SITE-NEUTRAL PAYMENT

2026 ISSUE BRIEF

Inequitable payment structures result in Medicare paying as much as two times more for services provided in hospital-owned provider-based outpatient departments (HOPDs) than for the same services provided in physician offices. This payment disparity has grown over the past two decades as Medicare physician payment has effectively been cut by 30%, adjusted for inflation, from 2001 to 2024.

While Congress has considered site-neutral legislation to reduce healthcare costs by aligning payment for services provided in HOPDs with physician practice rates, reasonable policies must be designed to balance cost reduction, hospital viability, and adequate reimbursement for Part B providers. Reducing reimbursements for HOPD services to the underfunded Physician Fee Schedule (PFS) rates is not a sustainable solution to ensuring high-quality care for the Medicare population. The PFS rate has not kept up with inflation, and 92% of medical groups report that Medicare Part B payments do not cover the cost of delivering care. MGMA urges Congress to create a uniform ambulatory payment rate system for services provided across various ambulatory sites of service. Payments under the new system must reflect the actual cost of care and be developed in a budget-neutral manner.

CURRENT LANDSCAPE

While Medicare payment rates for physician practices are determined solely by the PFS, payments for services provided in HOPDs include a reduced physician professional fee and a separate facility fee, determined by the Outpatient Prospective Payment System (OPPS). Hospitals contend that facility fees help cover the costs of community services, including 24-hour emergency care, regulatory and safety standards, special capabilities (such as burn units, trauma, neonatal, and psychiatric services), uncompensated care, and Emergency Medical Treatment and Labor Act (EMTALA) standards. However, reimbursing HOPD services at higher rates to subsidize shortfalls in other federal funding programs (e.g., Disproportionate Share Hospital payments (DSH), 340B drug discounts, rural hospital designations) results in an indirect tax on patients and creates market imbalances that disadvantage freestanding medical practices.

The 2015 Bipartisan Budget Act implemented site-neutral payment policies requiring services provided in HOPDs built after 2015 to be paid under PFS rates. However, these policies had limited impact, covering only 0.8% of total HOPD spending. There is growing evidence these higher payments for services provided in HOPDs coupled with year-over-year payment cuts to Medicare physician payment incentivize market consolidation through the sale of physician practices to hospitals, health insurers, and other corporate entities.

MGMA
Medical Group Management Association®

SITE-NEUTRAL PAYMENT

2026 ISSUE BRIEF

CONGRESSIONAL ATTENTION

Proposals to address pay differentials often oversimplify the issue. In 2024, Senators Bill Cassidy and Maggie Hassan released a **legislative framework** outlining two policies for addressing the pay differential between HOPDs and physician practices. The first policy proposal was to remove the exception from the 2015 Bipartisan Budget Act, which allowed existing HOPD facilities and facilities under construction during the time of passage to be exempt from site-neutrality requirements. The second policy proposal was to identify procedures that are commonly performed across HOPDs and physician offices and set uniform reimbursement rates based on the site where the procedure is most commonly performed. These proposed policies set payment based on the PFS or the site with the highest volume payment rate and fail to strategically determine adequate and sustainable payment rates for hospitals and physician practices. Additionally, the lack of a budget-neutral approach will simply result in undue financial instability.

ADVOCACY PRIORITIES

- **Policymakers should establish a uniform ambulatory payment rate system for services provided across various ambulatory sites of service.** Notwithstanding issues of clinical quality related to a particular site of service, all payments under the uniform ambulatory payment rate system should reflect the cost of care. The system should be established in a budget-neutral manner which may lead to increases in reimbursement for some settings and reductions for others
- **Policymakers should use sufficient and accurate data regarding the actual costs of providing care for services that are routinely and safely provided across sites of service** to implement the uniform ambulatory payment rate system
- **CMS should study and ensure federal funding for hospital programs such as DSH, 340B, and rural designations** to cover the costs of non-ambulatory needs of the hospital
- **Policymakers should create a uniform ambulatory payment rate system as the singular, comprehensive site-of service policy** to ensure lasting financial stability for practices rather than make piecemeal payment adjustments

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms.

MGMA GOVERNMENT AFFAIRS
1717 Pennsylvania Ave., Suite 600, Washington, DC 20006
202.293.3450 | govaff@mgma.com
www.mgma.com/advocacy
@MGMA | #MGMAAdvocacy