The Alliance to Fight for Health Care

Advancing employer-provided coverage

Frequently Asked Questions: Site-Neutral Payment Reform

What is "site-neutral payment"?

At a high level, site-neutral payment is the concept of paying the same amount for a service provided to a patient regardless of where the service is provided. Current Medicare and private health insurance payment policies pay higher reimbursement for services provided in hospital outpatient settings – and site-neutral payment aims to address that payment discrepancy by preventing hospital outpatient facilities (HOPDs) from charging higher rates for services that can be safely provided outside of a hospital.

Site-neutral payment policy has been advanced primarily in the Medicare program with much of the focus on ambulatory (or "outpatient") settings that have different Medicare payment rates for the same services. However, disparate payments also occur in the commercial market through the use of so-called "facility fees" that can be added to a patient's bill even for care happening outside a hospital's walls.

Why should Congress act now on site-neutral payment reform?

Health care is expensive! And hospital prices are the No. 1 driver of increased costs for patients[1]. If we want lower health care costs, we must address the prices that hospitals charge. Site-neutral payment reform addresses a specific hospital charge that is added to bills for HOPDs and is encouraging hospitals to purchase doctors' offices (where care is cheaper) to turn them into HOPDs where they can add this additional charge. In fact, Medicare Payment Advisory Commission (MedPAC) data suggest hospital acquisitions of standalone physician's offices have accelerated: the share of office visits billed under the hospital outpatient payment system grew from 9.6% in 2012 to 12.8% in 2021, while the share of chemotherapy administration billed under the hospital outpatient payment system grew from 35.2% in 2012 to 51.9% in 2021. This drives up costs for patients and taxpayers without increasing quality or improving outcomes for patients.

How do payments vary based on setting?

HOPDs are outpatient facilities that are owned by hospitals and include off-campus facilities that are not physically attached to the hospital. Free-standing offices are independent facilities that are owned by physicians, not by a hospital. Under Medicare, HOPDs typically receive the highest level of reimbursement while freestanding offices receive lower reimbursement.

When a physician renders a service in a HOPD, there are generally two claims submitted to Medicare: one claim submitted by the physician under the Medicare Part B Physician Fee Schedule (PFS) and one submitted by the hospital under the Outpatient Prospective Payment System (OPPS).

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[1] Health Affairs, "What Is Driving Health Care Spending Upward In States With Cost Growth Targets?," August 2022

When a physician renders a service at a free-standing facility, one claim is submitted to Medicare for reimbursement through the PFS. Typically, the payment is higher for care delivered at HOPDs.

Here's an example of the payment disparity:

Example of provider-based facility payment compared to freestanding facility payment for an office visit				
Provider-based facility payment			**Freestanding facility payment**	**Payment differential**
OPPS Payment (A)	Medicare Part B PFS Payment (B)	Total provider-based payment (A+B)	Medicare Part B PFS Payment (C)	Difference ((A+B) – C)
$85.28	$90.82	$176.10	$118.21	$57.89

Source: HHS Office of Inspector General, "Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 through 2017 Than They Paid to Freestanding Facilities In the Same States for The Same Types of Services," June 2022.

Similar billing practices can be seen in the commercial market, where HOPDs may add a facility fee to the physician's bill.

What percentage of providers are currently grandfathered from site-neutral payments?

The current scope of site-neutral payments is extremely limited. According to MedPAC, just .8% of total OPPS spending provided in off-campus HOPDs or ASCs is subject to site-neutral payment reforms included in the Bipartisan Budget Act (BBA) of 2015.

The BBA limited site-neutral payment reform to certain non-emergency outpatient services provided in off-campus HOPDs that began providing services after November 2, 2015. The law effectively "grandfathered" HOPDs operating prior to this date, applying the higher OPPS rates rather than the site neutral payment policies. Also, the BBA did not restrict those grandfathered hospitals from expanding the services they provide. This means any hospital that has acquired a physician practice and added it to an existing off-campus HOPD that is excepted from the BBA is reimbursed at the higher, hospital rates.

How does site-neutral payment affect patient costs?

Site-neutral payment can lower out-of-pocket costs for insured patients and reduce spending by federal and private payers because most insured patients pay a percentage of their bill through coinsurance. If the total bill rises, a patient's cost-sharing will rise with it.

Here's how this can play out: A patient visits their physician's office in March; if the visit is $100, the beneficiary's 20% coinsurance is $20. In April, the physician's office is purchased by a local hospital and, for billing purposes, turned into a HOPD. When the patient returns in May to the same office and the same physician, the same service could be $141 and the beneficiary's 20% coinsurance is now $28.20. These numbers can add up quickly if beneficiaries are receiving a series of cancer or other higher cost treatments. The higher price for the visit also raises the amount the insurer or employer is spending on the visit, increasing overall health care spending and premiums. Site-neutral payment reforms will reduce costs for patients.

How does site-neutral payment affect patients' access to care?

Hospitals argue that site-neutral payments threaten patients' access to care. CMS began implementing site-neutral payments in outpatient settings in 2017, and there has been no evidence that the changes have impacted Medicare beneficiaries' access to care.

In fact, MedPAC has projected that expanding site-neutral payment reform would not "have an adverse effect on providers' willingness or ability to furnish ambulatory services."[2] The American Medical Association supports site-neutral payment reform and the concept that provider "payment should be based on the service itself, and not where it is provided."[3]

Further, many of the facilities that often offer critical access to care, such as critical access hospitals, rural health centers, and dedicated EDs are excluded from site-neutral payment policy.

Do HOPDs treat sicker patients and therefore require higher payments?

No. While an analysis sponsored by the American Hospital Association suggested that patients who receive care in HOPDs have more severe complications than those who receive care in freestanding offices, an independent analysis by MedPAC found patient severity had no statistically significant impacts on the cost of care for the select number of services they recommended for site-neutral payment reform. MedPAC's analysis examined risk scores from CMS' hierarchical condition category risk-adjustment model to compare the medical complexity of patients who received care in an HOPD with those in freestanding offices.

Does site-neutral payment reform harm hospitals?

No. Hospital groups argue that site-neutral payment is a unilateral cost-cutting tool that would significantly harm rural hospitals and other facilities that care for patients and communities in underserved areas. But the Bipartisan Budget Act of 2015 (BBA), which created site-neutral payments for HOPDs, excludes on-campus HOPDs, remote locations of a hospital, dedicated EDs, and facilities that are not paid under the Outpatient Prospective Payment System (OPPS), including

[2] MedPAC, June 2023 Report to Congress https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

[3] AMA, Issue Brief: Payment variations across outpatient sites of service, 2023 https://www.ama-assn.org/system/files/issue-brief-pay-variations-outpatient-sites.pdf

critical access hospitals and rural health centers. Further, while the rural emergency hospital (REH) designation was not in place when the BBA passed, CMS has since made clear that those hospitals also are not impacted by site-neutral payments.

Site-neutral payment also is a flexible policy that can be applied to a set number of services while protecting rural and safety-net providers. For example, MedPAC recommends a volume-based calculation for identifying which outpatient services should be subject to site-neutral payment, with specific carve outs for emergency and trauma care that support hospitals' standby capacity.

The policy also can be designed and applied in ways that do not impact critical access hospitals and maintain financial adjustments for rural providers, such as through budget-neutrality or stop-loss policies.

Site neutral payment policies are not meant to harm hospitals but to correct the current Medicare reimbursement system that pays hospital-owned offices more than provider-owned offices, encouraging hospitals to purchased provider-owned practices to benefit from higher government payments. Site-neutral payments are intended to level the playing field between provider-owned practices and hospital-owned practices so market need and not federal payment policy will determine when consolidation makes sense.

Do all HOPDs have emergency departments and 24-hour standby hospital care?

No. Many are just plain old-fashioned doctors' offices that offer no special services. Hospitals commonly argue that hospitals are reimbursed for outpatient services at a higher rate than physician offices because they deliver 24/7 care. But hospitals fail to mention that in many cases hospitals are purchasing independent physician's offices, relabeling those offices as HOPDs, and collecting a higher payment for care provided in a physician's office, not the hospital.

Are HOPDs providing a different level of care than physician offices when providing the same treatment?

Not always. Hospitals commonly argue that they are providing a higher level of care than physicians' offices, but MedPAC found this is not true across the board. MedPAC's recommended list of services for site-neutral payment focus on "low complexity" outpatient services, which do not necessarily cost more, or require more staff or equipment, in an HOPD setting. Yes, hospitals should be able to bill for more complex services, such as emergency or trauma care that happens in a hospital, but patients should not pay hospital-level prices for a basic service they can commonly (and safely) receive in their physician's office.

Would site-neutral payment prevent hospitals from buying struggling medical practices?

No. Site-neutral payments aim to reduce perverse incentives and ensure access to health care providers. The federal government should not be providing a financial incentive for hospitals to

purchase physician practices. If we want to ensure the success (and maintain the independence of) physician practices, we should ensure physicians are properly reimbursed for the care they provide.

How does site-neutral payment impact health care spending?

MedPAC estimates $6.6 billion in annual savings for the Medicare program and $1.7 billion in savings from lower cost-sharing for Medicare beneficiaries, if site-neutral payments were expanded to include a selection of 68 services safely provided across three outpatient care settings – HOPDs, ambulatory surgical centers, and freestanding physician's offices.

The potential for savings expands beyond Medicare. New research by University of Minnesota economist Steve Parente conducted on behalf of the Alliance estimates that expanding site-neutral payment reform could result in nearly $60 billion in savings annually in the commercial market.

How should site neutral savings be applied?

Current Medicare policy requires site-neutral payment policy to be implemented in a budget-neutral manner, meaning any savings would be reallocated to hospitals potentially through increased payments for non-impacted services. But policymakers can consider alternative ways to use these savings to target underfunded services that provide high value for patients

Policymakers should avoid reintroducing incentives that shift services out of physician offices and into HOPDs.

The goal of the payment change is to reduce perverse incentives, ensure access and lower patient out-of-pocket costs. We NEED providers to provide patients with the highest quality care. One way we can make health care more affordable is to make sure we are not overpaying based on where care is received, so we can invest in the care we need.

Who is supportive of expanding site-neutral payment policies?

Site-neutral payments are a bipartisan solution to lowering patients' health care costs and are supported by a diverse array of stakeholders, including the American Medical Association; independent cancer centers; patient groups, including rare disease groups; consumer groups; employer groups; insurers; conservative and liberal think tanks, as well as non-partisan congressional advisers, such as MedPAC. The policy has also been supported and implemented by the Centers for Medicare and Medicaid Services and former Democratic and Republican administrations.

Are there any bills in Congress addressing site-neutral payments?

Yes, a number of bills have been introduced in Congress related to site-neutral payment reform, including:

- The SITE Act (S 1869)
- The PATIENT Act of 2023 (HR 3561)
- Preventing Hospital Overbilling of Medicare Act (HR 2863)
- The Medicare Patient Access to Cancer Treatment Act (HR 4473)