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Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals

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Summary

- Only 19% of Medicare off-campus hospital outpatient department (HOPD) spending is subject to existing outpatient payment system site neutrality policies.
- Medicare and beneficiaries typically pay two to four times more for a service in an off-campus HOPD than if they had received the identical service in an independent physician office.
- We estimate that expanding site neutrality policies to all off-campus HOPDs would save Medicare and beneficiaries $32 billion over ten years.
- Off-campus HOPDs are less common in rurally based hospitals, and site neutrality proposals do not impact facilities specifically targeting underserved populations such as critical access hospitals.

Background

Many medical services can be safely provided in multiple settings. Medicare and beneficiaries typically pay more for services performed in a hospital outpatient department (HOPD) than for equivalent services performed in a physician office. This is true regardless of whether the HOPD is located on the campus of a hospital or if the HOPD is in a different, off-campus location. Off-campus HOPDs are often established as the result of a hospital system acquisition of independent physician offices.

Site neutrality is the concept of aligning payment rates across service locations for identical services of equal complexity. Over the past several years, limited site neutral payment policies have been implemented. The Bipartisan Budget Act of 2015 required setting payments at new ("non-excepted") HOPDs at roughly equivalent levels to physician office payments, effective January 1, 2017, but all existing HOPDs were grandfathered ("excepted") from the legislation.[1] The Center for Medicare & Medicaid Services (CMS) used administrative authority in 2019 to establish site neutral payments for clinical visits at excepted off-campus HOPDs, but did not address site neutrality for other services.[2] In total, these policies impact only 19% of all Medicare off-campus HOPD spending.

Recently, Congress and other stakeholders have considered broadening site neutrality policies. The Medicare Payment Advisory Commission (MedPAC) has included chapters in each of its last two annual Reports to Congress recommending site neutrality in all HOPDs for services which can safely be performed in multiple settings.[3] In December, the Lower Costs, More Transparency Act passed in the House of Representatives and would expand site neutrality to drug administration services in off-campus HOPDs.[4] Other recently proposed bills in both the Senate and House also include modest expansions to site neutrality.[5] Unlike MedPAC's recommendations, all of these bills would only impact off-campus HOPD spending, with variations in the applicable services, timing, and exceptions.

In this brief, we aim to quantify the scope and projected savings of a range of site neutrality proposals and recommendations, using Actuarial Research Corporation's site neutrality simulation model.[6] We compare the scope of current site neutrality rules with the off-campus proposals being considered in congressional bills and contrast these bills to the broader HOPD neutrality recommended by MedPAC. We also provide insights on the impact of neutrality proposals in rural and underserved areas.

Current State of Medicare Outpatient Spending

Currently, 1% of outpatient facility spending is subject to site neutrality within the Medicare Outpatient Prospective Payment System (OPPS). Table 1 shows all outpatient facility spending in 2022, categorized by facility type and the applicability of site neutrality rules. Two categories, indicated by the highlighted cells, are currently impacted by OPPS site neutral policies.

The first site neutral category is non-excepted services provided by off-campus HOPDs. Site neutrality for non-excepted off-campus HOPDs was required in the Bipartisan Budget Act (BBA) of 2015 and became effective January 1, 2017. HOPDs are excepted, or grandfathered, from site neutrality for services they were already offering prior to the passage of the legislation. The portion of off-campus services which are non-excepted has gradually increased over time, yet still made up only 0.5% of all outpatient facility spending ($392 million) in 2022.

The second site neutral category is clinical visits provided by any off-campus HOPD, regardless of excepted status. Site neutrality was expanded to excepted clinical visits at off-campus HOPDs in the 2019 OPPS payment rule. This expansion roughly doubled the portion of spending subject to neutrality (an additional 0.5% or $415 million in 2022).

These two site neutral categories only represent 19% ($807 million out of $4.3 billion) of all off-campus HOPD spending. Expanding site neutrality to all off-campus HOPD services would increase the share of outpatient expenditures subject to neutrality provisions by a multiple of five. That said, off-campus HOPD spending represents only 5% of total outpatient facility spending, and therefore off-campus site neutrality proposals are much more modest than proposals that might also include on-campus HOPDs.

TABLE 1: MEDICARE OUTPATIENT FACILITY SPENDING BY FACILITY TYPE, GEOGRAPHY, AND SITE NEUTRALITY STATUS (2022)

Facility Type	Non-Rural ($ millions)	Rural ($ millions)	All Geographies ($ millions)		Site Neutrality Status
Off-Campus HOPDs	**$4,035**	**$301**	**$4,336**	***5.2%***	
Non-Excepted All Services	$371	$21	$392	*0.5%*	**Neutral** by BBA of 2015
Excepted Clinical Visits	$370	$44	$415	*0.5%*	**Neutral** by 2019 rule
Excepted Other Services	$3,294	$235	$3,529	*4.2%*	Not neutral; 2023 bills proposed partial expansion
On-Campus HOPDs	**$48,858**	**$6,087**	**$54,945**	***65.8%***	
Emergency Department	$5,829	$957	$6,786	*8.1%*	N/A; excluded from all recommendations and bills
All Other	$43,029	$5,130	$48,159	*57.7%*	Not neutral
Other Outpatient Facilities	**$14,712**	**$9,495**	**$24,207**	***29.0%***	
Critical Access Hospitals	$1,319	$5,646	$6,965	*8.3%*	N/A; payment based on cost
Rural Health Centers	$403	$1,536	$1,939	*2.3%*	N/A; payment based on cost
Federally Qualified Health Centers	$807	$359	$1,165	*1.4%*	N/A; FQHC PPS
End-Stage Renal Disease Facilities	$9,853	$1,735	$11,588	*13.9%*	N/A; ESRD PPS
Other Facilities	$2,330	$219	$2,549	*3.1%*	
TOTAL	**$67,605**	**$15,883**	**$83,488**	***100%***	

Notes: Based on ARC's analysis of the 2022 Medicare 5% sample Limited Data Set (LDS), extrapolated to 100% Medicare fee-for-service. Rural status corresponds to where the hospital is based, using the rural/urban indicator corresponding to the provider number of the facility in the CMS Provider of Services file. Excludes claim lines for drugs. Only outpatient facility payments are included; corresponding physician payments paid under the Physician Fee Schedule (PFS) are not included. Other Facilities includes certain rehabilitation facilities, home health, outpatient skilled nursing, and additional less common facility types.

It is also important to note that off-campus HOPD spending makes up a significantly smaller share of spending of facilities based in rural areas (1.9%, or $301 million out of $15.9 billion in 2022).[7] Furthermore, facility payments at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) are not determined by the OPPS and would not be impacted by site neutrality proposals.

Savings Impact of Site Neutrality Proposals

There have been numerous recent proposals and recommendations from various stakeholders to expand site neutrality. Among these, the breadth of expansion varies widely. Bills in the House of Representatives are the most limited. The Lower Costs, More Transparency Act, which passed in the House in December, would expand neutrality only to drug administration services in excepted off-campus HOPDs. In the Senate, the Site-Based Invoicing and Transparency Enhancement Act (SITE Act) would eliminate the exception for grandfathered off-campus facilities by expanding site neutrality to all services in off-campus HOPDs, with some facility exclusions. MedPAC's recommendation is the most comprehensive, expanding neutrality to all HOPDs for all services which can safely be performed in multiple settings.

Table 2 shows projected savings associated with a range of site neutrality expansion scenarios.[8] We project that site neutrality in off-campus HOPDs for drug administration services (consistent with the House bills) would save $5.6 billion over 10 years, of which $4.9 billion benefits the Medicare program and $0.7 billion benefits beneficiaries through lower Part B cost sharing, as shown in the first table row.[9] Imaging and diagnostic testing are two other narrowly defined but sizable categories of services for which neutrality at off-campus HOPDs may be considered. Combined, we project savings for these two categories of $6.1 billion.

As part of their June 2023 recommendation, MedPAC identified 66 ambulatory payment classifications (APCs) to consider for site neutrality based on services that currently take place in physician offices a majority of the time.[10] We project that expanding neutrality for these 66 APCs in off-campus HOPDs would save $21 billion over 10 years. While meaningful, these savings associated with off-campus expansion are only 15% of the $145 billion of savings if neutrality for the same services were expanded to all HOPDs.

TABLE 2: MEDICARE AND BENEFICIARY PROJECTED SAVINGS OF SITE NEUTRALITY EXPANSION SCENARIOS

Site Neutrality Scenario		**10-Year Projected Savings** (2025-2034)		
Applicable Services	**Applicable Locations**	**Total** ($ millions)	**Medicare Program** ($ millions)	**Beneficiary Cost Sharing** ($ millions)
Drug Administration	Off-Campus HOPDs	$5,589	$4,871	$718
Imaging (no contrast)	Off-Campus HOPDs	$5,252	$4,577	$675
Diagnostics	Off-Campus HOPDs	$858	$747	$110
All 66 APCs in MedPAC Recommendation	Off-Campus HOPDs	$21,026	$18,325	$2,701
All Services	Off-Campus HOPDs	$32,171	$28,038	$4,133
All 66 APCs in MedPAC Recommendation	All HOPDs	$145,459	$126,771	$18,688

Notes: Projected savings are from ARC's site neutrality simulation model (see endnote 6). Includes savings to Medicare fee-for-service and the impacts on Medicare Advantage benchmarks.

Site Neutrality Implementation and Projection Approaches

Existing site neutrality within the OPPS has been implemented by applying a uniform 40% multiplier ("Relativity Adjuster") to the non-neutral OPPS rates to approximate equivalence with physician office rates. This approach has been used given the complexity of precisely aligning Physician Fee Schedule (PFS) and OPPS rates. [11] Often, when a service is performed in an HOPD, the total payment includes a facility component determined by the OPPS and a physician component determined by the PFS, while the same service performed in a physician office only generates a single payment. Adding additional complexity, within the OPPS, payment for supporting services is often bundled with the primary facility payment. In calculating projected savings of site neutrality scenarios, we estimated the impacts using two methods. First, we assumed the 40% Relatively Adjuster would be expanded to the applicable services within the scenario. Second, we estimated a more precise neutrality implementation where the sum of the OPPS payment and PFS payment (when there is a physician component) would be set for each APC at the average rate paid for the same mix of services with a physician office place of service, adjusted for the additional cost of bundled services. Table 2 reflects the first method, for consistency with existing site neutral policy implementation. However, utilizing the second, more precise, method would have yielded savings which were only modestly higher. Comparing these two approaches indicates the Relativity Adjuster is a reasonably accurate simplification for implementing neutrality.

Savings estimates presented in this brief consider the impacts of lower fee-for-service (FFS) Medicare payments and the corresponding impact on benchmarks used to determine Medicare Advantage payments. There would likely be additional savings in commercial segments, given commercial contracting practices often follow Medicare, which are not included in estimates in this brief.

Examples of Service Level Payment Differences

Payments for services in HOPDs are typically more than twice as large as the payments for equivalent services in physician offices. Most HOPD services are paid under Medicare Part B, and the beneficiary is responsible for 20% coinsurance after a nominal deductible is met. Therefore, higher HOPD payments impact both beneficiaries and the Medicare program.

Table 3 shows the average Medicare and beneficiary payment for several common services when provided in different settings. Clinical Visits, as shown in the first row, are already approximately site neutral (relativity of 114%) under the 2019 rule-based expansion of neutrality discussed earlier. The other examples reflect an illustrative subset of the services for which savings are projected in Table 2 under various site neutrality expansion scenarios. HOPD rates include the sum of the facility component paid under the OPPS and, when relevant, the additional physician component paid under the PFS.

The amounts in Table 3 reflect payment per service. At a beneficiary level, the extra cost sharing associated with excepted off-campus HOPDs are concentrated on a small portion of the population with high utilization. For example, from our previous brief on drug administration site neutrality, we estimated that the highest utilizing 5,000 patients who received chemotherapy at excepted off-campus HOPDs paid $1,055 more in cost sharing than they would have had payments been site neutral.[12]

The utilization of imaging services is more widespread than chemotherapy. In 2022, 1.6 million Medicare beneficiaries received an imaging service at an excepted off-campus HOPD. Of these, about 400,000 beneficiaries paid at least $50 more in cost sharing than had payments been site neutral (not shown in tables).

TABLE 3: PER SERVICE AVERAGE MEDICARE AND BENEFICIARY PAYMENTS FOR EXAMPLE SERVICES (2022)

Service	Medicare Payment		Beneficiary Payment		Relativity
	Excepted Off-Campus HOPD	Office	Excepted Off-Campus HOPD	Office	Excepted Off-Campus vs. Office
Clinical Visits	$106.53	$93.10	$26.63	$23.28	114%
Therapeutic or Prophylactic Injection (APC: Drug Administration Level 2)	$51.94	$12.54	$12.99	$3.13	414%
Percutaneous Allergy Skin Test (APC: Diagnostic Level 4)	$719.16	$176.01	$179.79	$44.00	409%
Chest X-ray Single View (APC: Imaging Level 1)	$66.52	$17.22	$16.63	$4.30	386%
Cystoscopy (APC: Urology Level 2)	$543.46	$204.20	$135.86	$51.05	266%
Radiation Dosimetry (Planning) (APC: Radiation Therapy Prep Level 1)	$376.98	$155.65	$94.24	$38.91	242%
MRI - Lower Extremity w/o Contrast (APC: Imaging Level 3)	$263.93	$173.27	$65.98	$43.32	152%

Notes: From ARC's Site Neutrality Scenario model, benchmarked to claims in the 2022 Medicare 5% sample Limited Data Set. HOPD payments reflect the sum of the facility and physician payments when there are two payments for the same service.

Conclusions

Many recent proposals related to site neutrality have focused on off-campus HOPDs. These locations are more similar to physician offices than on-campus HOPDs and are often the result of hospital acquisitions of physician offices. While non-excepted and clinical services are already paid on a site neutral basis at off-campus HOPD locations, those services represent only a small fraction of off-campus HOPD facility spending (19%) and an even smaller fraction of all outpatient facility spending (1%).

We project that expanding site neutrality to all services at off-campus HOPDs would save approximately $32 billion over ten years. Over one-third of this savings potential is related to three narrow service categories: drug administration, imaging (without contrast), and diagnostics. Site neutrality for off-campus drug administration alone, as has recently passed in the House of Representatives, would save $5.6 billion.

The financial strength of outpatient facilities in underserved areas is an important consideration in determining Medicare payment policies. In the context of site neutrality, it is important to note that off-campus HOPD spending is less common among hospitals based in rural areas. Further, facilities which specifically target underserved populations, such as CAHs, RHCs, and FQHCs, are not paid under the OPPS and would not be impacted by OPPS site neutrality proposals.

Because HOPD claims are paid by Medicare Part B, patients typically share in 20% of the cost, either directly or through the premiums associated with supplemental coverage. The annual cost sharing savings for sicker patients, like those undergoing chemotherapy, would be hundreds (and occasionally thousands) of dollars. Expansion of site neutrality would meaningfully benefit this population.

Disclosures

This work was supported by Arnold Ventures. ARC maintains full editorial control over the written policy analysis and savings estimates.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all communications with respect to actuarial services. Tim Bulat and Ryan Brake are members in good standing of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this brief.

Notes

[1] The Bipartisan Budget Act (BBA) of 2015 introduced site neutrality for off-campus HOPDs. This bill also excepted off-campus HOPDs from site neutrality if they were already operating as off-campus HOPDs prior to the bill's passage. See: Section 603 of the Bipartisan Budget Act of 2015; https://www.congress.gov/114/plaws/publ74/PLAW-114publ74.pdf

[2] In 2019, site neutrality specific to the clinical visit service was expanded in the OPPS payment rule to excepted off-campus HOPDs. See: CY2019 OPPS Final Rule; Federal Register 83:225; Section X.B Method To Control Unnecessary Increases in the Volume of Outpatient Services (p59004-59014); https://www.federalregister.gov/documents/2018/11/21/2018-24243/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center

[3] Medicare Payment Advisory Commission (MedPAC); June 2023; Chapter 8: Aligning fee-for-service payment rates across ambulatory settings; https://www.medpac.gov/document/chapter-8-aligning-fee-for-service-payment-rates-across-ambulatory-settings-june-2023-report/

[4] See: Section 203 of the Lower Costs, More Transparency Act (HR5378); https://www.congress.gov/bill/118th-congress/house-bill/5378/text

[5] In the House of Representatives, see the Lower Costs, More Transparency Act (previous note) and Section 302 of the PATIENT Act of 2023 (HR5361); in the Senate, see Section 2 of the SITE Act (S1869): https://www.congress.gov/bill/118th-congress/house-bill/3561/text; https://www.congress.gov/bill/118th-congress/senate-bill/1869/text

[6] Actuarial Research Corporation (ARC) has developed a simulation model which illustrates the current state of billing practices and payment rates, and projects the impacts of site neutrality across a variety of inputs which define the scope of services and approach to payment neutrality. The model baseline data is the 2022 Medicare 5% sample Limited Data Set (LDS), extrapolated to 100% Medicare fee-for-service. Projections are calibrated to the CMS 2023 National Health Expenditures Accounts projections. All analyses in this brief are based on this model or other ARC analyses of Medicare 5% sample LDS claims.

[7] Identifying the rurality of spending is imprecise because off-campus locations of provider-based facilities often share the same provider number as the primary facility. Typically, off-campus locations are within 35 miles of the main provider, though there are several exceptions (see 42 CFR § 413.65(e)(3)). Both House of Representatives bills (see notes 4 and 5) include sections which would require a separate identification number for each off-campus HOPD.

[8] Savings estimates in this brief do not consider OPPS budget-neutrality requirements. Under current law, any decreases in payments for certain services would be offset by increases in services not made site neutral. To fully realize the savings, legislation would have to exempt site neutrality savings from budget neutrality calculations, as the recent House of Representatives bills propose.

[9] In Medicare Part B, a 20% coinsurance is required after a nominal deductible is met ($233 in 2022). While many beneficiaries have a Medicare Supplement plan which directly pays the Part B coinsurance, pricing in the Medicare Supplement market is extremely competitive, and we implicitly assume savings would be passed to beneficiaries in terms of lower Medicare Supplement premiums.

[10] See tables 8-2 and 8-3 of MedPAC June 2023 report (note 3). The 57 APCs from table 8-2 are set neutral with Physician Fee Schedule payments using the Neutrality Adjuster. The 9 APCs from table 8-3 are set neutral with ambulatory surgical center payments.

[11] When the site neutrality required in the BBA of 2015 was first implemented in the 2017 OPPS payment rule, the Relativity Adjuster approach was defined and set at 50%. The Relativity Adjuster was reduced to 40% in 2018. See: CY2017 OPPS Final Rule; Federal Register 81:219; Section X.A Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Off-Campus Provider Based Departments of a Hospital (p79699-79719); https://www.federalregister.gov/documents/2016/11/14/2016-26515/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment and CY2018 PFS Final Rule; Federal Register 82:219; Section II.G Establishment of Payment Rates Under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital (p53019-53030); https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

[12] T. Bulat and R. Brake; Actuarial Research Corporation; October 18, 2023; Potential Impacts of Medicare Site Neutrality on Off-Campus Drug Administration Costs; https://craftmediabucket.s3.amazonaws.com/uploads/Drug-Admin-Off-Campus-Site-Neutrality-2023.10.18.pdf