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10 FAQs on Site-Neutral Payment Reforms

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High health care costs are straining the budgets of American families. One little-known driver of these costs is Medicare's outdated policy allowing hospitals to charge more for basic services simply because they are provided at a hospital-owned doctor's office or clinic.

This is where *site-neutral payment reform* comes in. While the term may sound technical, the goal is simple: **ensure Medicare pays the same price for the same service**, no matter where it's delivered. In this memo, we answer 10 frequently asked questions on how site-neutral payments can lower costs, reduce incentives for consolidation, and protect patients from unnecessary fees.

1. What are site-neutral payments?

Right now, seniors pay different prices for services depending on whether they are performed at a hospital-owned clinic or an independent physician's office. And the prices—for the exact same service—are far higher at hospital-owned clinics. That means a cancer patient pays $228 for a single

round of chemotherapy at a hospital-owned clinic, compared to just $97 at an independent doctor's office. Hospital-owned clinics charge patients $581 for an echocardiogram (an ultrasound scan of the heart), nearly three times the $205 cost at a non-hospital site. Enacting site-neutral payments would reduce hospital payments for outpatient services to the same price charged in physician offices, lowering seniors' out-of-pocket costs.

2. What is Congress doing on site-neutral?

In December 2023, the House of Representatives passed the bipartisan Lower Costs, More Transparency Act to enact site-neutral payments in Medicare for drug administration services like chemotherapy. Earlier this year, Senators Bill Cassidy (R-LA) and Maggie Hassan (D-NH) released a framework for site-neutral payment reforms, including methods for reinvesting savings into rural and safety-net hospitals.

3. What services are considered outpatient?

Health care services that do not require a hospital stay are considered outpatient. These include routine visits, evaluation and management of diagnoses, labs, MRIs, and physician-administered drugs. These services can be delivered in independent physician's offices, in an off-campus hospital clinic, or within a hospital.

4. How would site-neutral payments affect health care consolidation?

Because Medicare pays hospital-owned clinics more than physician offices for the same services, hospitals are incentivized to buy physician practices to receive higher payments. If Medicare paid providers the same price for the same service, those incentives would decrease and encourage more competition. Less consolidation in health care means more competition and lower prices for all patients—not just those with Medicare.

5. How would these reforms impact the Medicare program?

Site-neutral payments would save Medicare billions of dollars. The Congressional Budget Office estimates that applying site-neutral payments broadly could save the Medicare program more than $150 billion over 10 years. Those savings would improve the financial security of the Medicare program while also reducing premiums and cost-sharing for seniors.

6. How would rural and safety-net hospitals be affected?

Major hospital systems that are highly consolidated would be the most affected by site-neutral payment reforms. Hospitals located in rural areas and low-income communities are less likely to own off-campus clinics and therefore account for a smaller share of Medicare outpatient spending. Furthermore, legislative reforms could exempt rural and safety-net hospitals or use savings to increase reimbursement for those hospitals—ensuring that the safety net is protected and strengthened.

7. How would these reforms impact the private market?

Prices paid by private insurers, including employers, are often based on a percentage of what Medicare pays for those same services. When Medicare pays more for the same service just because it was provided in a hospital-owned clinic, those inflated prices ripple out to private payers. Fixing this in Medicare would create a spillover effect for the private market—helping to lower health care costs for employers and families. Congress can also take direct action by regulating facility fees for those with private coverage.

8. What are facility fees?

A facility fee is an extra charge to patients for outpatient services provided in hospital-owned clinics, which are doctors' offices owned by a hospital system or, in some cases, for services provided via telehealth. In these locations, patients are charged a physician fee, the cost of the actual service, and a facility fee—the hospital's cut—despite never stepping foot in the hospital. However, facility fees are not always a separate charge on a medical bill; sometimes they are included in the high prices paid by patients for medical care.

9. How are patients affected by facility fees?

Facility fees drastically inflate the price patients pay to receive health care. For example, patients receiving an MRI pay hospitals $1,092, which is more than double the price of the procedure in an independent doctor's office. In addition to higher out-of-pocket costs, facility fees drive up premiums and can lead to substantial medical debt. Patients can also be charged facility fees for telehealth, despite never setting foot in a medical facility.

10. Is there any movement on reforms at the state level?

States cannot change federal Medicare reimbursement levels, but many states have made strides in regulating facility fees for patients with private coverage. Nearly 20 states have laws limiting specific

types of facility fees (like for telehealth) or requiring patient notification, billing transparency, or public reporting.