



Weekly Checkup

Site-neutrality and the Medicare O(o)PPS

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This past week, the House Energy and Commerce Subcommittee on Health [held a hearing](#) on policies to lower costs in the U.S. health care system. Of the numerous propositions discussed, site-neutral payments in Medicare received a heap of attention. A forthcoming AAF insight will provide a deep dive into site-neutral payments, but for now **let's take a brief look into what site-neutral payments are and the potential they have to reduce health care spending.**

First, the basics: **In Medicare Part B, a wide variety of services are performed in both hospital outpatient departments (HOPD) as well as physician offices. Yet the same service for the same patient will generally cost more when performed in a HOPD than when performed in a physician's office due to a difference in reimbursement calculations.** To illustrate this, here's an example provided by the Centers for Medicare and Medicaid Services' (CMS) 2017 [final Outpatient Prospective Payment System \(OPPS\) rule](#). 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 OPPS payment of \$106.56 (covering "hospital costs") and the payment for the physician performing the service at the HOPD, paid at the Physician Fee Schedule (PFS) "facility" (i.e., hospital-based) rate of \$77.88. But the exact same procedure for the same patient at a physician's office cost only \$109.46 – the standard "non-facility" (i.e., physician's office-based) PFS payment rate. In Part B, beneficiaries are usually responsible for 20 percent of the cost for a service, so 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 \$23 copayment for a standard clinic visit at a HOPD, while they paid only \$9 for the same service at a physician's office – a whopping 256 percent more.

Site-neutral payment policies propose to even out these costs by paying the same rate for the HOPD service that an independent physician receives. It's not just that Medicare (and the beneficiary) is spending more money for the exact same service, but also that the current payment policy is [widely regarded](#) as a [major reason](#) for cost-increasing consolidation in the U.S. health system, with hospitals buying up physician practices to receive higher payments and reduce their competition. In 2021, for the first time ever, [the majority of physicians](#) were employees rather than owners of their own practice. In 2015, Congress [passed legislation](#) that provided for limited site-neutral payments, but the limited scope has resulted in limited benefits. The Medicare Payment Advisory Commission [estimates](#) that a full site-neutral payment policy would have saved Medicare \$6.6 billion and beneficiaries another \$1.7 billion in 2019. 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 up to \$672 billion, reduce the national deficit by up to \$279 billion, and reduce cost sharing and premiums in private insurance by up to \$466 billion.

What's stopping a seemingly obvious, [bipartisan](#) policy win? Hospitals are worried about their bottom line. A site-neutral payment policy would lower reimbursements and potentially increase the competition they face. This author understands that, yes, input costs for the hospitals are higher and must be accounted for. But House Energy and Commerce Health Committee Chair Cathy McMorris Rodgers hit the nail on the head when she asked: "Should we support hospitals through a complex and opaque network of cross-subsidies with

unintended consequences...that increase costs for patients?? Or do we separately work on a transparent, accountable way to support hospitals that need it?" The time has come to consider site-neutral reforms and stop hurting providers, Medicare, and, most important, patients.