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[THC, HCA, SGRY] Are the Winds of Medicare Site Neutrality Blowing Again?

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Key Takeaways: The need for legislative savings to offset healthcare extenders during the lame duck puts a target on **hospital outpatient departments (HOPDs)** and **ambulatory surgery centers (ASCs)**. While we doubt Congress will slash operators' payments, there is risk it is considering cuts to include in an FY25 spending bill. Currently, though, we ascribe slightly less than toss-up odds for a slimmer, heavily qualified version of Medicare site neutrality. Even if not added, the next Congress is likely to revisit the issue, regardless of the outcome of the elections.

Meanwhile, HOPDs and ASCs have experienced positive trends over the past few years that we don't think will abate anytime soon. These include:

- A favorable CMS disposition to moving care outside the hospital,
- Consistent pattern of moderate Medicare rate increases, likely to be heeded again in CY25 Medicare payment rule due in the next two weeks,
- Faster outpatient procedural volume growth vs. inpatient levels, and
- Overall higher outpatient utilization.

More specifically, late next week/early the following week, we expect CMS' release of its final CY25 Medicare payment rule for HOPDs and ASCs. Specifically, CMS is likely to set a 2.4-2.7% increase in the base rate and expand the list of procedures that can be performed in these settings. We note that the size of the update is in-line with expectations and within the historical range. While the regulation sets payment policy, we don't expect the final decisions to move these operators' equities. Additionally, we anticipate that the overall outpatient volume growth that hospitals and insurers have noted is likely to persist, given the expanded availability, lower costs and cost-sharing associated, patient preferences, and policymakers' embrace.

At the same time, this growth has raised the question by think tanks and Medicare advisors whether Medicare is paying appropriately for this care, especially when the same procedure can be performed in HOPDs, ASCs, and physicians' offices at disparate payment levels. When a procedure can be done in any of these ambulatory settings, ASCs are generally being paid ~60% of Medicare HOPD rates and physician offices are paid ~40% Medicare HOPD rates.

Think tanks have estimated that transforming the specific Medicare payment for these ambulatory services site-neutral (i.e. payment at the lowest rate among the three settings) could generate $100B+ in federal savings. Hence, it is not surprising that the idea has caught the eye of Congress. However, opposition from the hospital industry and their protectors like Senate Majority Leader Chuck Schumer (D-NY) likely kills the chances of such a major change for the foreseeable future.

Tenet Healthcare Corporation (THC)

Price:	$141.00
52-Week High:	$171.20
52-Week Low:	$51.04

HCA Holdings Inc (HCA)

Price:	$369.20
52-Week High:	$417.14
52-Week Low:	$220.55

Surgery Partners Inc (SGRY)

Price:	$30.00
52-Week High:	$36.92
52-Week Low:	$22.05

Community Health Systems Inc (CYH)

Price:	$4.15
52-Week High:	$6.29
52-Week Low:	$2.01

Ardent Health Partners, Inc. (ARDT)

Price:	$17.75
52-Week High:	$20.72
52-Week Low:	$15.00

Universal Health Services Inc (UHS)

Price:	$208.00
52-Week High:	$243.25
52-Week Low:	$121.00

However, we can't rule out consideration of a skinnier, more heavily-qualified version of Medicare site neutrality, given the support from both sides of the aisle in the House and Senate and the need for legislative offsets to pay for must-pass annual healthcare extenders. Such a policy would likely be narrower than previously passed by the House and the Senate HELP committee. This version would lower reimbursement to physician office rates for those drug administration services provided at off-campus hospital-owned outpatient departments, with exclusions for rural providers, and it would also be accompanied by a requirement for these off-campus hospital-owned facilities to have separate identification numbers. While we think it is on the menu of legislative payfors, we lean towards Congress opting not to use it during the lame duck session due to the lobbying strength of the hospital industry.

From a holistic standpoint, this slimmed-down version of Medicare ambulatory site neutrality does not materially impact large for-profit hospital operators and does not implicate ASCs at all. In general, the policy seems manageable for the industry and the size of the federal savings is relatively small.

The Congressional Budget Office scored the slimmed-down Medicare site-neutrality policy that lowered payments for drug administration services at all off-campus hospital-owned outpatient departments at $3.7B over ten years and the requirement of a separate identification number and attestation for each off-campus hospital-owned facility at $2B over ten years. The risk is that enactment of a narrower version of Medicare site-neutrality sets down a marker by which future Congresses can expand when they need payfors.

Ironically, were Congress to attach these changes to an FY25 spending bill, it would likely remove this policy threat to these hospitals and ASCs in the near term since we doubt Congress would revisit the issue of Medicare site neutrality so soon after legislating and without evaluating the impact. However, should Congress not tap this as a legislative offset in an FY25 spending bill, we think there would be greater bipartisan animus to not only resurrect the discussion but also be open to expanding the policy's design to incorporate more procedures and more ambulatory settings as more federal savings will be needed to pay for future healthcare reforms

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