

Talking Points:

Why site-neutral looks simple—but isn't

1) Different missions, different fixed costs

Hospitals must maintain 24/7 standby capacity, disaster readiness, infection control, pharmacy oversight, blood bank, EMTALA compliance, advanced imaging backup, and specialist call coverage. Those fixed costs don't exist for physician offices or many ASCs. Flattening rates ignores those mandatory overheads that keep access available when things go wrong.

2) Safety-net cross-subsidy is real

Payment differentials help finance uncompensated care, underpaid Medicaid, and low-margin essential services (trauma, burn, NICU, behavioral health). Cut the differential and you erode the cross-subsidy that keeps safety-net access open—especially in rural and inner-city markets.

3) Hospitals treat sicker, more complex patients

Even for “same” HCPCS codes, HOPD case mix tends to be older, poorer, more comorbid, and medically complex (e.g., higher ASA class, chemo patients with neutropenia). Current code-level risk adjustment does not fully capture the added nursing intensity, pharmacy oversight, or complication risk borne by hospitals.

4) Regulatory load is unequal

HOPDs must meet Medicare **Conditions of Participation**, Hospital Outpatient Quality Reporting (OQR), price transparency, radiation safety, pharmacy/sterile compounding (USP 797/800), and survey/accreditation costs—requirements that are lighter or absent in non-facility settings. Equal pay for unequal regulatory burdens destabilizes the higher-standard setting.

5) Access will shrink where it's most fragile

When rates drop to physician-office equivalents, hospitals rationalize service lines: oncology infusion, complex drug administration, and advanced imaging often become financially nonviable. Closures hit rural and underserved communities first, increasing travel times, delays, and avoidable ED use.

6) “Savings” can be cost-shifts, not efficiencies

Lower HOPD prices reduce Medicare outlays and beneficiary coinsurance **only if** patients get timely access elsewhere. If hospitals cut hours or close sites, patients defer care or show up sicker in EDs and inpatient units—raising total cost of care and harming quality metrics.

7) It rewards cherry-picking and penalizes readiness

Office-based competitors can select low-risk patients and hours; hospitals can't. Site-neutrality pays the same while pushing higher-risk, after-hours, or complicated cases back to HOPDs without compensating the readiness cost.

8) Blunt policy, blunt outcomes

Applying a uniform site-neutral policy by APC/code ignores local market realities (e.g., sole community providers, public hospitals). A one-size cut can tip otherwise stable hospitals into negative margins, triggering multi-service retrenchment that far exceeds the targeted "excess payment."

9) Capital & cybersecurity obligations aren't optional

Hospitals face materially higher capital costs for life-safety infrastructure, negative-pressure rooms, sterile processing, EHR interoperability, and cybersecurity (federal expectations keep ratcheting up). Flattened rates crowd out those investments and increase systemic risk.

Counter-arguments—and how to respond

- **"Same service, same price."**
The code isn't the service. HOPD care embeds standby, pharmacy, infection control, and complication capacity that offices don't provide. Equalizing price while keeping unequal requirements is inequitable and unsafe.
- **"It lowers beneficiary coinsurance."**
Only if access is unchanged. If oncology infusion or drug administration shifts are curtailed, patients face delays and costlier downstream care. Protect coinsurance *and* access by carving out high-acuity services and safety-net providers.
- **"Hospitals are just acquiring offices to bill more."**

The 2015 Bipartisan Budget Act (BBA) Prohibition

Congress acted through **Section 603 of the Bipartisan Budget Act of 2015**, which:

- **Prohibits new off-campus HOPDs** (those established after Nov 2, 2015) from being paid under the hospital OPPS.
- Requires that those sites instead be paid under the **Physician Fee Schedule (PFS)** or other applicable system.
- "Grandfathers" existing off-campus HOPDs that were billing under OPPS before that date.