



Insight

# Site-neutral Payments

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## Executive Summary

- Site-neutrality is the policy of having Medicare Part B pay the same amount for the same outpatient services regardless of whether the service is performed in a hospital, ambulatory surgical center, or physician's office.
- Over 10 years, site-neutral payment policies could save Medicare up to \$153 billion, beneficiaries up to \$94 billion, the greater U.S. health care system up to \$672 billion while reducing the national deficit by a potential \$279 billion, and potentially reduce the Part A trust fund's shortfall.
- Legislation is required to make changes to current Part B payments and enact site-neutral payment policies.

## Introduction

As Medicare spending continues to increase, policymakers have been routinely focused on ways to reduce costs while preserving access to care for beneficiaries. As discussed at a [recent hearing](#) of the House Energy and Commerce Committee's Subcommittee on Health, site-neutral payments in Medicare Part B provide an avenue for reducing program costs without hurting beneficiary care. This paper discusses what site-neutral payments are, how they work, the current extent of their use in Part B, and their fiscal impact on the program.

## Site Neutral Payments and Medicare Part B

Site-neutrality is the policy of having Medicare Part B pay the same amount for the same service with the same case-mix regardless of where the service is provided. Medicare generally pays different rates for the same service depending on where it is provided. This payment disparity results from differences in how payments for services at hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and physician offices are calculated.

Payments for HOPD services are done through Part B and cover two parts: hospital costs (i.e., labor including staff salaries, resources such as medical devices and supplies, and capital costs including rent), which are paid through the [Outpatient Prospective Payment System](#) (OPPS), and professional services (including physicians, nurse practitioners, physician assistants, and other advanced clinicians) paid through the [Physician Fee Schedule](#) (PFS). The PFS payments have different rates depending on whether the physician provided the service in a facility (i.e., a hospital or ambulatory surgical center, known as the "facility rate"), or in a private practice (known as the "non-facility rate"). The PFS non-facility rate is higher than the facility rate because the non-facility rate is reimbursing the physician for costs related to running a private practice, including labor, resources, and capital costs, which do not apply to a facility-based physician. [ASC rates](#) are calculated similarly to OPPS payment rates and also have a separate PFS payment for physician services, but the conversion factor (i.e., the starting dollar value before all adjustments for procedure type, case-mix, etc. are made) is lower for ASCs than for OPPS payments.

Despite this lower PFS reimbursement, HOPD services are generally more expensive than the same services provided at a physician's office. As an example: In 2017, the total Part B payment for a standard outpatient visit for a new patient was \$184.44 and made up of two parts: the OPFS payment of \$106.56 and the PFS facility rate of \$77.88. But the exact same procedure for the same patient at a physician's office cost only \$109.46 – the standard PFS non-facility payment rate.[1] In another comparison, HOPD rates are on average almost double ASC rates, in part due to the different conversion factors.[2]

It is worth noting that in Part B, the beneficiary generally pays about 20 percent of the cost of a given service, regardless of site of care. In the above example, the HOPD visit would have cost the beneficiary \$36.89 while the physician's office visit would have cost the beneficiary \$21.89. On average, Part B beneficiaries in 2019 paid a \$9 copayment for a standard clinic visit at a physician's office and paid \$23 for the same service at a HOPD – 256 percent more.[3]

## **Inpatient-Only Procedures**

In addition to procedures that can be provided both in HOPDs and in physicians' offices, Medicare implicitly ties payments to the site of care through its Inpatient Only (IPO) procedures list. As the name implies, this list specifies services that Medicare will only pay for if those services are performed in an inpatient setting (and are thus paid under Medicare Part A). Traditionally, procedures were designated as IPO if they were determined to be “highly invasive, result in major blood loss or temporary deficits of organ systems (such as neurological impairment or respiratory insufficiency), or otherwise require intensive or extensive postoperative care.”[4] Yet as medicine has advanced and more procedures have become viable to perform in outpatient settings, this list has evolved. In fact, the Centers for Medicare and Medicaid Services (CMS) had decided in its final 2021 OPFS rule to eliminate the IPO list entirely, though the agency later reversed this decision in its final 2022 OPFS rule. [5] The potential savings of eliminating the IPO list entirely or just removing certain procedures are unclear and vary from procedure to procedure and hospital characteristics. For example, using 2020 payment rates for a total joint replacement, a suburban hospital without a teaching program would see a 10 percent decrease in payment if the procedure were done in an outpatient setting and not an inpatient one, while a large urban teaching hospital would see a 57 percent decrease in payment if done in an outpatient setting and not an inpatient one.[6] Removing some frequently performed procedures from the IPO list could reap major savings for the Part A trust fund: The 2023 Medicare Trustees Report cited the removal of hip and knee replacement surgeries from the IPO list as one of three major reasons Part A had a surplus in 2022.[7]

## **Fiscal Effects of Site Neutral Payments**

The Medicare Payment Advisory Commission (MedPAC) estimates that its recommended site-neutral payment policy (see below) in Part B would have reduced Medicare and beneficiary spending by \$6.6 billion and \$1.7 billion, respectively, in 2019, including a 13.2 percent reduction in beneficiary cost sharing.[8] The Committee for a Responsible Federal Budget calculated that a site-neutral payment policy would, between 2021–2030, reduce Medicare spending by \$153 billion and beneficiary spending by \$94 billion, reduce total national health expenditures by around \$346-\$672 billion, reduce the national deficit by around \$217-\$279 billion, and reduce cost sharing and premiums in private insurance by around \$140-\$466 billion.[9]

Some of these savings are a direct result of the lower payments that Medicare would be making for the services performed. Other savings would be from the indirect effects; the current payment differential for outpatient procedures is widely regarded as a major reason for the cost-increasing consolidation of the U.S. health system, incentivizing hospitals to purchase physician practices in order to receive higher payments and reduce competition.[10] It should be noted that this trend has caused a major shift in the health care system: In 2021,

for the first time ever, more physicians were employees rather than owners of their own practice.[11]

## **Current State of Site-neutral Payment Policy**

To combat the above-mentioned consolidation, Congress passed as part of the Bipartisan Budget Act of 2015 new legislation that required CMS to pay the same rates to off-campus provider-based departments (PBDs) of hospitals for outpatient services as was paid under the PFS non-facility rate. Off-campus PBDs are essentially physicians' offices that hospitals have integrated into their health system. This legislation excepted off-campus PBDs that were billing services under OPSS prior to November 2, 2015, however – essentially all the off-campus PBDs in existence at the time of passage. Most OPSS services today still occur in the excepted off-campus PBDs, but in 2019 CMS created a policy to pay all off-campus PBDs the PFS non-facility rate for clinic visits, which is 40 percent less than the standard OPSS rate for the same service, though that rule was not fully implemented until 2021.[12]

## **Solution**

As mentioned above, CMS can make some changes as to which services receive site-neutral payments as well as to the IPO list, but the agency's hands are generally tied when it comes to major programmatic changes. Congressional action is needed to implement site-neutral payments. In its 2022 report to Congress, MedPAC recommended that, of the 169 ambulatory payment classifications (APCs) – a set of services that have similar clinical attributes and costs – 57 are reasonable and appropriate to set payment rates at the PFS non-facility rate, and another 11 can equalize payments between HOPDs and ASCs. The remaining 101 APCs generally involve emergency department visits, critical care services, and trauma care visits, which are either almost always performed in HOPD settings or cannot practically be performed outside of HOPD settings.[13] This list may change as medicine advances, and so lawmakers should build with flexibility in mind when designing legislation.

As MedPAC notes, however, simply applying site-neutral payments without exempting the budget-neutrality requirements in Medicare would reduce the potential savings for Medicare and its beneficiaries, as a reduction in rates for one set of services would require an increase in rates for another set of services. Simultaneously, exempting the budget-neutrality requirements could potentially result in a loss of revenue for hospitals that serve high amounts of low-income patients.[14] If Congress wishes to maximize the savings for Medicare and beneficiaries without harming these hospitals, it may need to design legislation that includes explicit safeguards for hospitals that serve high shares of low-income beneficiaries.

## **Conclusion**

As Congress looks for ways to make the health care system more efficient and affordable, site-neutral payment policies are an intriguing prospect. The savings are in the hundreds of billions, but some care is needed when deciding which services are best suited for site-neutral payments and how to protect certain safety-net hospitals that may see a decrease in revenue.

[1] <https://www.federalregister.gov/d/2018-24243/p-1581>

[2] <https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care>

- [3] <https://www.federalregister.gov/d/2018-24243/p-1585>
- [4] <https://www.federalregister.gov/d/2022-23918/p-2056>
- [5] <https://www.federalregister.gov/d/2022-23918/p-2067>
- [6] <https://racmonitor.medlearn.com/the-demise-of-the-medicare-inpatient-only-list-the-myths-and-facts/>
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- [9] <https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care>
- [10] <https://www.federalregister.gov/d/2018-24243/p-1582>
- [11] <https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice>
- [12] [https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC\\_Payment\\_Basics\\_22\\_OPD\\_FINAL\\_SEC\\_v3.pdf](https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_22_OPD_FINAL_SEC_v3.pdf)
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