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Without Site Neutrality, the Differential in HOPD and Office Medicare Payments is Growing Faster than Medical Inflation

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Summary

- Medicare beneficiaries typically pay two to four times more when services are provided in a hospital outpatient department (HOPD) rather than a physician office. This payment differential is growing, providing increasing financial incentives to perform services in higher-cost settings.
- Without site neutrality, the differential between HOPD and office payment rates for the same service grew by an average of 4.0% annually from 2017 to 2022.
- This 4.0% trend in the payment differential exceeded the growth in payments at either HOPDs (2.6%) or offices (0.9%), as well as general measures of medical inflation.
- Implementing comprehensive site-neutral payment reform that accounts for the growth in the payment differential between HOPD and office rates would save Medicare $138 billion over the next ten years and lower out-of-pocket costs for Medicare beneficiaries by $21 billion.

Background

Many medical services can be safely performed in physician offices or hospital outpatient departments (HOPDs). However, Medicare and Medicare beneficiaries pay more for identical services in HOPDs than in physician offices – two to four times more for common services.[1,2] Even most off-campus HOPDs, which resemble physician offices and often were standalone offices before being acquired by hospital systems, are paid at the higher rate.

Site neutrality is the concept of aligning payment rates across service locations for matching services of equal complexity. Limited site neutral policies have been implemented which impact services at some off-campus HOPDs.[3] However, we have previously estimated that these existing policies apply to only 19% of off-campus HOPD spending and 1% of all HOPD spending.[4] Recently, Congress and other stakeholders have proposed broadening site neutrality policies. Several studies and analyses, including our own prior briefs, have quantified the differences in payment across locations, estimated the potential savings and beneficiary impacts of site neutrality expansion, and discussed considerations regarding facilities in rural and underserved areas.

In this brief, we highlight multiyear trends in HOPD and office payments within Medicare, adding context and urgency to site neutrality discussions. Our trend analysis reveals that the differential between HOPD and office payments is growing faster than general measures of medical inflation, such as the medical components of the Consumer Price Index (CPI) or Producer Price Index (PPI), as well as the specific market

basket inflation forecasts used by CMS when setting Medicare rate system increases. In the June 2024 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that it "has long been concerned" about this widening payment differential and discussed the potential for incentivizing vertical consolidation and increased service volume in HOPDs "if allowed to worsen."[5] Here, we quantify the extent to which the payment differential trend exceeds inflation and provide updated estimated impacts of potential site neutrality legislation which considers the growing differential.

The Growing Differential Between HOPD and Physician Office Payments

When a service takes place in a physician office, a single bill is typically generated, and Medicare reimbursement is based on the Physician Fee Schedule (PFS). Annual changes to the aggregate physician fee schedule are determined legislatively, while CMS calculates service-specific relativities. To support Congress in setting adequate annual increases, MedPAC assesses the adequacy of physician payment, considering beneficiary access, care quality, and clinicians' revenues and costs.[6]

When a service takes place in an HOPD, two bills are typically generated. An institutional bill, sometimes referred to as the "facility fee", is reimbursed based on the Outpatient Prospective Payment System (OPPS). Additionally, a professional bill is reimbursed based on the PFS. By statute, increases in the OPPS are based on the hospital market basket index forecast, and CMS calculates service-specific weights. As with physician payments, MedPAC advises Congress on the adequacy of OPPS payments.

Because annual changes to the OPPS and the PFS are determined separately, the annual increase in the differential between HOPD and physician office payments may not be reasonable. In fact, because OPPS annual increases have been greater than PFS annual increases over the last several years, the differential in HOPD and office payments has grown more rapidly than the PFS, the OPPS, or medical inflation.

Overall increases in the OPPS and the PFS, and service-specific relativities within these payment systems, are developed with consideration of multiple factors, including provider costs and revenue, beneficiary access, and quality. In this brief, we do not directly address the adequacy of OPPS and PFS increases or the accuracy of service-specific relativities, and we acknowledge that there is important ongoing discussion among stakeholders regarding the appropriate level of payment relative to access, volume, quality, service mix, inflation, and other factors.[7,8] Our focus here is specifically on the implications of annual changes to the PFS and the OPPS on the payment differential between HOPD and office settings for matching services in the context of site neutrality.

Table 1 illustrates the relationship between the increases in HOPD payments, office payments, and the payment differential. The table displays the allowed amounts for several individual services and categories of services in HOPD and office settings for the years 2017 and 2022. The payment differential represents the difference between the HOPD and office allowed amounts.

A unilateral hip x-ray serves as a representative example. From 2017 to 2022, the average allowed amount for this service in a physician office increased from $39 to $46, corresponding to an annualized increase of 3.1%. In the HOPD, the average allowed amount, which consists of the sum of the professional and institutional components, increased from $74 to $98, an annualized increase of 5.8%. The increase in the payment differential was leveraged by the higher reimbursement rate increases in the OPPS relative to the PFS. As a result, the payment differential grew from $35 to $52, an annualized increase of 8.6%.

This pattern – where the increase in the payment differential between the HOPD and office settings outpaced the increases at either site of service – is consistent across most services considered for site neutrality. The last row in Table 1 illustrates the broad category of services which MedPAC recommended for consideration for site neutrality with the PFS in their June 2023 report.[9] For these services, the average annual increase in the payment differential was 4.0%, compared to annual increases of 2.6% for HOPDs and 0.9% for offices.

TABLE 1: INCREASES IN HOPD, OFFICE, AND DIFFERENTIAL ALLOWED AMOUNTS
In total and for selected common example services and service categories

Service	Location	2017 Allowed Amount	2022 Allowed Amount	2022/2017 Increase (Annualized)	Comparable Inflation Metrics (Annualized)
Imaging: **X-ray exam – hip** CPT 73501,73502	HOPD	$74	$98	+5.8%	OPPS Market Basket Update: **2.2%**
	Office	$39	$46	+3.1%	
	Differential	$35	$52	**+8.6%**	
Imaging: **Echocardiogram** CPT 93306	HOPD	$524	$581	+2.1%	Medicare Economic Index: **1.7%**
	Office	$230	$205	-2.3%	
	Differential	$294	$376	**+5.0%**	Medical CPI: **2.9%**
Imaging: **Level 1 Imaging** CPTs in APC 5521	HOPD	$74	$98	+5.6%	
	Office	$32	$37	+3.4%	Medical PPI: **2.4%**
	Differential	$43	$60	**+7.1%**	
Drug Admin: **Hydration Intravenous** CPT 96360	HOPD	$187	$217	+3.0%	
	Office	$58	$35	-9.8%	
	Differential	$129	$182	**+7.2%**	
Drug Admin: **Chemotherapy Admin** Chemo-related CPTs[10]	HOPD	$180	$228	+4.9%	
	Office	$94	$97	+0.6%	
	Differential	$85	$131	**+8.9%**	
Diagnostics: **Pulmonary Function** CPT 94726	HOPD	$252	$294	+3.2%	
	Office	$51	$55	+1.2%	
	Differential	$200	$240	**+3.7%**	
Diagnostics: **Level 3 Diagnostics** CPTs in APC 5723	HOPD	$541	$647	+3.7%	
	Office	$264	$266	+0.2%	
	Differential	$277	$381	**+6.6%**	
All Services 57 APCs MedPAC recommended considering for site neutrality with PFS	HOPD			+2.6%	
	Office			+0.9%	
	Differential			**+4.0%**	

Notes: From ARC's analysis of 2017 and 2022 Medicare 5% sample Limited Data Sets (LDS). HOPD allowed amounts reflect the sum of the professional and institutional amounts for services when two bills are typical. HOPD allowed amounts reflect on-campus HOPD services only and are not blended with off-campus instances which may have already been paid on a site-neutral basis. All Services uses fixed service-level mix, although the resulting pattern is not sensitive to the weighting method.

The most relevant comparable measures of medical inflation are the forecasted regulation market basket updates published by CMS.[11] These measures reflect inflation expectations at the time OPPS and PFS rates are finalized and are specific to the services paid under these payment systems. From 2017 to 2022, the OPPS market basket averaged annual increases of 2.2%. Over the same period, the Medicare Economic Index, which reflects physician practice cost inflation, averaged annual increases of 1.7%. The average increase in HOPD and office payment differential, at 4.0%, was significantly higher than these metrics.

More general measures of medical inflation are the medical components of the CPI and PPI, produced by the Bureau of Labor Statistics (BLS) as retrospective measures of actual inflation.[12,13] From 2017 to 2022, these measures averaged annual increases of 2.9% and 2.4%, respectively. Although not specific to OPPS and PFS services, these measures suggest that medical inflation emerged higher than the forecasted market basket updates. Despite this, the annualized increase in the HOPD and office payment differential still exceeded these inflation measures.

Implications to Site Neutrality Considerations

Site neutrality was last expanded in 2020, when clinical services were made site neutral at all off-campus HOPDs. Despite that expansion and the growing number of non-excepted off-campus HOPDs, only 19% of off-campus HOPD spending and 1% of all HOPD spending were site neutral within the OPPS in 2022.[4]

Over the past several years, stakeholders have proposed various expansions of site neutrality. MedPAC has suggested expanding site neutrality with the PFS to all HOPDs for a broad set of 57 ambulatory payment classifications (APCs) that are regularly performed in physician offices (and, for an additional 9 APCs, neutrality with ambulatory surgical centers).[9] The Lower Cost More Transparency Act, passed in the House of Representatives in December 2023, would enact a more limited expansion of site neutrality specifically for drug administration services in off-campus HOPDs.

Table 2 contains projections of site neutrality savings under various scopes. While these projections are generally consistent with our previous estimates, they assume the relativity adjuster applied to the OPPS to implement neutrality will be updated over time to reflect the growing OPPS and PFS payment differential.[14] Previous estimates – both ours and estimates by others[15] – assumed that neutrality would be implemented with a flat 40% adjuster, consistent with current implementations of neutrality. Assuming that the relativity adjuster is updated to consider the growing differential leads to modestly higher savings.

Under these assumptions, if site neutrality were implemented at all HOPDs for the full set of services MedPAC proposed, beneficiaries would save $20.6 billion in cost sharing and the Medicare program would save $138 billion over the next ten years.

TABLE 2: PROJECTED SAVINGS OF SITE NEUTRALITY EXPANSION VARIATIONS

Site Neutrality Expansion Scope		10-Yr Projected Savings (2025-2034)	
Services	Applicable HOPDs	Beneficiaries ($ millions)	Medicare ($ millions)
Drug Administration APCs 5691-5694	Off-Campus	$682	$4,557
	All	$3,405	$22,761
Imaging (without contrast) APCs 5521-5524	Off-Campus	$817	$5,465
	All	$4,534	$30,317
Diagnostics APCs 5721-5724	Off-Campus	$132	$883
	All	$817	$5,465
All Services in MedPAC site neutral recommendation	Off-Campus	$2,796	$18,687
	All	$20,592	$137,656

Notes: Projected savings are from ARC's site neutrality simulation model, calibrated to 2022 Medicare 5% sample Limited Data Set (LDS). Projections are calibrated to the 2024 Medicare Trustees Report. Neutrality is assumed to be implemented with a relativity adjuster which is updated to reflect differences in OPPS and PFS increases. OPPS and PFS increases are assumed to steadily converge to projected medical inflation over the 10-year period.

In these estimates, we have not quantified the impact of excluding rural facilities or other underserved areas from neutrality expansion. However, we previously noted that such exclusions would have small effects on the estimates because critical access hospitals, rural health centers, and federally qualified health centers are not paid under OPPS, and other off-campus HOPDs are relatively less common in rural areas.[16]

Conclusion

There continues to be interest among numerous stakeholders in expanding site neutrality. In this brief, we have updated savings projections for various proposals. The most significant update is to assume that site neutrality implementation would consider the pace of growth in the differential between HOPD and physician office payments. With this assumption, broad implementation of site neutrality would save $158 billion over the next 10 years, of which nearly half ($68 billion) relates to the three specific categories of drug administration, imaging, and diagnostics. These impacts are modestly higher than implementation using a fixed relativity adjuster.

Our multiyear analysis found that growth in the payment differential is outpacing both medical inflation and the HOPD and office payment rates themselves. From 2017 to 2022, the payment differential grew by 4.0% annually, roughly double the growth in comparable metrics of rate system increases and medical inflation. If not addressed, this growing differential will further incentivize performing services in higher cost HOPDs.

Since HOPD services are covered under Medicare Part B, patients typically pay 20% of the cost, either directly or through premiums for supplemental coverage.[17] Therefore, the growing payment differential directly affects beneficiaries, increasing the cost for beneficiaries who receive care at HOPDs relative to those who receive care at physician offices. These beneficiaries may not appreciate the significant cost difference between settings which appear similar. As we have previously estimated, sicker patients receiving drug administration

services at HOPDs are already paying hundreds (and occasionally thousands) of dollars more for care compared to what they would pay at physician offices.[1] These beneficiaries would experience the greatest benefit from an expansion of site neutrality.

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.

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Notes

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

[2] Cooper Z, Jurinka E, Stern D. Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program. October 30, 2023. https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf

[3] Site neutrality was first implemented in OPPS at non-excepted off-campus HOPDs as a result of the BBA of 2015 in the 2017 OPPS payment rule. Site neutrality was expanded to all off-campus HOPDs for evaluation and management services (HCPCS G0463) in a two-year phase-in from 2019-2020. These existing site neutrality rules do not apply to OPPS payments at on-campus HOPDs and excepted off-campus HOPDs for all other services.

[4] Bulat T, Brake R. Actuarial Research Corporation. Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals. January 3, 2024. https://assets.arnoldventures.org/uploads/Sizing-Medicare-Off-Campus-HOPD-Site-Neutrality-Proposals-2024.01.03.pdf

[5] Medicare Payment Advisory Commission (MedPAC). Chapter 1 Approaches for updating clinical payment and incentivizing participation in alternative payment models. June 2024 Report to the Congress. June 11, 2024. https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf

[6] Medicare Payment Advisory Commission (MedPAC). Chapter 2 Assessing payment adequacy and updating payments in fee-for-service Medicare. March 2024 Report to the Congress. March 15, 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch2_MedPAC_Report_To_Congress_SEC.pdf

[7] Cottrill A, Cubanski J, Neuman T. What to Know About How Medicare Pays Physicians. March 6, 2024. https://www.kff.org/medicare/issue-brief/what-to-know-about-how-medicare-pays-physicians/

[8] Medicare Payment Advisory Commission (MedPAC). Chapter 4 Physician and other health professional services. March 2024 Report to the Congress. March 15, 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf

[9] Medicare Payment Advisory Commission (MedPAC). Chapter 8 Aligning fee-for-service payment rates across ambulatory settings. June 2023 Report to the Congress. June 15, 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

[10] CPTs included in the chemotherapy administration category are: 96423, 96549, 96401, 96402, 96405, 96411, 96415, 96417, 96406, 96409, 96422, 96542, 96413, 96416, 96420, 96425, 96440, 96446, 96450, G0498

[11] CMS. Market Basket Data. Actual Regulation Market Basket Update. https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip. The OPPS values used in this brief are net of the productivity adjustment, consistent with the values used to update the OPPS. The productivity adjustment is implicit in the MEI.

[12] BLS. Consumer Price Indexes. https://www.bls.gov/cpi/. Values correspond to the series: medical care in U.S. city average, all urban consumers.

[13] BLS. Producer Price Indexes. https://www.bls.gov/ppi/. Values correspond to the series: PPI industry data for general medical and surgical hospitals for Medicare patients.

[14] The difference between these estimates and those in our January 3, 2024 brief are primarily driven by the assumption that the relativity adjuster is updated to reflect the growing payment differential. We have also made other updates to the model for minor methodology changes and to align several assumptions with the 2024 Medicare Trustees Report and the latest CMS National Health Expenditures Accounts.

[15] American Hospital Association (AHA). Estimated Impact Analysis of Site-neutral Provisions in the Lower Costs, More Transparency Act. December 8, 2023. https://www.aha.org/fact-sheets/2023-12-08-estimated-impact-analysis-site-neutral-provisions-lower-costs-more-transparency-act-hr-5378

[16] See our January 2024 brief (note 3) which is directionally consistent with findings from a January 2024 Avalere study: Gustafson K, Creighton S, Morley M. CMS Site-Neutral Payments Affect Small Share of Spending. January 10, 2024. https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending

[17] Many Medicare FFS beneficiaries have a supplemental plan which pays all or a portion of Part B cost sharing. Pricing in the Medicare Supplement market is highly competitive, and we assume beneficiary cost sharing savings would be passed to beneficiaries in terms of lower Medicare Supplement premiums. A GenRe study found new business Medicare Supplement ratios were 87% in 2022, a steady increase from 79% in 2017. See: Maiale B. Medicare Supplement Premium Rates – Looking to the Past and Planning for the Future. October 24, 2023. https://www.genre.com/us/knowledge/publications/2023/october/medicare-supplement-premium-rates-en