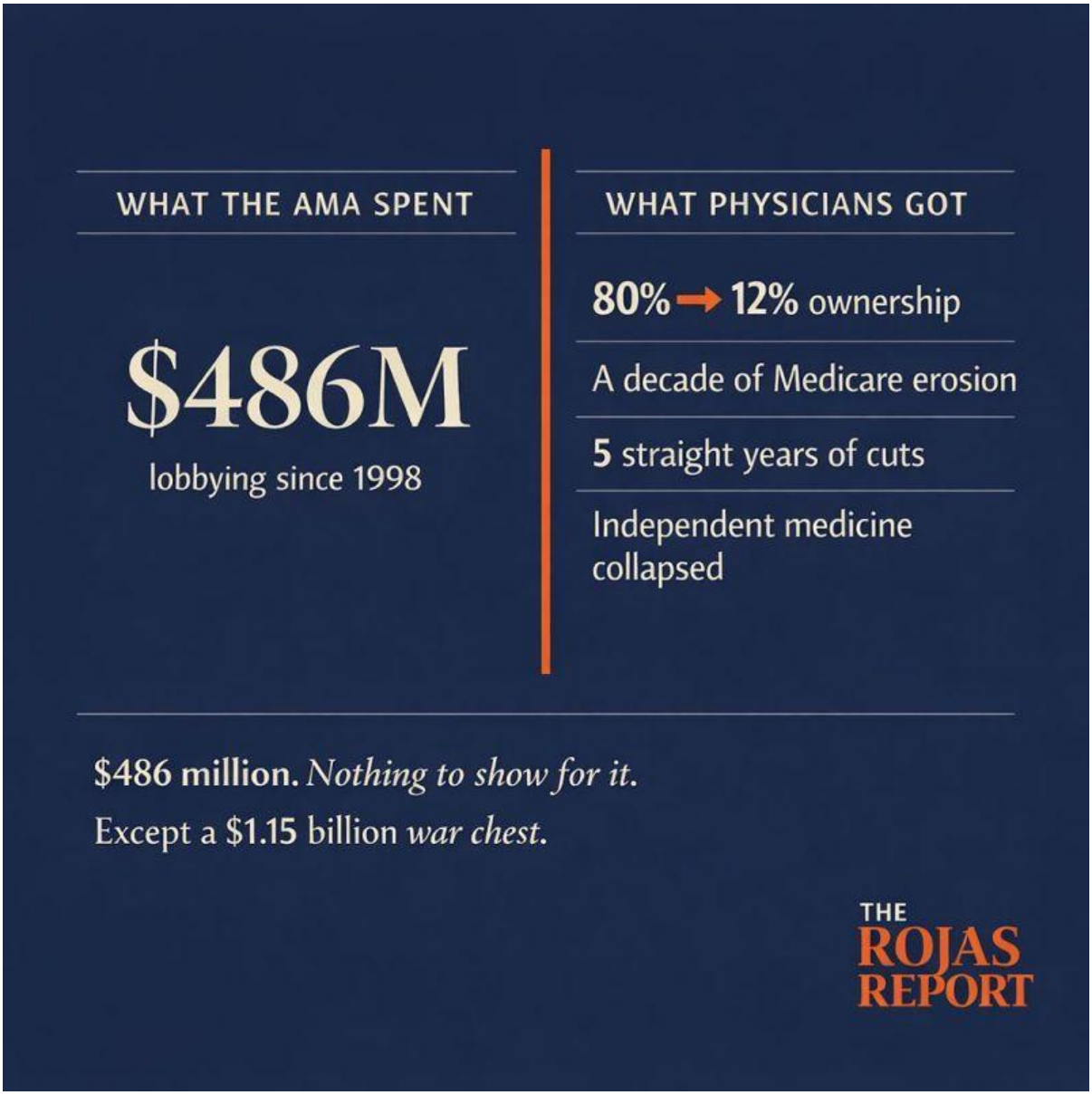
Testimony on Site-Neutral Payments for Out-Patient Services

Since 1998, the AMA (the Americal Medical Association) spent $486 million lobbying.
Results: Independent physician ownership went from 80% → 12%
Consolidation: won **Private practice:** bled out
$486 million later, **physicians got weaker**. The **AMA got richer.**

$1.15 billion war chest.



History

Medicare had been paying hospital outpatient departments higher rates than physician-owned practices, leading to higher spending and incentivizing hospitals to acquire physician practices. The Bipartisan Budget Act of 2015 introduced site-neutral payments for new outpatient departments but exempted existing ones. To evaluate the impact of this law, 2013–20 Medicare claims data were analyzed, comparing spending under site-neutral rates with spending under site-based rates and using difference-in-differences analysis to assess the effect on hospital-physician integration. During the period 2017–20, most Medicare payments were unaffected by the Bipartisan Budget Act: Only 1.5 percent of outpatient department spending occurred at site-neutral facilities. Counties subject to the Bipartisan Budget Act did not show a statistically significant difference in the percentage of hospital-integrated physicians (2020 estimate: −0.2 percentage points). The act did little to reduce Medicare spending or hospital-physician integration, suggesting that **site-neutral legislation could be strengthened by reducing exceptions.** https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00972

Why Is the Expansion of Site-Neutral Policy Being Recommended?

The Medicare site-neutral payment policy is driven by the broader goals of reducing healthcare costs, enhancing efficiency, and fostering fair competition among healthcare providers.

Cost Containment

The rising cost of healthcare has been a major concern for both public and private payers. By equalizing payment rates across different settings, CMS aims to reduce financial incentives that drive up costs without improving patient outcomes. While proposals vary in scope, **the Congressional Budget Office (CBO) estimates savings from site-neutral payments ranging from less than $5 billion to more than $100 billion over ten years.**

Promoting Fair Competition

Higher reimbursement rates for hospital-based services can create a competitive advantage over independent physician practices and ASCs. Site-neutral payments aim to create a more balanced environment. This would allow smaller providers to compete more effectively and creating more choice for patients. When smaller providers can sustainably operate, they can offer high-quality care that attracts more patients and increases their market share. Healthy competition can drive down costs and improve quality of care.

Encouraging Efficient Care Delivery

Site-neutral payments aim to align financial incentives, encouraging providers to deliver care in the most appropriate and cost-effective setting. This approach can lead to better resource utilization and potentially improved patient outcomes

Practice Expense Adjustments (2026 Update)

For the 2026 payment year, CMS finalized a shift in how it calculates **Practice Expense (PE)** values **to favor office-based settings over hospital facilities.**

- **Non-Facility Rate Increase:** CMS increased the PE relative value units (RVUs) for services provided in "non-facility" settings (like independent PT offices) to recognize their higher indirect costs.
- **Facility Rate Reduction:** Conversely, it reduced the portion of indirect PE RVUs for services provided in facility settings.
- **Outcome:** This narrows the payment gap between independent practices and hospital-based services by redistributing funds to independent clinicians.

In the commercial insurer market, site-neutral payments for physical therapy (PT) are emerging primarily through individual insurer policies and new state-level legislation rather than a single nationwide mandate.

1. Major Commercial Insurer Policies (2026)

Several national insurers have adopted policies to reduce the disparity between hospital-based and independent PT reimbursement:

- **UnitedHealthcare (UHC):** Effective March 1, 2026, UHC implemented a policy applying a **60% payment reduction** for specific clinic services (HCPCS code G0463) when billed with modifier PO at off-campus hospital-based departments. While this primarily targets general clinic visits, it often extends to the evaluation and management components associated with PT plans of care in those settings.
- **Blue Cross Blue Shield (BCBS) Entities:** In 2026, several BCBS plans (such as BCBS Massachusetts) updated their PT review processes to streamline authorizations across both independent and hospital-owned practices, effectively removing the administrative barriers that previously favored hospital systems.
- Aetna **and Anthem:** These carriers have historically benchmarked their commercial rates to a percentage of the Medicare Physician Fee Schedule (MPFS). Since Medicare's 2026 rules have narrowed the "practice expense" gap between settings, these commercial payers' rates for PT are becoming more site-neutral by default.

2. State Legislative Mandates

- **NASHP Model Legislation:** Several states are considering model legislation released in late 2025 by the National Academy for State Health Policy (NASHP). This model requires commercial insurers to reimburse all providers—regardless of setting or affiliation—at rates not exceeding **150% of the Medicare non-hospital rate** for designated outpatient services

https://nashp.org/designating-applicable-services-for-statewide-outpatient-site-neutral-payment-policy/