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WHITE PAPER / HEALTHCARE

SITE-NEUTRAL PAYMENTS IN U.S. HEALTHCARE

SITE-NEUTRAL PAYMENTS IN U.S. HEALTHCARE

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Site-neutral payments refer to policies designed to equalize reimbursement rates for healthcare services regardless of the care setting. In other words, the same service would receive the same Medicare reimbursement whether performed in a hospital outpatient department (HOPD), physician's office, or ambulatory surgery center (ASC).

Proponents argue that site-neutral payments eliminate payment discrepancies, lower overall healthcare costs, and create a more efficient healthcare market. Critics, however, contend that site neutrality could financially strain hospitals, reduce care quality, and limit healthcare accessibility in rural areas.

This paper provides a comprehensive analysis of site-neutral payments, examining their history, regulatory landscape, key arguments for and against the policy, and the broader implications for healthcare stakeholders, including patients, providers, and investors.

Cicero does not endorse specific platforms or policies, nor does it take a position on the issues discussed in this white paper. Instead, this article provides an objective analysis of the history, ongoing debates, and potential implications of site-neutral payments for different stakeholders. The intent is to educate and engage readers on this complex policy topic.

1. Reasoning Behind Site-Neutral Payments

Site-neutral payments have been widely debated for five key reasons:

1. The pace of increasing Medicare spending[i]
2. Cost disparities between HOPDs and physician offices or ASCs
3. Vertical integration and consolidation of healthcare providers
4. The need for affordable healthcare for an aging population[ii]
5. Efforts to prioritize and incentivize quality care over procedure volume

1

Increasing Medicare Spending

Medicare spending is growing faster than the U.S. GDP and accounts for an increasing share of national healthcare expenditures. Site-neutral payments aim to curb costs by reducing Medicare reimbursements for higher-cost hospital outpatient settings.

2

Cost Disparity Between HOPDs and Physician Offices / ASCs

A significant cost disparity exists between HOPDs and physician offices/ASCs, despite often providing the same level of care. Common procedures, such as colonoscopies or mammograms, can cost up to 58% more in HOPDs than in ASCs.

3

Vertical Integration and Consolidation of Healthcare Providers

Higher reimbursements for hospital-owned practices create incentives for hospitals to acquire physician groups, increasing consolidation in healthcare. Site-neutral payments reduce this financial incentive, potentially slowing vertical integration.

4

Affordable Healthcare for the Aging Population

The aging U.S. population is expected to drive higher Medicare enrollment in the coming decades. Site-neutral payments aim to reduce out-of-pocket expenses for seniors and ensure more cost-effective care delivery.

5

Need for Quality to be Prioritized Over Volume

Fee-for-service payment models encourage high service volume over care quality, leading to overutilization and increased costs. Site-neutral payments seek to reduce inefficiencies by standardizing reimbursement rates for similar services, regardless of setting.

Figure 1: Reasoning Behind Site-Neutral Payments

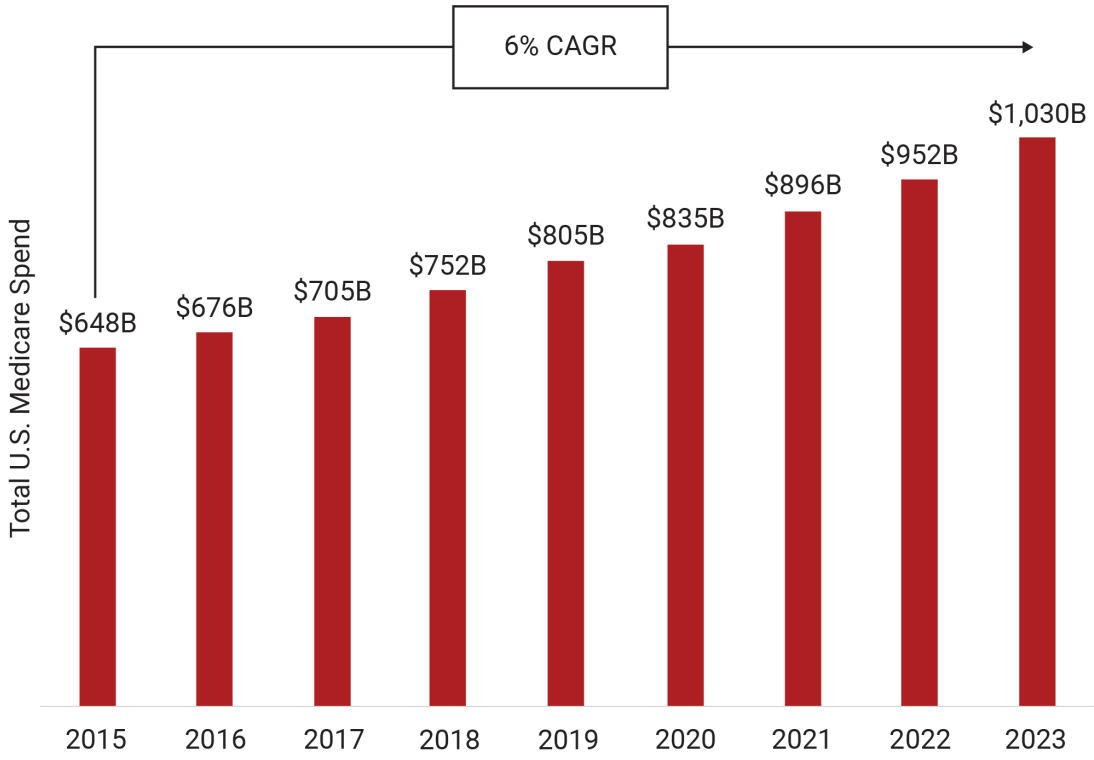

Figure 2: Total U.S. Medicare Spend: 2015 - 2023

2. History of Site-Neutral Payments

Site-neutral payment policies are part of a broader effort over several decades to control healthcare spending. Initial discussions on aligning payment structures and controlling Medicare costs emerged in the early 2000s, leading to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This legislation amended the Social Security Act to establish the Voluntary Prescription Drug Benefit Program, which expanded Medicare coverage for outpatient prescription drugs and enhanced beneficiary options. The Act also facilitated greater integration across Medicare, including private fee-for-service plans, marking a shift toward a more cohesive Medicare approach to pharmaceuticals.[iii]

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 represented another milestone, prioritizing quality of care over volume. By repealing the Sustainable Growth Rate (SGR) formula and introducing the Quality Payment Program (QPP), MACRA created incentives to improve care quality and reduce unnecessary medical services.[iv]

The Bipartisan Budget Act (BBA) of 2015 marked a significant shift in site-neutral payment policies, introducing reforms that standardized Medicare reimbursement rates for new off-campus HOPDs, aligning them with those of freestanding physician offices and ASCs. The BBA provisions applied to off-campus HOPDs that began billing Medicare under the Outpatient Prospective Payment System (OPPS) on or after November 2, 2015, the date of enactment. In contrast, facilities that had already

been operational and billing before this date retained their higher reimbursement status.[v]

Subsequent legislation, including the 21st Century Cures Act of 2016, introduced additional exemptions for certain off-campus HOPDs, such as dedicated emergency departments, affiliated cancer hospitals, and facilities under construction at the time of the BBA's enactment.[vi]

Developments toward site-neutral payments continued with the Centers for Medicare & Medicaid Services' (CMS') 2019 final OPPS ruling. The ruling expanded site-neutral policies by equalizing payments for all clinic visits in off-campus HOPDs and physician offices. The ruling also included all off-campus HOPDs that were exempt under the BBA of 2015. Under current regulations, exempt off-campus HOPDs can still bill under the OPPS for new services, such as those added through the acquisition of additional physician practices.[vii]

Although the American Hospital Association (AHA) appealed the Department of Health and Human Services' (HHS') site-neutral policy, the policy was ultimately upheld when the Supreme Court declined to hear the appeal in June 2021.

In 2022, CMS declared that, starting in 2023, rural sole community hospitals would no longer be subject to site-neutral payment reforms, granting them an exemption from the policy.[ix]

Overall, these developments demonstrated incremental—albeit modest—progress toward site-neutral payments aimed at controlling Medicare costs while maintaining care quality across healthcare settings.

3. Current State of Legislation and Regulation

3.1. Recent Legislative Policies and Proposals

Bipartisan legislators and the CMS have continued to refine site-neutral payment policies through new bills, amendments, and reimbursement policy updates. The 2023 and 2024 policy debates maintained a strong focus on further equalizing payments across different care settings. These efforts generally aimed to standardize payments across all HOPDs and extend site-neutral policies to additional services, ensuring greater payment equity across healthcare settings. None of the following bills, however, passed with the full Congress's support.

The Site-based Invoicing and Transparency Enhancement (SITE) Act, introduced in the Senate in 2023, sought to eliminate the site-neutral exemption for existing HOPDs under the BBA of 2015, ensuring equal payment structures across outpatient and office-based settings. The SITE Act also proposed allocating $100 million in cost savings to address the nursing shortage by funding graduate nursing education programs and training costs. Despite bipartisan support, the SITE Act never got out of committee when introduced in the Senate on June 7, 2023.[xi]

The Health, Education, Labor, and Pension (HELP) Committee approved the Bipartisan Primary Care and Health Workforce Act of 2023, which aimed to prohibit facility fees for certain outpatient and telehealth services while also implementing identifier requirements. The Congressional Budget Office (CBO) projected that this legislation would generate approximately $5 billion in savings.[xii]

The Lower Costs, More Transparency Act sought to apply site-neutral payments to drug administration services and require Medicare provider identification numbers for off-campus outpatient departments, but the Senate blocked its advancement in February 2024.[xiii]

A measure similar to the identifier rule was included in a 2024 year-end health package that ultimately failed in December. The bill's rejection was due to then-President-elect Donald Trump and Elon Musk opposing the government funding proposal for unrelated reasons.[xiv]

The House Education and Workforce Committee advanced the Transparent Telehealth Bills Act of 2024, which sought to eliminate facility fees for telehealth services. While expected to reduce government spending, the bill also extended its provisions to commercial insurance.[xv]

House Budget Committee Chair Jodey Arrington (R-Texas) has also proposed legislation aimed at standardizing reimbursement rates for services commonly and safely performed in off-campus settings, ensuring payment parity regardless of whether they take place in a hospital or another facility. In January, the committee projected that this measure could result in $146 billion in savings.[xvi]

Several additional bills have been introduced to address site-neutral payment policies. The ROCR Value-Based Program Act of 2024 focused on oncology and radiation treatment, aiming to enhance treatment quality, encourage the use of advanced technologies, and reduce price disparities between HOPDs, ASCs, and physician offices.[xvii]

Another bill targeting oncology, the Medicare Patient Access to Cancer Treatment Act, introduced in 2023, sought to establish site-neutral payment models for cancer treatments provided in HOPDs compared to physician offices.[xviii]

Other proposed legislation, such as the Health Care Fairness for All Act and the Prevent Hospital Overbilling of Medicare Act, would eliminate exceptions to off-campus site neutrality and require unique identifiers for facilities seeking exemptions. While none of these bills have passed as of March 2025, discussions around Medicare payment reform and site-neutral payment policies gained momentum throughout 2024.[xix]

To counter the shift toward site-neutral payments, stakeholders such as the AHA have launched significant legal challenges against CMS policies, citing concerns over potential revenue losses—particularly in rural settings[xx] Throughout the years, CMS has continued to revise regulations in response, with ongoing debates on balancing hospital funding, fair payment practices, and incentivizing high-quality care.

3.2. Trump Administration and 119th Congress

In December 2024, House Republicans informally proposed $2.5 trillion in net mandatory spending cuts in exchange for raising the debt limit by $1.5 trillion.[xxi] Given that healthcare constitutes a significant portion of mandatory spending, the Trump Administration and the 119th Congress are targeting healthcare as a key area for cost reductions. More recently, the House's budget blueprint ordered the Energy and Commerce (E&C) Committee to find $880 billion in spending cuts over the next decade, and Medicare and Medicaid account for the lion's share of programs within E&C's jurisdiction.[xxii]

While President Trump has ruled out direct Medicare cuts, site-neutral payment reforms in Medicare have emerged as a leading cost-saving measure, with bipartisan support in Congress.

The CBO recently released a report titled "Options for Reducing the Deficit: 2025 to 2034," outlining

policy measures to reduce federal budget deficits.[xxiii] Among these, site-neutral payment reform was identified as a major cost-saving opportunity. To address site-neutral reform, the CBO presented three options. The first and most drastic policy would pay site-neutral rates for most services to all on- and off-campus HOPDs (saving $157 billion over 10 years). The others would apply site-neutral rates to all off-campus HOPD imaging services (saving $7.6 billion) and drug administration services (saving $5.6 billion).

Congressional Budget Office Report – "Options for Reducing the Deficit: 2025 – 2034"	
Medicare Site-Neutral Payment Reform	**10 Year Savings**
Paying site-neutral rates for most services to all on- and off-campus HOPDs	$157 billion
Applying site-neutral rates to all off-campus HOPD imaging services	$7.6 billion
Applying site-neutral rates to all off-campus HOPD drug administration services	$5.6 billion

Figure 3: CBO Options for Reducing the Deficit: 2025 - 2034

Following the CBO report, the House Ways and Means Committee released a proposal outlining healthcare spending options for 2025–2034. Medicare site-neutrality emerged as the second-largest proposed saving option, projected to generate $146 billion in savings.[xxiv]

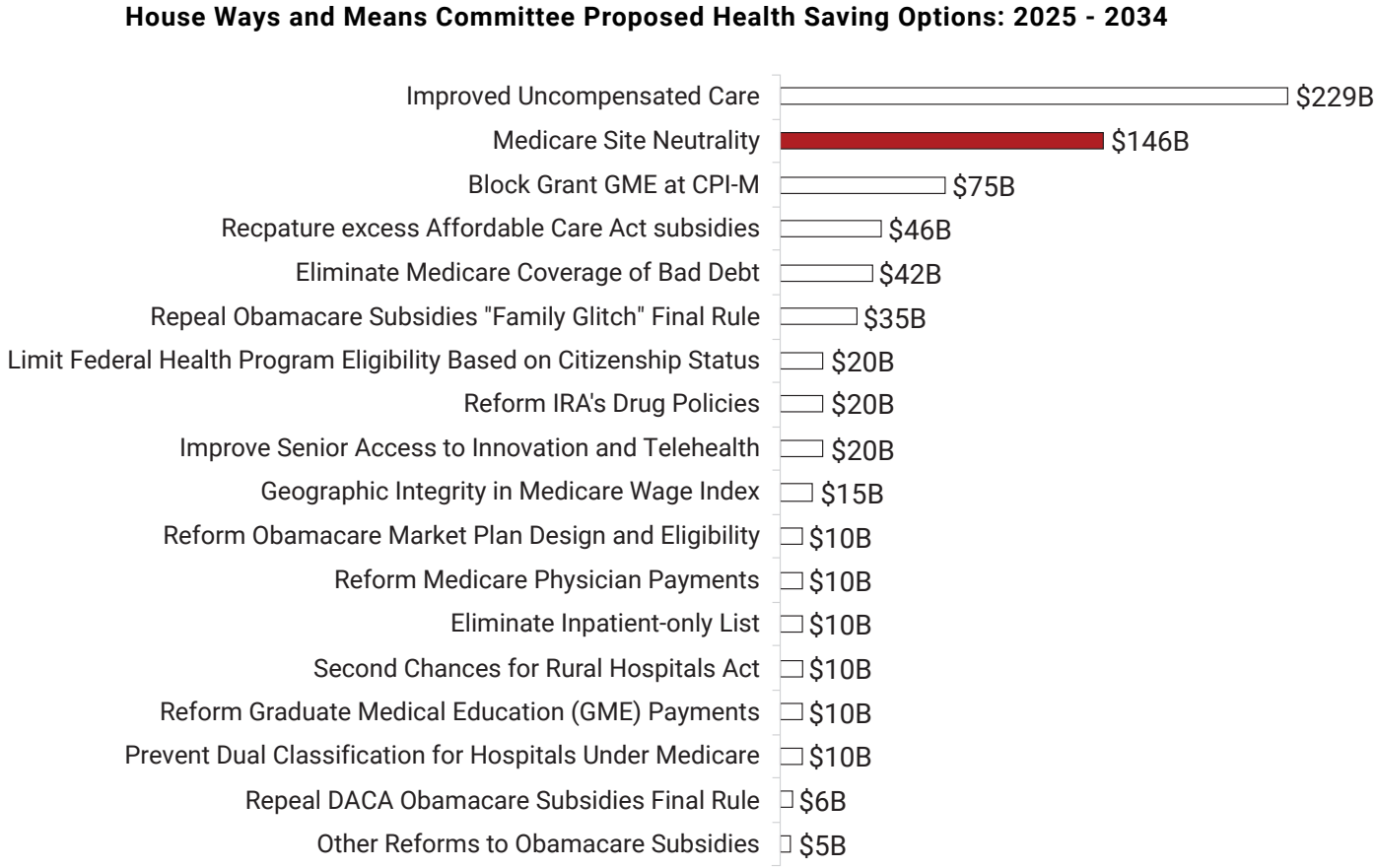

Figure 4: House Proposed Healthcare Saving Options: 2025 - 2034

All this said, site-neutral payments have not received as much attention in 2025.[xxv] But Sen. Bill Cassidy (R-La.) who heads the HELP Committee says site-neutral payments could emerge as a key negotiating item for the tax-extension bill in the coming months.[xxvi]

Overall, these developments reflect a concerted effort to reduce payment disparities across healthcare settings, promoting transparency, cost-effectiveness, and improved patient care. While the legislative landscape continues to move toward site-neutral payments, progress remains challenged by opposing stakeholder interests.

4. Policy Arguments in Favor of Site-Neutral Payments

4.1. Cost Savings

Proponents argue that equalizing payments removes incentives in place that cause unnecessary Medicare spending. By removing incentives for hospitals to charge higher rates simply due to their classification as HOPDs, site-neutral payments may save an estimated $471 billion in taxpayer funds and patients' expenses over 10 years.[xxvii] In addition, CMS estimates that their 2019 ruling on site-neutral payments for clinic visits generated approximately $800 million in savings in 2020,[xxviii] and expanding this initiative across additional services will continue to significantly reduce Medicare spending.

4.2. Increased Competition

Site-neutral payments foster fair competition across different care settings, particularly for ASCs and physician practices, by equalizing reimbursements, leveling the playing field, and providing patients with transparency and options. In a new system that rewards quality and outcome over volume, hospitals and healthcare systems will be encouraged to increase efficiency and drive innovation and improvements in care delivery to stay competitive.[xxix]

4.3. Reduction in Consolidation

By removing several financial incentives for hospitals to acquire physician practices or outpatient centers to capitalize on higher reimbursement rates, site-neutral payments will reduce consolidation in the healthcare industry. Between 2019 and 2022 alone, hospitals acquired nearly 4,800 practices, and 58,000 more physicians became hospital employees.[xxx] Reducing consolidation helps provide more choices for patients and prevents monopolistic behavior in certain markets.

4.4. Equity in Care Access

Equalizing payments ensures that care settings with lower overhead, like freestanding physician offices and ASCs, remain competitive and accessible to patients. This can expand care options, particularly in rural or underserved areas, which are of particular concern.

4.5. Reduction in Overutilization

Shifting towards value-based incentives from fee-for-service models and reducing consolidation will help reduce procedure overutilization and unnecessary care. Decreasing overall procedure utilization has the potential to be yet another lever to decrease healthcare spend.[xxxi]

5. Policy Arguments Against Site-Neutral Payments

5.1. Impact on Hospital Revenue

The proposed (but not passed) SITE Act and PATIENT Act were projected to reduce hospital revenue by $34.3 billion and $4.1 billion, respectively, over 10 years.[xxxii] Opposition from the hospital industry argues that site-neutral payments disproportionately harm hospitals, particularly large teaching hospitals that provide higher acuity care and additional services such as education and research. These hospitals may struggle to maintain operations in a reduced reimbursement rate environment.

5.2. Quality of Care Concerns

Hospitals argue that they provide enhanced care quality through specialized equipment and staffing, which justifies higher reimbursement rates. Site-neutral critics argue that the policy may lead to cost-cutting measures that could negatively impact care quality, particularly in specialized hospital settings.

Additionally, hospitals claim that site-neutral policies may reduce unique benefits associated with HOPDs, such as 24/7 emergency standby capacity and specialized capabilities in psychiatric, burn, and neonatal services.[xxxiii]

5.3. Rising Operating Costs for Hospitals

Inflation and rising labor costs have significantly impacted hospitals, particularly between 2021 and 2023.[xxxiv] In 2022, based on data from more than 5,600 hospitals, the average hospital operating margin was -13.5%.[xxxv] The AHA's 2023 report further stated that Medicare outpatient margins were even lower, averaging -17.5% in 2021.[xxxvi] While hospital operating margins have generally improved post-pandemic, nearly 50% of rural hospitals are still operating at a loss.[xxxvii]

5.4. Financial Pressures on Safety-Net Hospitals

Safety-net hospitals, which serve a large proportion of low-income and Medicaid patients, could face significant revenue losses due to site-neutral payments. These hospitals often rely on higher outpatient reimbursement rates to subsidize uncompensated care, and site-neutral policies may exacerbate their financial strain.

Since safety-net hospitals already operate on lower-than-average margins, further revenue reductions could jeopardize their ability to remain operational, potentially limiting access to care for uninsured patients, Medicaid beneficiaries, and other vulnerable groups.

5.5. Potential Reductions in Access to Complex Care

Hospitals argue that reducing reimbursements through site-neutral payments may limit their ability to offer complex, high-cost services, such as advanced diagnostics and specialized treatments that are not typically available in outpatient centers or physician offices.

According to the AHA, site-neutral payment policies could lead to longer hospital wait times and reduced access to care for many patients. As noted above, the impact may be even greater in rural or underserved communities, where alternative care settings are limited or unavailable.

5.6. Financially Struggling Physician Offices

Hospitals have pushed back against claims that vertical integration harms independent physician practices, arguing that many physician offices are already financially struggling.

Physician offices are heavily impacted by regulatory changes and unexpected events (e.g., COVID-19). During the pandemic, an estimated 8% (or 16,000) of physician offices closed for financial reasons.[xxxix]

Rising regulatory pressures, reporting requirements, and declining physician reimbursement rates continue to challenge the financial stability of independent practices. In some cases, hospital acquisition may provide greater economic security for these physician groups.

6. Implications of Site-Neutral Payments

6.1. Hospitals

Hospitals are expected to face significant revenue reductions primarily due to lower Medicare reimbursement rates, potentially leading to service cutbacks, particularly in outpatient departments. These reductions may also impact hospital care quality and limit access to care in underserved areas.

Rural hospitals and those serving large indigent patient populations—such as safety-net hospitals—may experience disproportionate financial strain under site-neutral payment policies, as they tend to serve higher numbers of uninsured and Medicaid patients.

6.2. Physician Practices and ASCs

Physician practices and ASCs may benefit from site-neutral payment policies, as these reforms help reduce payment disparities between HOPDs and independent providers.

By leveling the playing field, site-neutral payments could increase patient demand for ASCs and physician offices due to lower out-of-pocket costs and more competitive pricing. Additionally, payers are likely to direct patients toward cost-effective and accessible settings, potentially boosting patient volume for these providers.

6.3. Patients

For Medicare beneficiaries, site-neutral payments may lower out-of-pocket costs for outpatient services as Medicare reimbursement rates decline for HOPDs.

For non-Medicare beneficiaries, site-neutral payments may also help lower insurance premiums as insurers pass cost savings onto consumers. However, patients could face challenges accessing care if hospitals reduce service lines or close outpatient centers due to revenue losses. Cutbacks and cost-saving measures may also affect outpatient care quality.

6.4. Medicare

Medicare is expected to achieve cost savings through reduced reimbursements, which could help extend the solvency of the Medicare Trust Fund. Policy reforms align with broader value-based care initiatives, aimed at enhancing efficiency and reducing costs.

Reducing Medicare spending and extending solvency can improve CMS's ability to serve an aging U.S. population, with projections indicating that Medicare-eligible beneficiaries will increase from 63 million in 2020 to over 93 million by 2060.[XI]

New bills and policies surrounding site-neutral payments are also expected to pave the way for expanding covered procedures and services over time.

6.5. Private Equity Firms

Private equity firms play a significant role in the healthcare industry through ownership stakes in physician offices, ASCs, urgent care clinics, and hospitals. Site-neutral payments may affect a provider asset's investment attractiveness, exit opportunities, and valuations.

Site-neutral payments reduce incentives for hospital-led vertical integration and consolidation, but they may also make hospitals less attractive and physician groups and ASCs more attractive for private equity investors. The impact on investment funds will depend on market dynamics, cost structures, and reliance on facility-based reimbursements. The effects will also vary based on the type of practice and the services offered.

Even where site-neutral payments do not directly impact practices offering complex medical services, it remains important to monitor regulatory developments and technological advancements that could enable more procedures to be performed in lower-cost settings.

7. Conclusion

Site-neutral payments represent a major shift in healthcare reimbursement, designed to control costs while ensuring fair competition across care settings. While these policies offer potential benefits—including cost savings, equity, and increased competition—they also present challenges, particularly for hospitals and specialized care providers.

As Congress and CMS continue evaluating site-neutral policies, healthcare providers, payers, and policymakers must collaborate to ensure cost savings do not come at the expense of care quality and access.

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