

Spotlight

Site-Neutral Payment for Outpatient Care: Why It Matters for People with Medicare

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Outpatient care—medical services and procedures provided on an outpatient basis and not requiring an inpatient admission in a hospital or other facility—is critically important for older adults.¹ People with traditional Medicare (also known as Original Medicare) can often receive the same outpatient service in different types of settings, including provider offices, ambulatory surgical centers (ASCs), and hospital outpatient departments (HOPDs). Although the care received is equivalent across settings, in general, the amount traditional Medicare pays health care providers for that care is not. Under Medicare’s site-specific payment rules, providers often get paid considerably more for the same outpatient service in certain care locations such as HOPDs.

This *Spotlight* explores the implications of traditional Medicare’s site-based provider payments for the program’s spending, the health care system, and the millions of people who rely on the program for their health care—including paying more out of pocket for services they receive in certain settings when those services could be provided safely and effectively in lower-cost settings. The report highlights the importance of outpatient care in Medicare, explains Medicare’s site-specific payments for outpatient care, and describes policy solutions to mitigate their effects on consumers.

Importance of outpatient care for people with traditional Medicare

Outpatient care, which is covered by Medicare Part B, refers to a broad range of services, including routine medical visits, treatment of certain illnesses and injuries, minor

Key Takeaways

- ✓ Outpatient care—services and procedures provided without an inpatient admission to a hospital or other facility—is crucial for people with Medicare.
- ✓ Consumers can often receive the same outpatient service safely and effectively in different types of settings, including a provider’s office, ambulatory surgical center, and hospital outpatient department.
- ✓ Even though the outpatient service is equivalent, Medicare generally pays health care providers more for the same service in some settings such as hospital outpatient departments.
- ✓ Medicare’s site-based payments result in consumers spending more out of pocket for services they receive in a hospital outpatient department than for the same service in a different, less expensive setting. They also increase spending for the Medicare program and lead to greater costs across the health care system.
- ✓ To protect against the harmful effects of site-based payments, Medicare has put in place a limited number of policies that align provider reimbursement for the same outpatient services regardless of setting.
- ✓ As policymakers consider larger-scale site-neutral reforms, ensuring consumers’ affordable access to the outpatient care they need should be front and center.

surgical and medical procedures, preventive care, chronic disease management, physical therapy, and diagnostic procedures.² In 2021, 9 out of 10 people with traditional Medicare (about 33 million individuals) used Medicare Part B-covered services.³

Health care professionals provide outpatient care in different settings (see box titled “Where Do People with Medicare Get Outpatient Care?”). Moreover, people with Medicare can often receive the same outpatient service at more than one location. For example, health care providers can see patients for a follow-up office visit, to remove a skin lesion, or to take a chest X-ray in a medical provider’s office, an ASC, or a HOPD.

Over time, many health care procedures have shifted from inpatient to outpatient settings. This shift is the result of a variety of factors, including provider consolidation, changes in patient preferences, and advancements in technology that allow certain complex procedures to be performed on an outpatient basis.⁴ Accordingly, outpatient services have grown in importance for people with traditional Medicare and as a share of Medicare’s spending (see figure 1). In 2013, Part B services accounted for 43 percent of Medicare spending.⁵ In 2023, Medicare’s spending for Part B had grown to almost half (49 percent) of total spending—more than what the program spent that year for Part A inpatient services (40 percent) such as hospitalization, rehabilitation in a skilled nursing facility, and end-of-life hospice care. Spending for Part B services as a share of total Medicare spending is expected to continue growing and reach 53 percent in 2033.⁶

Site-based payments: More than a provider payment issue

Providers typically receive different payment rates for the same outpatient service in different settings because Medicare uses different systems and methodologies to determine payment rates depending on those settings. For outpatient care delivered in a provider’s office, Medicare pays for the

Where Do People with Medicare Get Outpatient Care?

People with Medicare most often get outpatient care in one of four locations:

- **Medical providers’ offices.** Physicians and other health professionals provide a wide range of outpatient services, including primary and specialty care, at independent, freestanding practices. These offices can range in size from a sole practitioner to a large group and have various ownership models (e.g., private practice, medical group, corporate control).⁷ In 2021, about 28 million individuals with traditional Medicare received outpatient care in an office setting.⁸
- **On-campus hospital outpatient departments (on-campus HOPDs).** These hospital-affiliated units typically offer a wide range of outpatient services such as diagnostic tests, treatment and follow-up care, minor surgical procedures, and emergency care. On-campus HOPDs are located on hospital grounds and account for two-thirds of all Medicare outpatient facility spending.⁹
- **Off-campus hospital outpatient departments (off-campus HOPDs).** Like on-campus HOPDs, these hospital-affiliated units offer a wide range of outpatient services. Off-campus HOPDs are located outside of hospital grounds. Many are former freestanding provider offices purchased by a hospital. In 2021, an estimated 22 million individuals with traditional Medicare received outpatient care in an on-campus or off-campus HOPD.¹⁰
- **Ambulatory surgical centers (ASCs).** These facilities primarily provide outpatient surgical procedures to patients who do not require an overnight stay. Examples of common services provided in ASCs include cataract surgeries, colonoscopies, and steroid injections to treat back pain.¹¹ In 2022, over 3 million people with traditional Medicare were treated in an ASC.¹²

specific service based on the Physician Fee Schedule. Meanwhile, when that same service is delivered in a HOPD, Medicare pays based on the Outpatient Prospective Payment System (OPPS) methodology. And similarly, Medicare pays for care in an ASC based on the Ambulatory Surgical Center Payment System.

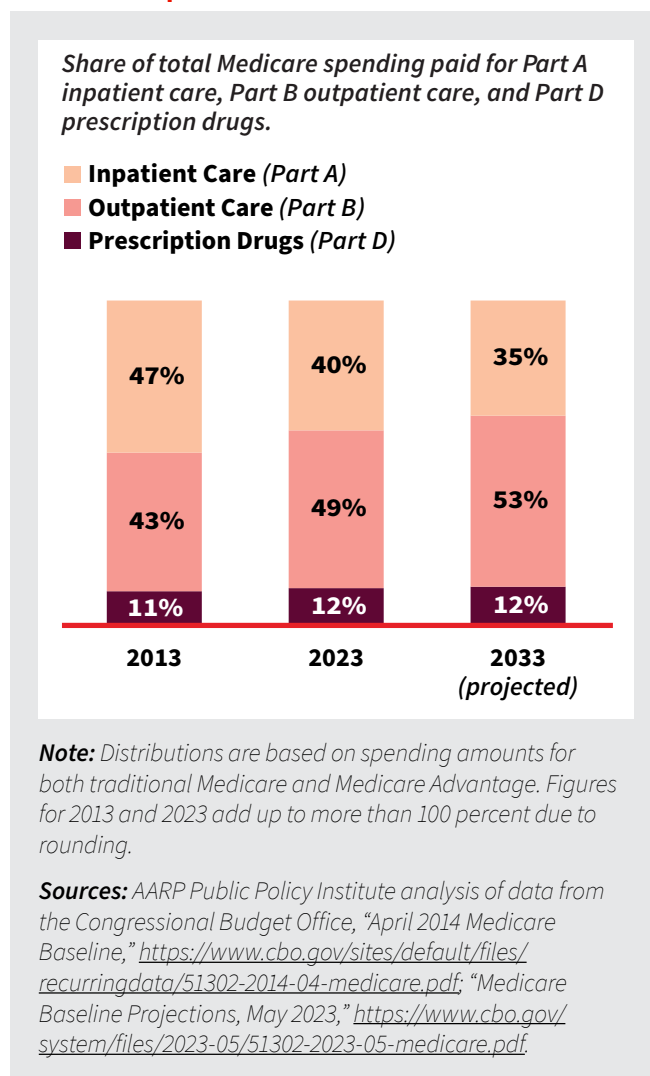
As a result, Medicare's total payment for the same outpatient service is typically higher in an HOPD or ASC than in a provider's office. Paying HOPD and ASC providers more for less complex services that can safely and appropriately be performed in provider offices has significant implications for both how much consumers pay out of pocket for outpatient care and overall costs to Medicare and the health care system.

Higher provider payments in some outpatient care settings

Under traditional Medicare's site-specific payment methodologies, the program makes either one or two payments for an outpatient service, depending on the setting. In all care locations, providers and other health care professionals receive a physician fee for their clinical services.¹³ Providers who deliver outpatient services in an office setting receive only a physician fee, which is typically higher than the facility-based physician fee received when they perform a service in an HOPD or ASC. In addition to the lower physician fee, Medicare pays HOPDs and ASCs a facility fee, which is intended to reflect the cost of resources those facilities need, such as equipment, nursing and administrative staff, and medical supplies.

Medicare's total payment (facility fee plus physician fee) is higher for an outpatient service performed in an HOPD or ASC than for the same service furnished in a freestanding provider office. Higher facility fees in HOPDs relative to ASCs result in total Medicare payment typically being the highest in HOPDs. For example, in 2023, physicians and hospitals received \$1,015 for performing a colonoscopy in a HOPD—almost three times the amount

FIGURE 1
Medicare Spending Trends Reflect Movement Toward Outpatient Services



the physician receives for delivering the same service in an office setting (\$345), and over 60 percent more than a physician and ASC receive for a colonoscopy performed in an ASC (\$616) (see figure 2 for additional examples).

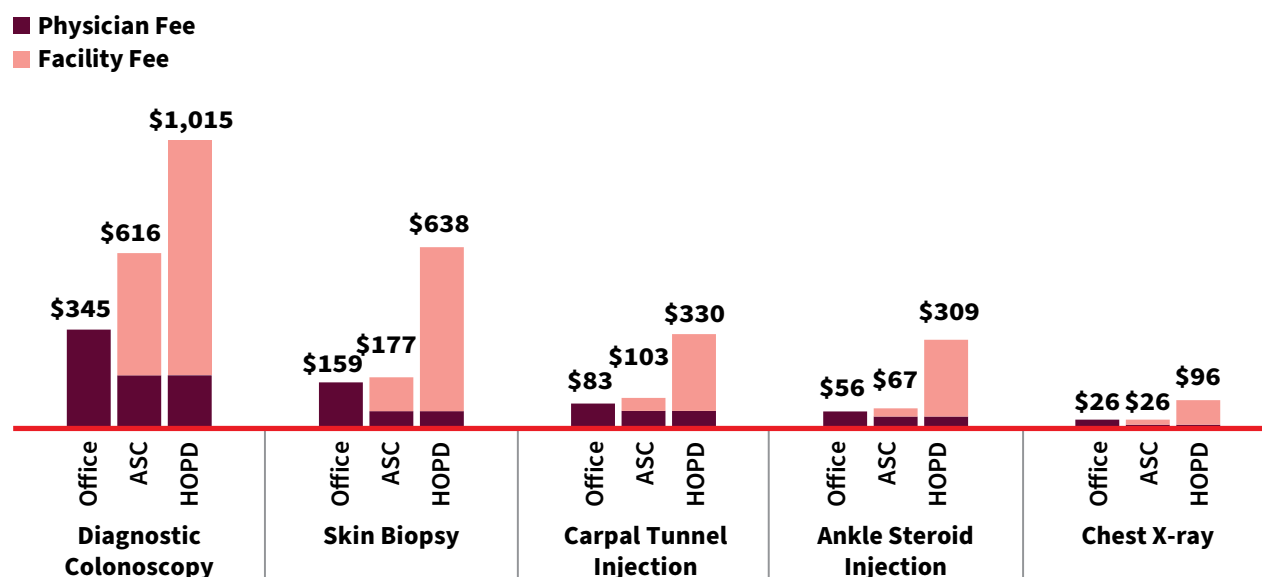
Consumers face higher out-of-pocket spending in facility-based settings

Beyond affecting payments for providers of outpatient care, Medicare's site-specific payments significantly affect consumer health care spending. Under Medicare Part B, consumers are typically responsible for

FIGURE 2

In Medicare, Hospital Outpatient Departments Often Receive the Highest Payments for Care

Total provider payments for outpatient care under traditional Medicare by location, 2023.



Note: Amounts represent total Medicare payments, which include Medicare payments and cost-sharing liabilities for people with traditional Medicare. HOPD = hospital outpatient department not currently subject to site neutral policies; ASC = ambulatory surgical center. CPT codes are 45378 for diagnostic colonoscopy, 11106 for skin biopsy, 20526 for carpal tunnel injection, 20605 for ankle steroid injection, and 71045 for chest X-ray.

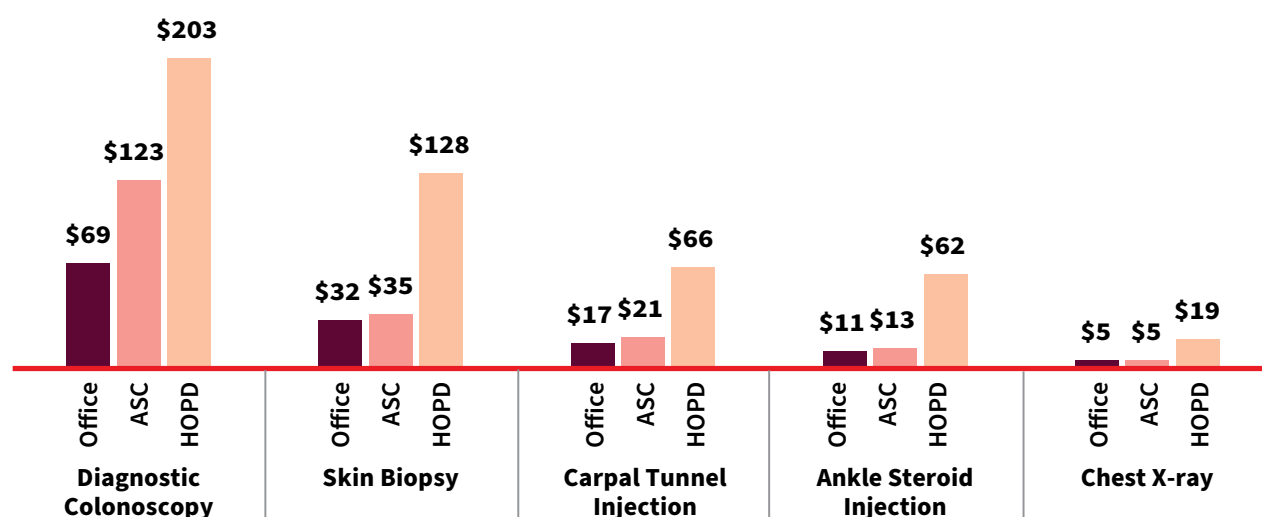
Source: AARP Public Policy Institute analysis of Medicare's Physician Fee Schedule (<https://www.cms.gov/medicare/physician-fee-schedule/search>) and of Medicare's facility fees in the "2023 Procedure Price Lookup Comparison File" (<https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/annual-policy-files/2023>).

20 percent of each outpatient service cost, after meeting a deductible.¹⁴ When payment rates to providers are higher, as they are in HOPDs and ASCs, consumers pay more out of pocket. In fact, people with traditional Medicare often pay two to four times more for a service delivered in an HOPD than for one delivered in an office setting.¹⁵ For example, in 2023, the out-of-pocket cost for a skin biopsy procedure in an HOPD was \$128, which is about four times what people with traditional Medicare paid for the same procedure in an ASC (\$35) and in a provider's office (\$32) (see figure 3 for additional examples). Such cost differentials can add up to considerable amounts, especially for people who receive multiple outpatient services.

In addition, traditional Medicare's site-specific payments have indirect implications for consumer spending. Because Medicare Part B is funded by general tax revenues (government contributions) and premiums (consumer contributions), increased program spending linked to facility fees translates into greater costs for taxpayers who fund the Medicare program and higher Part B premiums for everybody with Medicare, including those with Medicare Advantage, Medicare's private plan option. For individuals who have supplemental coverage that helps pay for out-of-pocket costs under traditional Medicare (such as Medigap or retiree coverage), Medicare's site-specific payments could also mean greater premiums for those plans.

FIGURE 3
Medicare Cost Sharing Is Typically Higher at Hospital Outpatient Departments

Out-of-pocket spending for outpatient care under traditional Medicare by location, 2023.



Note: Amounts represent cost-sharing liabilities for people with traditional Medicare. HOPD = hospital outpatient department not currently subject to site-neutral policies; ASC = ambulatory surgical center. CPT codes are 45378 for diagnostic colonoscopy, 11106 for skin biopsy, 20526 for carpal tunnel injection, 20605 for ankle steroid injection, and 71045 for chest X-ray.

Sources: AARP Public Policy Institute analysis of Medicare's Physician Fee Schedule (<https://www.cms.gov/medicare/physician-fee-schedule/search>) and of Medicare's facility fees in the "2023 Procedure Price Lookup Comparison File" (<https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/annual-policy-files/2023>).

Site-specific payments increase costs to the health care system

System-wide, Medicare's site-specific payments affect health care costs in several ways.

First, increased payments for the same outpatient service at different sites, when the service could be performed safely and effectively in lower-cost settings, unnecessarily increases Medicare spending. Evidence suggests that higher spending related to site-specific payments can total millions of dollars annually for just one outpatient service. For example, a recent Congressional Budget Office estimate showed Medicare payments for drug administration services, such as intravenous infusions, resulted in additional annual payments to HOPDs of \$39 million to \$755 million compared with those services being performed in a physician's office.¹⁶ Another

recent estimate calculated additional Medicare payments for all services provided at off-campus HOPDs to be more than \$28 billion over a 10-year period relative to those same services being performed in a provider's office.¹⁷

Second, site-specific payments in Medicare indirectly increase health care costs across the health sector because commercial health insurers typically set their provider payments as a percentage of traditional Medicare rates. Thus, higher payments for outpatient services in Medicare result in higher payments to providers under private plans and higher cost sharing and premiums for consumers with private health insurance coverage.¹⁸

Finally, site-specific payments may incentivize providers to take advantage of the highest rate for outpatient services.¹⁹ Site-specific payments are one potential driver for the significant

increase in the number of hospital systems that have merged with or acquired provider offices in recent years.²⁰ In 2024, over half (59 percent) of physician practices were hospital owned—a significant increase from 39 percent just five years earlier.²¹ Accordingly, certain low-complexity outpatient services, such as drug administration and clinic visits, are increasingly provided in on-campus and off-campus HOPDs rather than in provider offices—resulting in increased health care costs.²²

Mitigating the effects of Medicare’s site-specific payments: Site-neutral payment reforms

Policies that seek to address the negative impacts of site-specific payments are commonly referred to as “site-neutral” policies. By updating reimbursement methodologies so that outpatient provider payments are based on the type of service, these policies aim to align provider payments for the same or similar services regardless of setting.

Site-neutral policies vary from broad ranging to narrowly focused, depending on several factors, including which outpatient services are covered and which sites of care are affected.

Some more expansive Medicare site-neutral policy proposals aim to align provider payments for a broad range of services across most sites where the service is provided. Other policies target a narrow set of outpatient services or even a single outpatient service, aiming to align payments across only two care sites.

Medicare’s existing site-neutral policies are limited in scope

Since the early 2000s, policymakers have implemented a small number of Medicare site-neutral policies (see table 1). For a limited number of outpatient services (e.g., therapy services, mammography, dialysis, and clinical lab tests), traditional Medicare pays providers based on the same methodology across most care settings.

In 2015, the Bipartisan Budget Act (BBA) mandated that Medicare pay providers a rate equivalent to the physician office rate for all outpatient care provided in off-campus HOPDs established after passage of the bill.²³ Although important, this first step in site neutrality was limited. The law exempted existing off-campus HOPDs and did not apply to on-campus HOPDs or ASCs.²⁴

TABLE 1
Summary of Existing Site-Neutral Policies in Traditional Medicare

Authority	In Effect Since	Policy Change	Sites Excluded
Services excluded from payment under the Hospital Outpatient Prospective Payment System (OPPS)*	Various years, dating back to 2003	Requires that providers in HOPDs bill for therapy services, mammography tests, dialysis services, and clinical lab tests under the Physician Fee Schedule rather than the OPPS	ASCs
Bipartisan Budget Act (BBA) of 2015	2017	Prevents new off-campus HOPDs from billing under the OPPS for all outpatient services	On-campus HOPDs, existing off-campus HOPDs, and ASCs
2019 Hospital OPPS Rule	2020	Aligns payment for clinic visits in all off-campus HOPDs with office-based payments	On-campus HOPDs and ASCs

Note: HOPD = hospital outpatient department; ASC = ambulatory surgical center.

* See “Hospital Services Excluded from Payment under the Hospital Outpatient Prospective Payment System,” 42 CFR § 419.22, 2000, <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B/section-419.22>.

In 2019, the Centers for Medicare & Medicaid Services (CMS) used administrative authority to align provider payments for clinic visits (i.e., Evaluation and Management or E&M visits) at off-campus HOPDs that were exempted under the BBA with payments for office-based clinic visits.²⁵ Although notable for expanding site-neutral policies in traditional Medicare, only about one-third of clinic visits are provided in off-campus HOPDs and therefore affected by the rule.²⁶

To date, Medicare's site-neutral policies have had limited impact. Combined, these policies affect less than 1 percent of Medicare's spending for outpatient care provided across all outpatient care facilities and only an estimated 19 percent of the program's spending for outpatient care in off-campus HOPDs.²⁷

Additional Medicare site-neutral reforms being considered

Legislators and other stakeholders have continued to debate site-neutral reforms for Medicare, with particular focus on expanding site-neutral policies for off-campus HOPDs. Site neutrality for on-campus HOPDs and ASCs has received less attention. Recent congressional proposals include The Lower Costs, More Transparency Act (HR 5378). Passed by the House of Representatives in December 2023, the bill would align Medicare payments for drug administration services (e.g., injections or infusions for cancer treatment) at off-campus HOPDs (including those exempt under prior reforms) with payments for the same services at physician offices.²⁸

Key health care policy organizations have also put forth proposals for Congress to consider, including:

- The Medicare Payment Advisory Commission (MedPAC) recommends that CMS implement site-neutral payments for certain services provided in HOPDs (both off and on campus) that can safely be performed in multiple settings.²⁹ MedPAC identified 57 services for Medicare to align HOPD payments with physician office rates

and 9 services to align payments with ASC rates.

- The Committee for a Responsible Federal Budget recommends that CMS align payments for all off-campus HOPD services with physician's office payments.³⁰
- Ellis Health Policy and others recommend aligning payments across all outpatient services and all settings, with exceptions for rural hospitals.³¹

The stakes for Medicare site-neutral reform are high

Proponents of site-neutral policies believe they have the potential to generate savings for consumers, the Medicare program, and commercial insurers, while also slowing the growth of health care costs.

Better aligning payments for the same service across settings could reduce the amount, both people with Medicare and those with private insurance, spend for cost sharing when they use outpatient care and for insurance premiums. The proposals identified in this report could reduce out-of-pocket spending for people with traditional Medicare between \$700 million and \$18 billion over the next decade.³² Similarly, broad site-neutral Medicare reforms could reduce cost sharing among commercially insured individuals by \$18 billion over 10 years.³³

Potential savings to Medicare would result from reducing program spending for certain services when delivered in higher-cost settings and limiting incentives for hospitals to purchase provider offices. Projected Medicare savings from the site-neutral payment proposals above range from \$5 billion to \$202 billion over the next decade, depending on policy scope and timing for implementation.³⁴

As Medicare reduces its prices for certain outpatient services, commercial insurers are likely to follow. Under the broadest proposal for Medicare site-neutral reform, commercial insurers would save an estimated \$117 billion.³⁵

Beyond savings, Medicare site-neutral policies may also expand consumer access to needed outpatient services and improve provider choice. Without higher reimbursement, providers lose an incentive to recommend and deliver care in more expensive settings.³⁶ Eliminating disparate reimbursement rates for the same service may allow consumers more options to receive care in preferred settings based on convenience and access.

Meanwhile, critics of site neutrality claim that hospitals' greater costs to furnish services justify HOPDs' higher payment rates. Those higher costs, they argue, result from stricter regulations for hospitals, requirements to maintain certain hospital services (e.g., around-the-clock emergency care, hospital care in case of public health or other emergencies), and the greater health care needs of individuals treated in HOPDs. Those against site-neutral policies in Medicare express concern that payment reductions to HOPDs could force hospitals to reduce or eliminate certain services—with harmful

consequences for consumers' ability to access needed outpatient care, especially in rural and underserved areas.³⁷ Notably, researchers have identified several policy options to mitigate these concerns.³⁸

Putting consumers first under Medicare site-neutral payment reforms

Overall, Medicare site-neutral payment reforms have the potential to mitigate the harmful effects of site-based payments that enable providers in some settings to receive significantly higher payments for the same outpatient service than providers in other locations. Chief among those negative effects are higher out-of-pocket costs for millions of people with traditional Medicare who receive an outpatient service at an HOPD or ASC rather than a provider's office. As policymakers continue to weigh site-neutral payment reforms in Medicare, protecting consumers from paying more than is necessary while ensuring they have access to the outpatient care they need, should be front and center.

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- 1 Outpatient care is sometimes referred to as ambulatory care.
 - 2 In addition to outpatient services, Medicare Part B helps pay for the cost of other services and items, including durable medical equipment, prescription drugs administered at a doctor's office, and some home health services.
 - 3 AARP Public Policy Institute analysis of Centers for Medicare & Medicaid Services data. This figure includes individuals who used durable medical equipment and/or home health services. It also excludes people who received outpatient care in an ambulatory surgical center. Data are accessible at "CMS Program Statistics – Medicare Part A & Part B – All Types of Service," Centers for Medicare & Medicaid Services, <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-part-a-part-b-all-types-of-service>.
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- 11 “Ambulatory Surgical Center Services: Status Report,” in *Report to the Congress: Medicare Payment Policy*, MedPAC, March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf.
- 12 “CMS Program Statistics – Medicare Outpatient Facility.”
- 13 The physician fee reflects the relative time needed to deliver an outpatient service, the costs of malpractice insurance, and the costs of maintaining a practice (such as renting office space and buying supplies and equipment). This latter component typically leads to higher physician fees for outpatient services in provider office settings.
- 14 Certain preventive care services may not be subject to Medicare’s deductible or have no consumer cost sharing.
- 15 Bulat, “Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals.”
- 16 “Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act,” Congressional Budget Office, December 8, 2023, https://www.cbo.gov/system/files/2023-12/hr5378-DS-and-Revs_12-2023.pdf.
- 17 Bulat, “Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals.”
- 18 Phillip Ellis, “Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare,” Ellis Health Policy, February 2023, https://www.bcbs.com/dA/5bb94182e2/fileAsset/Phil_Ellis_Site_Neutral_Payment_Cost_Savings_Report_BCBSA_Feb_2023.pdf.
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- 24 MedPAC has expressed concern that existing Medicare site-neutral policies may have created a loophole wherein a hospital could purchase a physician’s office, relabel it as an HOPD by adding it to a grandfathered off-campus HOPD, and receive facility fees for services provided in former physician offices. See *Report to the Congress: Medicare and the Health Care Delivery System*, MedPAC, June 2022, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v4_SEC.pdf.
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