're accredited. So, yeah, they have to make sure that when they purchase a physician office that they do convert it basically to a hospital outpatient department.

Larry Levitt: That's helpful. Thanks. So swirling in the background here, and all of you have brought this up is the question of hospital finances, how hospitals are doing and the adequacy of current payment rates, particularly in Medicare. Zach Levinson, let me turn back to you. Give us a very quick view of how hospital finances have been recently and how that's changed over the course of the pandemic and as we've come out of the pandemic.

Zachary Levinson: Sure. So early in the pandemic, hospitals were obviously facing significant challenges on the ground. Actually, they seem to be doing relatively well financially, and that had to do in large part with the large amounts of pandemic relief they received from the government. In 2022, things took a sharp term for the worse. As those dollars started to go away, as hospitals were struggling with high labor costs and had high supply expenses, which is reflecting broader inflationary pressures, it does seem that the hospital sector is starting to recover. Industry reports suggests that margins are increasing, that volume is going up, that hospitals are doing a better job at reigning in labor costs.

It's certainly the case though that hospital finances very substantially so there's certainly hospitals out there that are doing very well. There are other hospitals that are struggling to break even in some extreme cases, even struggling to keep their doors open. So I think this again points to an important question that all three of us have raised, which is for these site neutral payment reforms, what sort of protections, if any, will there be for certain vulnerable hospitals like rural facilities, safety net hospitals that might have difficulty absorbing any losses in revenues under these policy changes?

Larry Levitt: Zack Cooper, you mentioned the idea of maybe carve outs for those vulnerable hospitals or different kinds of subsidies for those hospitals, and we've had several questions from the audience about that as well. I mean, what would a separate financing stream, a separate subsidy or help for rural hospitals look like?

Zack Cooper: Yeah, I mean, first just take a step back. It turns out most rural hospitals actually aren't going to be directly affected by a lot of these changes because most of the places we're really nervous about are part of this critical access program. They're not paid using the PPS system, right? This is only going to apply to facilities that are paid using the OPPS. So that's I think, the first point we'd make. I think there are a range of payment programs that are out there in the Medicare program that we think about enhancing or extending. So dish payments, which are scheduled to go down, we could think about bulking those up. We could think about different ways to really target the hospitals that are vulnerable and steer money to them. I think that's just a way better strategy than saying let's look at Yale Haven Hospital that's doing pretty well and give them money in the hope that that equally trickles down to other hospitals out there.

So I think we need to think about which hospitals are in places where there's not another facility nearby. We need to preserve access to them. I think we need to think very, very carefully about which hospitals are probably right at the

limits of viability that needs to stay open and then think about how to pay them at some cost plus basis.

Larry Levitt: Ashley, is that a viable approach here in your view?

Ashley Thompson: Our understanding is that site neutral policies will actually disproportionately impact rural hospitals for a couple of reasons. One is that rural areas see a disproportionate number of Medicare and Medicaid patients. So most government payers, they're disproportionately Medicare and Medicaid, Medicare also underpays and Medicaid. I'll say that our understanding is that hospitals get 82 cents on the dollar on average for the outpatient departments. There's been over a hundred million, billion I should say with a B, in Medicare shortfalls. And that as of 2022, and granted Zach Levinson said that that was probably the worst financial year for hospitals, we agree, two thirds had negative margins.

I want to mention that 151 rural hospitals have actually closed since 2010, and that we think that while site neutral proposals will affect all hospitals, we do think that they'll disproportionately impact rural areas. And one more thing. In rural areas, we've found that patients don't visit physician offices as much as they do hospital outpatient clinics just because there are less physician offices in the area. So most of the patients go to hospital outpatient departments, so cuts in this area might decrease access to them to those facilities.

Zack Cooper: I guess that's the question I think maybe for Ashley. If we took rural hospitals out of the equation, can we agree that maybe Mass General doesn't need to be paid more for doing something an outpatient visit? Is it rural?

Ashley Thompson: So I know that Zach Levinson's hand is up. Because that 82 cents on the dollar is across all hospitals, and I agree that there's variation there, but for Mass General too, this would be devastating. It's just a flawed policy. If you look at inflation in the last two years from 2022 to 2024, I think increased 12% general inflation and the updates that we're getting from Medicare are 5.2%, so we're getting half the update in our Medicare payments than the level of general inflation, and that's just completely unsustainable.

Larry Levitt: Definitely swirling in the background here is this question of the adequacy of Medicare payments. Generally, it's hard to escape that. Zach Levinson, let me ask you just very quickly, how do Medicare payments compare to commercial payments for hospitals, and what is the evidence out there of the adequacy of these payments? And then Zack Cooper, I'm going to want to bring you in as well.

Zachary Levinson: Sure. So there's actually in many instances where we have longstanding history of Medicare rates having a large influence on how private health insurance plans are reimbursing providers. And they're actually many instances where private plans are benchmarking their prices based on what Medicare pays, but typically it's at a much higher percentage. So they're paying at much higher levels than Medicare. In terms of the adequacy of Medicare payments, this is something that's monitored by MedPAC and reflected in their recommendations to Congress each year. It does seem to be the case that overall there's a negative Medicare margin for hospital care. There's usually something closer to a breakeven point for what MedPAC defines as relatively efficient hospitals. So that's what we see from MedPAC reports.

Larry Levitt: And Zack Cooper, I mean, we know that commercial rates are roughly double what Medicare rates are. Does that tell us that Medicare rates are inadequate or commercial rates are too high or some combination of both?

Zack Cooper: Yeah, I mean, it's a super important point. So I think the first thing, let's set the benchmark. Private players are paying about double Medicare rates. The second thing we've got to really double click on is that costs aren't somehow preordained, right? It's really a choice that hospitals are making. And what you see is that the hospitals that are treating primarily Medicare and Medicaid patients are actually making money on those. It's just that there are a lot of hospitals out there who set a cost structure out there to really prioritize getting privately insured patients who then tend to lose money on Medicare reimbursement rates.

Again, I think the analogy here is if this year I decided to put an in-ground swimming pool in my backyard and it increased my costs year to year, and next year I went to Yale and said, "Look, I can't cover my costs," Yale wouldn't go to me and say, "Oh, well by all means we will give you a pay increase." They'd say, "You sort of need to think about your cost structure." And so I think what we really need to think about is what are the investments that hospitals are making? Are they making them because of their payer mix? And if not, then taking a step back from there.

Ashley Thompson: Can I respond to both of those? So Zach Levinson, I appreciate you quoting MedPAC, and I'm just going to say in their 2021 report, Medicare outpatient margins were negative 17.5%. I don't know any company that would continue providing services if their margins were that negative. And even for the efficient hospital, I think that it's, yes, around break even, but I think it's actually negative for the first time. So I think that it creates a big challenge. And then I think that 25 years ago when Congress moved to the outpatient payment system, before

then it was cost-based. So Zack Cooper, I think you're right, you put in the swimming pool, you get paid a portion of that swimming pool. But what Congress did is they set it to a prospective payment so that each patient that you had that came in with the MRI, you're getting the same rate for that MRI basically or that clinic visit perhaps severity adjusted.

I think that they controlled for that great expansiveness of costs with their prospective payment system policy. Congress has three different payment systems for ambulatory procedures. The ASC, the physician payment system, and then the hospital outpatient department. And all of them were structured completely differently. And I blame Congress for some of this. It was kind of a morass of how they put it together. And when they implemented site neutral, they wanted it based on the physician fee schedule, but there was no way they could even do that because the two payment systems are so far off. And then I'll just chime in because maybe it's a good time. I know we're talking about how hospitals are paid. If you think that basing it on the physician payment system is actually an accurate payment system, I think that that's a deeply flawed assumption because as we know, physicians have not really received a real payment update if you talk to AMA in the past 25 years when they tracked it for inflation, which is why there's a lot of discussion on the hill right now to try to fix their payment system.

Zack Cooper: I do think we've got to take a look at that 2021 MedPAC report. So they do absolutely say what you said, but about 10 pages after they say that, they say that the payments are adequate, and this is an organization that's got a statutory obligation to report on that. Year in and year out, they say, "Okay, here are the margins, but we do see the payments are adequate."

Larry Levitt: So I want to move us on. I'm pretty sure we could take the entire time talking about the adequacy of Medicare payments. We have a bunch of questions from the audience about site neutral and the mechanics. Also a lot of questions about transparency, and that's an issue. It came up in the New York Times op-ed today that Zack Cooper mentioned. Zach Levinson, talk a little bit about is there any way for a patient to know ahead of time what kind of facility they're going into? Does the price transparency rules that are in effect enable that, and are there some proposals out there to make this more transparent?

Zachary Levinson: Yeah, I think in general it would not be possible to do so. There have been some states that have started to introduce requirements around hospitals disclosing ahead of time whether there'd be a separate facility fee. It's also potentially not possible for private payers to determine whether given services or it could be very difficult for private payer to determine whether a given service was

provided at an off-campus department. There have been some proposals that, for example, would require hospital outpatient departments to obtain a separate identifier so that this could be tracked in claims and so that researchers and payers could separately determine where exactly the cure is being provided. And that would also facilitate on the payer side, if an insurer did want to pay separately for an outpatient service, for example, at an off-campus department, that they could use that identifier to administer that policy change.

Larry Levitt: And, actually, I mean, is transparency a potential area for consensus here that payers, patients should at least be able to know what they're getting into?

Ashley Thompson: Well, AHA has always been for transparency and been supportive of our price transparency rules and regulations. The additional modifier on the claim is an unusual circumstance because we already identify, we bill according to federal guidelines, and we already put where the service was being held so that information's already on the claim. And so any additional modifier would just be in addition to what we're already doing, which seems overly burdensome and perhaps not very useful.

Zack Cooper: So this is one where I disagree. Nobody writes country music songs about NPI coding and HOPDs, but having those ideas there is really going to change things, right? That way you can actually see what's happening. You can have private payers set their payment rates for those and not have it lumped into the whole hospital system. I also want to double click on the transparency. There's a good randomized trial out this morning about what happens when you put this pricing information out there. And what it does is it actually leads providers to increase their prices, and then consumers don't use the information. And so I think the idea that somehow transparency is going to make the system work better is not realistic. It really is why.

If we want to fix some of the big issues in healthcare, it has to start with the Medicare fee schedule. And that filters through the rest of the system. You see that when Medicare raises their reimbursement rates, private rates go up. When Medicare's reimbursement rates go down, private reimbursement rates follow. So a lot of the world follows this Medicare fee schedule, and it's why it's really, really important to get this fee schedule right.

Larry Levitt: So Zack Cooper, let me stick with you. So we've been talking a lot about Medicare. Obviously, there's a whole private payer system out there of commercial insurers and employers. If I heard you right, you would suggest that if Medicare did put in place site neutral payment policies that you think that would filter down to private payers as well?

Zack Cooper: A hundred percent. In two ways. So the first is when you don't have site neutral payments, you incentivize vertical integration. And when these organizations, hospitals and physicians gain market power, it allows them to raise the prices for the privately insured. So that's the first. The second is that private insurers' fee schedules are off of the Medicare fee schedule. They're usually in multiple. And the best evidence we have, this is worked by Jeff Clemens and Josh Gottlieb, is when Medicare reimbursements change, the private ski fee schedules follow, right? So often you'll hear talk of cost shifting, right? If Medicare rates go down, private rates go up. That's just not what the evidence shows. If anything, it shows that the private prices follow the Medicare fee schedule.

Larry Levitt: I want to bring in some more of the audience questions. And one just a clarification, which I can do. When we were talking about commercial rates being roughly double, which I think everyone agrees with, Medicare rates, we were talking about commercially insured people not Medicare Advantage, and that Medicare Advantage hospital rates are roughly comparable to traditional Medicare rates. They largely mirror the traditional Medicare system. So we've had a bunch of questions about just the mechanics of the payments here. We've been talking about facility fees at these off-campus hospital outpatient departments. Zach Levinson, let me maybe return to you. Can you explain what is a facility fee? What are the components of a payment that a patient or a payer might make? I mean, there's the facility fee, there's the professional fee. Those aren't necessarily on the same bill.

Zachary Levinson: Sure. And maybe I'll start by just describing the Medicare context. So in Medicare, if you receive a service at a freestanding physician office, Medicare is paying the provider based under the professional fee, based under the physician fee schedule. And that's covering both the costs of their labor and also the costs of running the clinic, including administrative costs and overhead. And if a patient instead went to a hospital outpatient department, Medicare would be providing two payments. First of all, there'd again be a payment to the clinician for the professional fee that's typically a little bit lower or is typically lower. And that's reflecting the fact that some of the administrative and overhead expenses that a clinician would normally cover in a freestanding office is instead being covered by the hospital. And for that reason, the hospital also receives a payment under the outpatient prospective payment system. This is to cover the overhead costs of the hospital for providing that care.

Similarly, on the commercial side, the OPPS is essentially a facility fee. On the commercial side, providers are often billing separately for the professional fee and for the facility fee, which may come to the patient as two separate bills.

Larry Levitt: We also had a question about these hospital purchases of these freestanding physician practices, which in many ways is at the root of a lot of what we're talking about here. And, Ashley, we had a question about what happens when these acquisitions occur. I mean, you talked about the higher standards being applied. Are there cases where hospitals are buying physician practices but leaving them as physician practices, not putting them under the hospital license, charging a facility fee? Is there a variety of approaches when these acquisitions occur?

Ashley Thompson: So getting back to physician acquisition, I want you to know that most of the time physicians are the ones coming to hospitals because of the low Medicare reimbursement under the physician fee schedule. A lot of the admin burden, especially when you see the increased MA plans and just all the delays and denials and care as well as some work-life balance issues, a lot of the physicians really want to be employed and just draw a salary. So we did a study looking at physician acquisitions, and it turns out that most physician acquisitions are done by private equity and then large physician groups. So when we looked in, I am sorry, I don't have the year in front of me, but I think it was over the last five years, 65% of physician acquisitions was from private equity, 14% from medical groups, 11% from health insurers like UnitedHealthcare and Optum, and only 6% by hospitals and health systems. And when we drill down into that, most of the physician acquisitions that we're doing are actually in rural areas so that we can keep those offices open.

Whether we keep them as physician offices, I actually don't know how many of them become converted to hospital outpatient departments versus stay as physician offices. It probably depends on whether that community, the physicians in that community, when they're a physician office have less rules and regulations versus when they become a hospital outpatient department. And also when they're a hospital outpatient department, they tend to treat more Medicaid patients and low income patients and more people who come to their front door. They treat everyone. So I think that that might be one of the reasons. Hopefully you can see that the physician acquisition, it's really not all hospitals, and when we do, what we found is actually in rural areas to keep an access point to care.

Zack Cooper: Emily from my team, she's terrific and I actually found this number this morning. If you look across the physician sector, about 4.5% of physicians are employed by a private equity firm. The plurality of physicians, about 32%, are actually employed by hospitals. So the idea that most of the acquisitions happening outside the hospital space just doesn't match with the distribution of physicians and the ownership structures out there. I think if I'm a physician, it isn't crazy

that I want to get acquired by a hospital, right? That's why we need site neutral payments, right? They're just not on an even playing field when the same coffee is twice the price. If you're owned by a hospital, it just doesn't make sense to be independent. And part of the reason we see this absence of independent physicians is the incentive structure the Medicare program is creating. It's why we need to move to this sort of site neutral payment policy in the first place.

Ashley Thompson: Can I just add, because I think I failed to do this, any physician office that hospitals purchase post 2015, all of them get the site neutral rate already. I know Zach Levinson said that at the very beginning, but let me just underscore that.

Larry Levitt: I just want to clarify something, and maybe both you and Zach Levinson can help. So my understanding was an exempt hospital outpatient department that does that purchases a new physician practice would continue to be exempt from site neutral. Is that correct?

Zack Cooper: Yeah, that's my understanding. And part of what Ashley was talking about with the trends, part of the reason it's slowed down is because of this change in policy, and a lot of the acquisitions that I think are so problematic are actually exempted. And if you look at the impact of that 2015 policy change, it actually didn't hit most of the care because it wasn't affecting all the people who have become vertically integrated over the past 15 years.

Ashley Thompson: Can we go over that again? And I know that I'm a little bit sick, but I just want to make sure that it's clear for folks on the line that if hospitals purchase a physician office today, they will be getting the site neutral rate on all outpatient HOPD rates. Is that correct, Zach Levison?

Zack Cooper: Yeah, that's correct. And I guess the question is, do you want to go back and apply that to all the folks in the past if you're comfortable with it going forward? Are you comfortable saying, "Look, the same thing going forward, we're going to apply to the 25% or so physicians who aren't affected?" Are we willing to do that?

Ashley Thompson: I think that they were grandfathered for a reason, and given the poor Medicare underpayment and all, I just don't see a reason. No.

Zack Cooper: No. And I think this is really the-

Ashley Thompson: I think it's a deeply flawed policy, actually. I go back to what you said in the beginning that Congress is looking for low hanging fruit. I think this is the wrong low hanging fruit to look at. I think there's got to be other areas to target.

Zack Cooper: I think this is the big question, and in some ways it's a question for the HA, is there any policy that Congress that could introduce that would lower hospital revenue that you would support, right? Because if the answer to that is no, this isn't really a conversation about site neutral. It's a conversation about how we get a fiscally sustainable future.

Ashley Thompson: It's a really good question if I can respond to that. Hospitals are so underpaid for Medicare right now that I think that you're absolutely right. If anything, we should be reinvesting in our hospitals in order to make sure that we can continue our 24/7 standby capacity. I mean, hospitals stepped up tremendously during COVID. We just stepped up tremendously during the biggest cyber attack on US history through United Healthcare and change. And many of our hospitals are going eight, 10, 12 weeks without receiving a single bill because of the cyber actions that happened. And we have to invest so much more money in order to make our system safe. And all of these are unfunded mandates. So I think that you're absolutely right, and I will say that the cost shift does continue occurring, and really it's just really relying on employers to pick up the differences from Medicare and the government's underpayment.

Larry Levitt: Well, I think as we've discovered, it is hard to avoid that bigger context of the debate over whether Medicare payments for hospitals are adequate or not and hospital finances more generally. And that this debate oversight neutral is occurring in the context of that larger debate about which there's disagreement. So we're coming close to the end. I want to, particularly for Zack Cooper and Ashley, ask you what you hope Congress will do this year, what you hope Congress will not do this year. And Zack Cooper, maybe I'll start with you.

Zack Cooper: Look, I think the lower cost, more transparency legislation makes a lot of sense. I think we've got, honest to God, fiscal challenges out there. High costs are keeping folks from accessing healthcare. This is a small change. It would lead to lots of benefits, the folks who are going to benefit or folks getting chemotherapy. I think this is not a huge change, and I'd like to see this get across the finish line.

Larry Levitt: And Ashley?

Ashley Thompson: And so for me, instead of Congress considering flawed policies that might put patient access to care at risk. I mean, I think Congress should focus on ways to

make sure hospitals and health systems have the resources they need to continue to provide 27 care to their patients and communities that they serve.

Larry Levitt: Well, I think that's a great place to leave it. I want to thank all of you for participating, particularly Ashley and Zack Cooper being sick at the same time. It didn't show except for maybe the croaks of your voices and Zach Levinson as well. I thought it was a great conversation, and I think we've got three more workshops coming out of this that we need to do at some point in the future. So thanks to the three of you. Thanks to the audience for the great questions and for listening in, and watch out for a recorded version of this later today. Thank you.