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Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program

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Introduction

Medicare fee-for-service payments for identical outpatient services may differ markedly based on the location where the services are delivered. For example, Medicare usually pays more for services delivered in a hospital setting than for the same services (e.g., infusions) provided in a physician's office. The question is whether there are differences in the nature of the care being delivered in hospitals and at non-hospital clinics that justify these payment differences. In general, the prevailing literature has highlighted that, despite marked differences in payment rates for a range of services, identical services are being delivered to very similar patients across physicians' offices, hospital-based clinics, and ambulatory surgical centers (ASCs). Moreover, there is no peer-reviewed evidence that shows differences in the quality of services delivered across, for example, hospital outpatient departments and physicians' offices. Several policies have been proposed and implemented to address differences in payment rates across sites of care for specified outpatient services. These proposals generally suggest that for services that are routinely offered in physicians' offices, moving towards site-neutral payments would lower health spending without adversely impacting clinical quality. In general, however, these policies would lower hospital revenue. This document provides a synthesis of the key academic and neutral, third-party literature on the status and impact of Medicare's site-neutral payment policies to date. Attached is a spreadsheet highlighting the key literature.

Key Findings

Key Finding 1: Medicare has traditionally allowed differences in payment rates for identical outpatient services depending on the service location where the care is delivered (e.g., in a physician's office, hospital outpatient department, or ambulatory surgical center).

Key Finding 2, Impact on Medicare Spending: Both academic studies and third-party reports have found that the current payment policy generates additional costs to the Medicare program and that eliminating the differences in payment rates would save Medicare billions of dollars. This policy also raises costs, relative to the lowest-cost setting, for Medicare beneficiaries, since beneficiaries' cost-sharing is higher in hospital-based settings.

Key Finding 3, Impact on Health Care Markets: Academic work has found that site-based payment differences in the Medicare program incentivize consolidation between hospitals and physician practices—known as "vertical integration." A growing academic literature shows that vertical integration of hospitals and physician practices raises health spending without commensurate improvements in patient outcomes.

Key Finding 4, Impact on Quality: There is no peer-reviewed evidence which shows that, for care that is routinely delivered in physicians' offices, care delivered in a hospital produces better outcomes than care provided in physicians' offices.

Key Finding 5, Impact on Commercial Spending: Private health insurance plans often use Medicare's system as a basis for paying physicians and hospitals, though generally at higher average rates of payment. As a result, Medicare's policies have also led to site differences in commercial insurer payment rates for identical outpatient services.

Key Finding 6: Section 603 of the Bipartisan Budget Act of 2015 attempted to create site-neutral payments for certain outpatient services but included significant exemptions. As a result, the change only impacted a small percentage of outpatient hospital services delivered in off-campus hospital outpatient settings.

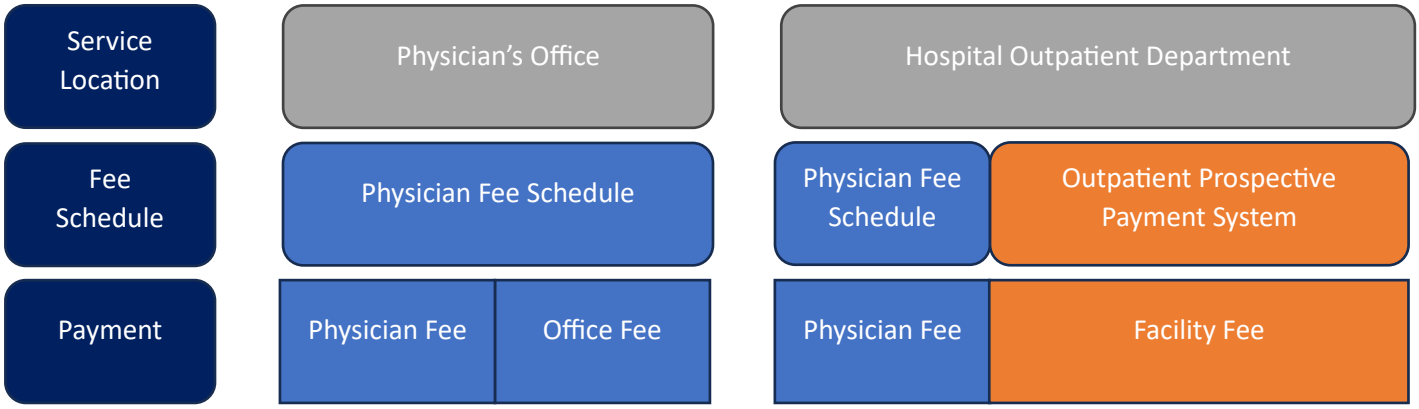
Key Finding 7: In 2018, the Centers for Medicare & Medicaid Services (CMS) released its 2019 Hospital Outpatient Prospective Payment System Final Rule to expand site-neutral payments to all off-campus hospital outpatient locations for certain services. Though challenged in court, CMS was ultimately allowed to keep the rule in place. The policy was phased in beginning in 2019 and was fully implemented in 2020 (see "Site-Neutral Policies" for more details).

Background and Policymaking to Date

Historically, Medicare fee-for-service payments for identical services differed markedly based on the location where the services were delivered. In a physician's office, the Medicare program makes payments for services under the Physician Fee Schedule. Physician Fee Schedule payments cover the labor, material, and overhead costs of physicians and other health professionals providing outpatient services. In a hospital outpatient department, in addition to paying a physician fee for services rendered, the Medicare program makes a payment to the hospital under the Outpatient Prospective Payment System (OPPS) to cover its facility costs, including medical supplies, equipment, and rooms. This additional OPPS payment means that Medicare almost always pays more for identical services provided in a hospital outpatient setting than for the same services provided in a physician's office.[1] Figure 1 below demonstrates how Medicare makes fee-for-service payments for outpatient services.

[1] Medicare Payment Advisory Commission, "March 2014 Report to the Congress: Medicare Payment Policy, Chapter 3," March 2014, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_ch03.pdf; Medicare Payment Advisory Commission, "June 2022 Report to the Congress:

Figure 1. Outline of Medicare Fee-for-Service Payments for Outpatient Services



Until recently, Medicare did not distinguish between on-campus and off-campus hospital outpatient departments when setting payment rates for outpatient services. On-campus hospital outpatient departments are part of a larger hospital campus that may include an emergency department, inpatient department, and ancillary services. Off-campus hospital outpatient departments (also known as provider-based departments) are facilities that are affiliated with a hospital but are physically separate from the hospital itself and, in general, closely resemble a physician's office. To date, legislators and regulators have focused primarily on resolving differences in Medicare payments between off-campus hospital outpatient departments and physicians' offices, though the debate has also included reimbursement differentials with ambulatory surgical centers, as well.

Site-Neutral Policies

Section 603 of the Bipartisan Budget Act of 2015 ("Section 603") was intended to address certain site-based differences in Medicare payment policy. It established that future off-campus hospital outpatient departments (i.e., where construction began after the passage of the bill) would be compensated for specified services under the Medicare Physician Fee Schedule at the physician's office rate rather than using OPPS payment rates. However, the policy had several exceptions. First, it did not apply to existing off-campus hospital outpatient departments unless they relocated or added new specialty types.[2] Second, it did not apply to other location types, including ambulatory surgical centers, freestanding emergency departments, or on-campus hospital outpatient departments.[3] Consequently, Section 603 had little effect on site-based payment differences. The

Medicare and the Health Care Delivery System, Chapter 6," June 2022, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.

[2] Jim Price, Rick Buchsbaum, and Kyle Price, "Medicare's Site-Neutral Payment Impact on Hospital Outpatient Services," *Healthcare Financial Management* 70, no. 11 (2016).

[3] Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care," February 23, 2021, https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

nonpartisan Medicare Payment Advisory Commission ("MedPAC") reported that after Section 603's passage, only 0.8% of total OPPS spending was subject to site-neutral payments due to the law's exceptions.[4]

President Obama and President Trump both included proposals to expand site-neutral payment policies in their subsequent budgets.[5] In 2018, CMS promulgated a final rule ("CY 2019 Hospital OPPS Rule") intended to expand site-neutral payments to clinic visits—also known as evaluation and management visits—at all off-campus hospital outpatient locations. The CY 2019 Hospital OPPS Rule would reimburse for these services at a rate equivalent to physician's office reimbursement starting in 2019 and phased in through 2020.[6] The American Hospital Association ("AHA") immediately challenged this rule in court, though CMS moved forward in implementing it. The district court held that the rule was outside of CMS's authority and granted AHA's motion for summary judgment.[7] Under the court's order, CMS repaid hospitals for any underpayments on 2019 claims resulting from the CY 2019 Hospital OPPS Rule while simultaneously implementing the second part of the phase-in under its 2020 rule ("CY 2020 Hospital OPPS Rule").[8] The Court of Appeals for DC then reversed the district court's decision, holding that the 2019 rule was entitled to deference and the rule could remain in place.[9] Accordingly, CMS again reprocessed affected 2019 claims to recoup the additional payments it had paid back to hospitals after the district court's ruling.[10] In 2021, the Supreme Court declined to hear the case on appeal, allowing the rule to remain in place.[11]

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[4] Medicare Payment Advisory Commission, "June 2022 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 6."

[5] Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care."

[6] U.S. Centers for Medicare & Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs," Pub. L. No. 225, 83 Federal Register 58818 (2018), https://www.federalregister.gov/documents/2018/11/21/2018-24243/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center. A second rule, released in 2019, further lowered OPPS payments. See U.S. Centers for Medicare & Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity to Apply for Available Slots," Pub. L. No. 218, 84 Federal Register 61142 (2019), https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center.

[7] American Hospital Association v. Azar, 410 F. Supp. 3d 142 (D.D.C. 2019).

[8] Jacqueline LaPointe, "Judge OKs 2020 Site-Neutral Payments, but Criticizes CMS Policy," RevCycleIntelligence, December 18, 2019, https://revcycleintelligence.com/news/judge-oks-2020-site-neutral-payments-but-criticizes-cms-policy.

[9] American Hospital Association v. Azar, 964 F.3d 1230 (D.C. Cir. 2020).

[10] Alia Paavola, "CMS to Reprocess Some 2019 Outpatient Claims after Ruling on Site-Neutral Payments," January 15, 2021, https://www.beckershospitalreview.com/finance/cms-to-reprocess-some-2019-outpatient-claims-after-ruling-on-site-neutral-payments.html.

[11] Dave Muoio, "Supreme Court Declines to Hear AHA's Appeal of Site-Neutral Payments Decision," Fierce Healthcare, June 28, 2021, https://www.fiercehealthcare.com/hospitals/supreme-court-declines-to-hear-aha-s-appeal-site-neutral-payments-decision.

The table below summarizes laws and regulations regarding Medicare's site-neutral payment policies:

Table 1. Summary of Site-Neutral Payment Policies

Policy	Passage Year/Final Rule Published	Implementation Year	Description*
Section 603 of the Bipartisan Budget Act of 2015	2015	2017	Requires Medicare to pay at Physician Fee Schedule rates for services furnished in non-grandfathered off-campus HOPDs
CY 2017 Hospital OPPS Rule	2016	2017	Implements Section 603 by: - Defining excepted items and services - Determining that nonexcepted items and services will generally be paid at 50% of the OPPS rate, rather than directly from Medicare Physician Fee Schedule
CY 2019 Hospital OPPS Rule	2018	2019	Adjusts implementation of Section 603 by paying hospitals at 70% of the OPPS rate for all off-campus HOPD clinic visits in 2019
CY 2020 Hospital OPPS Rule	2019	2020	Adjusts implementation of Section 603 by paying hospitals at 40% of the OPPS rate for all off-campus HOPD clinic visits in 2020 and beyond

* HOPD = hospital outpatient department

The table below details some examples of site differences in payment that still exist in 2023:

Table 2. Estimated 2023 Medicare Payments for Select Services by Service Location[12]

HCPCS Code	Short Description	Office-Based Physician Payment (A)	Facility-Based Physician Payment (B)	Baseline OPPS Facility Payment (C)	Total Payment: *Office* =(A)	Total Payment: *On-Campus Hospital* =(B+C)	Total Payment: *Existing* Off-Campus Hospital* =(B+C)	Total Payment: *New* Off-Campus Hospital* =(B+C*0.5)
G0402	Initial preventive exam	$166.73	$131.48	$120.86	$166.73	$252.34	$252.34	$191.91
92002	Eye exam—new patient	$86.07	$45.75	$120.86	$86.07	$166.61	$166.61	$106.18
92004	Eye exam—new patient	$150.46	$93.87	$120.86	$150.46	$214.73	$214.73	$154.30
99214	Level 4 office visit—est. patient	$128.43	$97.60	$120.86	$128.43	$218.46	$145.94**	$145.94**
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa	$90.48	$52.19	$644.34	$90.48	$696.53	$696.53	$374.36
62273	Inject epidural patch	$170.79	$113.18	$644.34	$170.79	$757.52	$757.52	$435.35
64420	Injection of anesthetic agent (nerve block)	$98.61	$58.63	$644.34	$98.61	$702.97	$702.97	$380.80
64445	Injection of anesthetic agent (nerve block)	$163.34	$73.54	$644.34	$163.34	$717.88	$717.88	$395.71
64644	Chemodenervation of extremity or trunk muscle(s)	$178.92	$116.91	$644.34	$178.92	$761.25	$761.25	$439.08
78451	Myocardial perfusion imaging, tomographic (spect)	$320.23	$64.05	$1,327.27	$320.23	$1,391.32	$1,391.32	$727.69
78456	Acute venous thrombus image	$294.82	$46.76	$1,327.27	$294.82	$1,374.03	$1,374.03	$710.40
78802	Radiopharmaceutical localization of tumor	$292.79	$37.28	$1,327.27	$292.79	$1,364.55	$1,364.55	$700.92
78830	Radiopharmaceutical localization of tumor	$453.75	$67.77	$1,327.27	$453.75	$1,395.04	$1,395.04	$731.41

*As of passage of Bipartisan Budget Act of 2015.

**For 99214, off-campus hospital payments are equal to (B) + (C)*0.4.

[12] See Addenda to U.S. Centers for Medicare & Medicaid Services, "Hospital Outpatient Prospective Payment—Notice of Final Rulemaking with Comment Period (NFRM), CY 2023," accessed October 12, 2023, https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc; U.S. Centers for Medicare & Medicaid Services, "Physician Fee Schedule Look-Up Tool," accessed October 12, 2023, https://www.cms.gov/medicare/payment/fee-schedules/physician/lookup-tool. Figures represent estimated payments based on national payment amounts designated in each fee schedule. Payment amounts vary by geographic area and service location.

Literature on Differences in Payment Rates across Sites of Care

Literature studying the effects of Medicare's site-based payment differentials has focused on savings that could be realized by the Medicare program and Medicare beneficiaries by implementing site-neutral payment policies, the impact of payment differentials on health care markets, and the effectiveness of policies intended to harmonize payment rates for similar services across sites of care.

Impact on Medicare Spending

While estimates vary, most studies agree the Medicare program would realize significant savings if it adopted site-neutral policies by compensating for services delivered in hospital outpatient departments at the same rate as those delivered in physicians' offices. In 2014, MedPAC estimated implementing a site-neutral payment policy for select groups of physician outpatient services that would save the Medicare program and beneficiaries $1.1B a year, including saving Medicare beneficiaries $180M a year in cost-sharing, without adversely affecting quality.[13] When Congress passed Section 603 of the Bipartisan Budget Act of 2015, establishing site-neutral payments for new off-campus hospital outpatient departments, the Congressional Budget Office (CBO) estimated that the policy would save $9.3B between 2016 and 2025.[14] The table below summarizes scoring for site-neutral policies that have been implemented or proposed since 2015:

Table 3. Official Cost Saving Scoring of Site-Neutral Policies and Proposals

Source	Source Year	Policy*	Savings Year(s)	Medicare Savings	Beneficiary Savings	Total Savings
CBO	2015	Section 603 of the Bipartisan Budget Act of 2015 (pay services at new off-campus HOPDs at physician's office rates)	2016–2025	$9.3 billion		
CMS[15]	2018	CY 2019 Hospital OPPS Rule (pay all off-campus HOPD clinic services at physician's office rates, first phase)	2019	$300 million	$80 million	$380 million
CMS[16]	2019	CY 2020 Hospital OPPS Rule (pay all off-campus HOPD clinic services at physician's office rates, second phase)	2020	$640 million	$160 million	$800 million

[13] Medicare Payment Advisory Commission, "March 2014 Report to the Congress: Medicare Payment Policy, Chapter 3."
[14] Congressional Budget Office, "Estimate of the Budgetary Effects of H.R. 1314, the Bipartisan Budget Act of 2015, as Reported by the House Committee on Rules on October 27, 2015," October 28, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf.
[15] U.S. Centers for Medicare & Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs."
[16] U.S. Centers for Medicare & Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to

Source	Source Year	Policy*	Savings Year(s)	Medicare Savings	Beneficiary Savings	Total Savings
CBO[17]	2018	**Proposal**: Pay all off-campus HOPD services at physician's office rates	2019–2028	$13.87 billion		
OMB[18]	2018	**Proposal**: Pay all off-campus HOPD services at physician's office rates	2019–2028	$33.98 billion		
CBO[19]	2020	**Proposal**: Pay all off-campus HOPD services at physician's office rates	2021–2030	$39.14 billion		
CBO[20]	2020	**Proposal**: Pay on-campus HOPDs at physician's office rates for certain services	2021–2030	$102.33 billion		
OMB[21]	2020	**Proposal**: Pay all off-campus HOPD services at physician's office rates	2021–2030	$47.24 billion		
OMB[22]	2020	**Proposal**: Pay on-campus HOPDs at physician's office rates for certain services	2021–2030	$117.2 billion		
MedPAC[23]	2022	**Proposal**: Pay all HOPDs at physician's office or ASC rates for certain services	2019	$6.6 billion	$1.7 billion	$8.3 billion
MedPAC[24]	2023	**Proposal**: Pay all HOPDs at physician's office or ASC rates for certain services	2021	$6.0 billion	$1.5 billion	$7.5 billion
CRFB[25]	2021	**Proposal**: Pay on-campus HOPDs at physician's office or ASC rates for certain services, and for all off-campus HOPD services	2021–2030	$153 billion	$94 billion	$247 billion

* HOPD = hospital outpatient department

Grandfathered Children's Hospitals-within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity to Apply for Available Slots."

[17] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2019 Budget," May 30, 2018, https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf.

[18] U.S. Office of Management and Budget, "Budget of the U.S. Government, Fiscal Year 2019," February 2018, https://www.govinfo.gov/content/pkg/BUDGET-2019-BUD/pdf/BUDGET-2019-BUD.pdf.

[19] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget," March 25, 2020, https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf.

[20] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget."

[21] U.S. Office of Management and Budget, "Budget of the U.S. Government, Fiscal Year 2021," February 10, 2020, https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/02/budget_fy21.pdf.

[22] U.S. Office of Management and Budget, "Budget of the U.S. Government, Fiscal Year 2021."

[23] Medicare Payment Advisory Commission, "June 2022 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 6."

[24] Medicare Payment Advisory Commission, "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8," June 2023, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

[25] Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care."

Impact on Health Care Markets

There is evidence that higher Medicare payments for care delivered in hospital outpatient settings have incentivized vertical integration between hospitals and physician practices.[26] One study found that a 2010 increase in Medicare reimbursement for services delivered in hospital outpatient departments relative to physicians' offices contributed to 20% of the increased vertical integration between hospitals and physician practices from 2009 to 2013.[27] Another study found that vertical integration accelerated between hospitals and cardiology practices after CMS reduced fees for cardiology services in office settings compared to hospital settings.[28] This is consistent with a 2010 survey that indicated 40% of cardiologists planned to vertically integrate due to these fee cuts.[29] The CBO has endorsed that eliminating differences in payments across sites of care would disincentivize vertical integration.[30] That these differential payments encourage vertical integration is problematic because there is strong evidence showing that vertical integration of hospitals and physician practices raises health spending without commensurate improvements in patient outcomes.[31]

Impact across Provider Specialties

The impact of Medicare's current and proposed payment policies varies by provider specialty. Across specialties, there is variation in the magnitude of payment differentials by site of care as well as the share of providers employed in hospital-based versus office-based settings. Medicare reimbursement for primary care services from 2010 to 2016 was 78% higher when delivered in a hospital compared to an office setting; for medical specialties, this differential was 74%; and for surgical specialties, it was 224%.[32] The impact of site-based payment differentials on vertical integration between hospitals and physician practices also varies across specialties.[33] Primary care and medical specialties (e.g., cardiology and neurology) are generally more responsive to site-based payment differentials in their integration decisions compared to surgical specialties.[34]

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[26] Michael E. Chernew, "Disparities in Payment across Sites Encourage Consolidation," *Health Services Research* 56, no. 1 (2021): 5–6, https://doi.org/10.1111/1475-6773.13612.
[27] David Dranove and Christopher Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy* 11, no. 4 (November 2019): 249–71, https://doi.org/10.1257/pol.20170020.
[28] Zirui Song et al., "Medicare Fee Cuts and Cardiologist-Hospital Integration," *JAMA Internal Medicine* 175, no. 7 (July 1, 2015): 1229–31, https://doi.org/10.1001/jamainternmed.2015.2017.
[29] Song et al., "Medicare Fee Cuts and Cardiologist-Hospital Integration."
[30] Congressional Budget Office, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," September 2022, https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf.
[31] Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 1, 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001.
[32] Brady Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," *Health Services Research* 56, no. 1 (2021): 7–15, https://doi.org/10.1111/1475-6773.13613.
[33] Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments."
[34] Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments."

Likewise, site-neutral payment policies have varying financial impacts across provider specialties. For example, one study shows that surgical specialties perform a small percentage of clinic visits in off-campus hospital outpatient departments; therefore, they should be only mildly affected by the CY 2019 Hospital OPPS Rule limiting payments for clinic visits in these service locations.[35] The same is likely true for dermatology, although the overall financial impact of the Rule is particularly large for this specialty because of its high service volume.[36] Another study showed that, of all surgical specialties, oral and maxillofacial providers perform close to the highest proportion of clinic visits in off-campus hospital outpatient departments; however, the relatively low volume of these services means that the absolute impact of the CY 2019 Hospital OPPS Rule will generally be low.[37]

Impact on Commercial Spending

Medicare's payment policies influence other sectors. Private health insurance plans tend to follow Medicare's system as a basis for compensating physicians and hospitals, though generally at higher average rates of payment. One study found that a $1 increase in Medicare reimbursement for physician services leads to a $1.16 increase in commercial prices,[38] while another study found that a 10% reduction in Medicare reimbursement for inpatient services led to a 3–8% reduction in commercial prices.[39]

As a result, Medicare's differentiated payment rates have contributed to differences in commercial insurer payment rates for identical outpatient services delivered in physicians' offices and hospital outpatient settings.[40] This impacts total private health care spending and commercially insured patients, who typically incur higher cost-sharing for services received in hospital-based settings. A 2022 study found that commercial spending is 145% higher in a hospital outpatient department than in a physician's office, and a patient's out-of-pocket spending is 109% higher.[41] Other

[35] Neil S. Kondamuri et al., "Financial Implications of Site-Neutral Payments for Clinic Visits in Otolaryngology," *JAMA Otolaryngology–Head & Neck Surgery* 146, no. 1 (January 1, 2020): 78–79, https://doi.org/10.1001/jamaoto.2019.3229.

[36] Christian Gronbeck, Paula W. Feng, and Hao Feng, "Economic Assessment of the 2020 Site-Neutral Payment Reform for Dermatologists.," *Journal of the American Academy of Dermatology* 83, no. 4 (October 2020): 1196–98, https://doi.org/10.1016/j.jaad.2020.02.035.

[37] N.A. Patel, "Estimating the Financial Impact of Site-Neutral Payments for Outpatient Consultations in Oral and Maxillofacial Surgery," *Journal of Oral and Maxillofacial Surgery* 78, no. 10 (2020): 1664–65, https://doi.org/10.1016/j.joms.2020.05.024.

[38] Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy* 125, no. 1 (February 2017): 1–39, https://doi.org/10.1086/689772.

[39] Chapin White, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," *Health Affairs* 32, no. 5 (May 2013): 935–43, https://doi.org/10.1377/hlthaff.2012.0332.

[40] Committee for a Responsible Federal Budget, "Moving to Site Neutrality in Commercial Insurance Payments," February 14, 2023, https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

[41] Aditi P. Sen, Yashaswini Singh, and Gerard F. Anderson, "Site-Based Payment Differentials for Ambulatory Services among Individuals with Commercial Insurance.," *Health Services Research* 57, no. 5 (October 2022): 1165–74, https://doi.org/10.1111/1475-6773.13935.

research shows commercial insurers would save 45% on infused oncology treatments if hospital outpatient departments were paid at physician's office rates.[42]

MedPAC Assessment of Services That Should Have Payments Aligned across Sites of Service

In June 2023, MedPAC recommended Medicare align payments between physicians' offices and hospital outpatient departments for 57 types of outpatient services (formally known as ambulatory payment classifications or APCs) and between ASCs and hospital outpatient departments for nine types of outpatient services (a full list of these services is contained in the Appendix).[43] MedPAC determined that these hospital outpatient services should be paid at the physician's office or ASC rate because they are primarily performed in physicians' offices or ASCs, respectively.[44] Services that are primarily performed in physicians' offices and recommended for site-neutral payments include clinic visits, drug administration, nerve injections, imaging, diagnostic tests, and skin procedures.[45] Services that are primarily performed in ASCs and recommended for site-neutral payments include lower gastrointestinal procedures, ocular procedures, and lower-acuity nerve procedures.[46]

The Impact of Site-Neutral Billing on Hospital Revenue

Reductions in health spending would reduce hospitals' revenue.[47] However, the impact on revenue would depend on the precise site-neutral policy implemented. For example, MedPAC estimated that rural hospitals could see a 2.5% reduction in Medicare revenue under a policy that equalizes payments for certain services for all hospital outpatient departments and applies a budget neutrality adjustment.[48] This policy would also reduce Medicare revenue by 1.7–2.3% for smaller hospitals (under 100 beds) and overall increase Medicare revenue for for-profit hospitals.[49] To the

[42] Paul Fronstin, M. Christopher Roebuck, and Bruce C. Stuart, "Location, Location, Location: Cost Differences for Oncology Medicines Based on Site of Treatment," Employee Benefits Research Institute, January 16, 2020, https://www.ebri.org/content/cost-differences-for-oncology-medicines-based-on-site-of-treatment.
[43] Medicare Payment Advisory Commission, "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8."
[44] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8." A handful of services were excluded from the payment alignment recommendation because separate MedPAC analysis determined differentiated payments were warranted.
[45] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8."
[46] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8."
[47] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8."
[48] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8." Alternatively, MedPAC has proposed a policy that would implement site-neutral payments without a budget neutrality adjustment but create a stop-loss that limits the reduction in total payments to hospitals that serve a disproportionate share of low-income patients. However, this could dampen the desired impacts of a site-neutral policy by limiting the number of hospitals it affects. See Medicare Payment Advisory Commission, "June 2022 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 6"; Loren Adler, Matthew Fiedler, and Benedic N. Ippolito, "Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce," Brookings, May 25, 2023, https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/.
[49] "June 2023 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8."

extent that some hospitals require financial support, MedPAC recommends providing targeted support to those facilities as opposed to maintaining distortions in Medicare reimbursement that can have broader implications for the functioning of health care markets.[50]

[50] "June 2022 Report to the Congress: Medicare and the Health Care Delivery System, Chapter 6."

Appendix

Outpatient Services for which MedPAC Recommends Aligning Fee-for-Service Payments between Outpatient Hospitals and Physicians' Offices

APC	APC Description	Program Spending (in millions)	Beneficiary Cost Sharing (in millions)	Volume (in thousands)
5012	Clinic visits	$2,056	$514	27,835
5693	Level 3 drug administration	879	220	5,459
5694	Level 4 drug administration	680	170	2,819
5524	Level 4 imaging w/o contrast	680	170	1,778
5593	Level 3 nuclear medicine	642	160	619
5522	Level 2 imaging w/o contrast	632	158	7,333
5523	Level 3 imaging w/o contrast	547	137	3,000
5521	Level 1 imaging w/o contrast	453	113	7,072
5052	Level 2 skin procedures	288	72	1,048
5691	Level 1 drug administration	283	71	8,987
5373	Level 3 urology and related services	240	60	169
5443	Level 3 nerve injections	238	59	364
5054	Level 4 skin procedures	230	58	169
5442	Level 2 nerve injections	223	56	443
5724	Level 4 diagnostic tests and related services	191	48	267
5692	Level 2 drug administration	189	47	3,963
5441	Level 1 nerve injections	176	44	873
5722	Level 2 diagnostic tests and related services	141	35	671
5611	Level 1 therapeutic radiation treatment preparation	136	46	1,454
5051	Level 1 skin procedures	102	26	722
5822	Level 2 health and behavior services	95	24	1,596
5053	Level 3 skin procedures	78	20	190
5734	Level 4 minor procedures	77	19	871
5071	Level 1 excision/biopsy/incision and drainage	76	19	154
5372	Level 2 urology and related services	69	17	153
5723	Level 3 diagnostic tests and related services	65	16	169
5733	Level 3 minor procedures	60	15	1,360
5823	Level 3 health and behavior services	58	14	558
5101	Level 1 strapping and cast application	51	13	454
5721	Level 1 diagnostic tests and related services	49	12	447
5153	Level 3 airway endoscopy	46	11	39
5731	Level 1 minor procedures	34	9	1,751
5371	Level 1 urology and related services	34	8	160
5671	Level 1 pathology	31	8	768
5164	Level 4 ENT procedures	29	7	13
5741	Level 1 electronic analysis of devices	28	7	955

APC	APC Description	Program Spending (in millions)	Beneficiary Cost Sharing (in millions)	Volume (in thousands)
5055	Level 5 skin procedures	$28	$7	10
5481	Laser eye procedures	20	5	52
5151	Level 1 airway endoscopy	16	4	127
5111	Level 1 musculoskeletal procedures	10	2	58
5163	Level 3 ENT procedures	8	2	8
5732	Level 2 minor procedures	8	2	305
5743	Level 3 electronic analysis of devices	7	2	34
5102	Level 2 strapping and cast application	7	2	36
5161	Level 1 ENT procedures	7	2	41
5152	Level 2 airway endoscopy	6	1	19
5413	Level 3 gynecologic procedures	4	1	8
5411	Level 1 gynecologic procedures	4	1	29
5412	Level 2 gynecologic procedures	4	1	17
5162	Level 2 ENT procedures	3	1	9
5742	Level 2 electronic analysis of devices	3	1	36
5502	Level 2 extraocular, repair, and plastic eye procedures	2	1	4
5501	Level 1 extraocular, repair, and plastic eye procedures	2	1	12
5735	Level 5 minor procedures	1	0	7
5821	Level 1 health and behavior services	1	0	66
5621	Level 1 radiation therapy	1	0	12
5811	Manipulation therapy	1	0	25

Source: Medicare Payment Advisory Commission, "June 2023 Report to the Congress," Table 8-2.

Outpatient Services for which MedPAC Recommends Aligning Fee-for-Service Payments between Outpatient Hospitals and Ambulatory Surgical Centers

APC	APC Description	Program Spending (in millions)	Beneficiary Cost Sharing (in millions)	Volume (in thousands)
5312	Level 2 lower GI procedures	$725	$181	877
5491	Level 1 intraocular procedures	568	142	343
5431	Level 1 nerve procedures	221	55	159
5311	Level 1 lower GI procedures	215	54	339
5492	Level 2 intraocular procedures	212	53	68
5112	Level 2 musculoskeletal procedures	92	23	83
5462	Level 2 neurostimulator and related procedures	69	17	14
5503	Level 3 extraocular, repair, and plastic eye procedures	40	10	25
5504	Level 4 extraocular, repair, and plastic eye procedures	13	3	5

Source: Medicare Payment Advisory Commission, "June 2023 Report to the Congress," Table 8-3.

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