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IN FOCUS

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Medicare's Site-Neutral Payment Policy

Overview

By law, the Centers for Medicare & Medicaid Services (CMS) determines Medicare program Parts A and B payments to providers and suppliers for services furnished to covered beneficiaries through multiple payment systems. Some Medicare payment systems pay for services furnished at particular sites of service (e.g., a physician's office, an acute care hospital inpatient setting, a hospital outpatient department, or skilled nursing facility), while other payment systems apply to certain services independent of location, such as clinical laboratory or durable medical equipment services.

Each payment system uses a separate methodology specified in statute to determine the value and payment rate for covered services. Discrepancies can exist for similar types of care furnished to a beneficiary across the payment systems—for example, whether a patient is treated in a physician's office and paid under the physician fee schedule (PFS), in a hospital outpatient department (HOPD) and paid under the outpatient prospective payment system (OPPS), or in an ambulatory surgery center (ASC) and paid under the ASC payment system.

Medicare's site-neutral payment policy sets payments for certain services to be equivalent independent of the location where a beneficiary receives the service. The policy is intended to eliminate the differences and any corresponding incentives that might lower the quality of patient care or lead to inefficiencies in the Medicare program. This In Focus summarizes the background and rationale behind the site-neutral payment policy, the statutory basis for and implementation of the policy, legal challenges to the policy, and considerations for Congress.

Background and Rationale

Medicare payments for similar services are typically higher under the OPPS than the PFS, as the additional overhead costs associated with being part of the hospital or health system are included in the calculation under the OPPS but not in the PFS. The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise Congress on issues affecting the Medicare program, cites this payment differential as one incentive contributing to vertical integration and industry consolidation, as independent physician practices have been acquired by hospitals, health systems, and corporate entities (such as private equity firms) who then receive higher Medicare payments under the OPPS. The Government Accountability Office (GAO) found that "at least 47% of physicians were consolidated with hospital systems in 2024—up from less than 30% in 2012," and that industry consolidation was associated with higher health care prices. Because Medicare beneficiary coinsurance is generally 20% for Part B services, higher Medicare payments under the OPPS rather than the PFS for similar or identical services require greater out-of-pocket obligations for the beneficiaries receiving the care. Higher OPPS payments also place more pressure on the Supplementary Medical Insurance (SMI) Trust Fund, which draws on general revenues to fund ~75% of Part B expenditures.

MedPAC recommended in 2012 that payments for certain evaluation and management (E&M) services be aligned whether delivered in physicians' offices or hospital outpatient departments. MedPAC subsequently expanded its recommendations in 2015 to include payments in post-acute settings for care furnished in inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). Policymakers continue to evaluate whether services are sufficiently comparable for site-neutral payment. Patients treated in one setting (a hospital outpatient department) may differ from those treated in a seemingly comparable one (physician offices), in terms of severity, clinical complexity, comorbidities, and need for ancillary services. Similar concerns would apply to additional settings under consideration, including IRFs and SNFs.

Statutory Authority

Medicare OPPS payments are governed by an intricate set of requirements under Social Security Act (SSA) Section 1833(t). In addition to specifying various statutory formulas for setting payment rates, Section 1833(t)(2)(F) authorizes CMS to "develop a method for controlling unnecessary increases in the volume of covered [outpatient] services." The Bipartisan Budget Act of 2015 (P.L. 114-74, BBA 2015) Section 603 added subparagraph (21) to SSA Section 1833(t) to generally exclude items and services furnished by off-campus outpatient departments from payment by OPPS. Such services provided on or after January 1, 2017, were to be paid under "the applicable payment system" (subsequently determined by CMS rule to be the PFS; see below) rather than the OPPS.

BBA 2015 Section 603 also included a "grandfather" exception for HOPDs billing for Medicare services prior to November 2, 2015. The 21st Century Cures Act (P.L. 114-255) expanded the exceptions to allow certain additional off-campus HOPDs to receive higher OPPS payments, including HOPDs under construction but not yet billing by November 2, 2015, and rural sole community hospitals.

CMS Rules and Implementation

In implementing BBA Section 603, CMS stated its belief that Congress intended the provision "to eliminate the Medicare payment incentive for hospitals to purchase physician offices, convert them to off-campus [provider-

based departments], and bill under the OPPS for services furnished there." The CY2017 OPPS and ASC Final Rule established the PFS as the applicable Part B payment system "for the majority of the nonexcepted items and services furnished by nonexcepted off-campus [HOPDs]."

Invoking its authority under Section 1833(t)(2)(F), CMS later issued the CY2019 OPPS and ASC Final Rule, which further extended the site-neutral payment policy by applying it to clinic visits, the most billed service at hospital outpatient departments, when the service is delivered at an "excepted" off-campus HOPD. CMS asserted that "to the extent that similar services are safely provided in more than one setting, it is not prudent for the OPPS to pay more for such services because that leads to an unnecessary increase in the number of those services provided in the OPPS setting." The policy was phased in over two years; OPPS payments were reduced to 70% in CY2019 and 40% in CY2020. OPPS payments for these services were set to be the same as under the PFS in subsequent years.

The CY2026 OPPS and ASC Final Rule extended the site-neutral payment policy to drug administration services under Part B (physician-administered drugs such as those used in chemotherapy, immunotherapy, and related injections) across off-campus HOPDs and ASCs. Beginning January 1, 2026, the OPPS and ASC payment for these services are the same as the payment under the PFS.

Not all attempts to broaden the site-neutral payment policy have advanced. To extend the policy beyond the overlap between care furnished and paid under the PFS and the OPPS, MedPAC's April 2024 meeting considered options to lower payments for certain inpatient rehabilitation facility (IRF) services to similar care furnished in skilled nursing facilities (SNFs). MedPAC's analyses, included in the June 2024 report, concluded that patient populations and clinical conditions in IRFs and SNFs were not sufficiently comparable to support a broader site-neutral policy for those services.

CMS has expressed its intent to expand the site-neutral payment policy to other services and solicited input on services to be considered, as noted in the CY2026 OPPS and ASC Final Rule.

Legal Challenges

Critics of the site-neutral payment policy assert that the lower payments tied to the PFS would be insufficient to cover costs (e.g., overhead) that are higher in HOPDs. The impact on rural hospitals, many of which are under financial stress, has increased concern about access in already medically underserved areas.

The American Hospital Association (AHA) and other plaintiffs filed suit to challenge the 2019 OPPS final rule. They argued that the rule's extension of the site-neutral payment policy—which reduced the payment rate for the clinic visit service for all off-campus HOPDs and not just non-excepted HOPDs—exceeded CMS's authority under Section 1833(t)(2)(F) to "develop a method for controlling unnecessary increases" in outpatient department services volume and was contrary to BBA 2015 Section 603. In *AHA v. Azar*, the U.S. Court of Appeals for the D.C. Circuit (D.C. Circuit) applied *Chevron* deference—a doctrine that required courts to defer to reasonable agency interpretations of ambiguous statutes those agencies administer—and upheld the 2019 rule. The court concluded that "the OPPS statute does not unambiguously foreclose [CMS's] adoption of a service-specific, non-budget-neutral rate cut as a 'method for controlling unnecessary increases in' volume," and "[n]othing in the text of section 603 indicates that preexisting off-campus PBDs are forever exempt from adjustments to their reimbursement."

Since the D.C. Circuit's decision in *AHA*, the Supreme Court overruled *Chevron* deference in *Loper Bright Enterprises v. Raimondo*. At the same time, the Court stated that the decision "do[es] not call into question prior cases that relied on the *Chevron* framework."

The CY2026 OPPS and ASC Final Rule's expansion of the site-neutral payment policy to drug administration services has drawn public statements of concern from hospital stakeholders. As of date of publication, however, no suits have been filed to challenge the rule.

Considerations for Congress

Congressional interest in Medicare's site-neutral payment policy includes budgetary and health care quality concerns.

A December 2024 CBO analysis estimated that expanding site-neutral payment rates across three alternatives could save more than $170 billion over the 10-year window from 2025 to 2034. Most of the savings would result from the application of "full site-neutral rates for most service to all HOPDs (on-campus and off-campus" ($156.9 billion), with additional savings from applying site-neutral rates for drug administration services ($5.6 billion) and imaging services ($7.6 billion) to all off-campus HOPDs. Further, any reductions in OPPS payments would similarly lower beneficiary coinsurance obligations.

Considerations for Congress as CMS explores potential expansions to the policy include the following:

- Questions remain regarding when services, patient populations, and clinical conditions are sufficiently comparable across care settings to justify equivalent payment rates.
- New legal challenges may limit the expansion of site-neutral payments to other Medicare payment systems, patients, and clinical conditions.
- Hospital groups continue to oppose expansion of the site-neutral payment policy amid concerns about patient access to care and the potential impact of financial stresses on a health care workforce facing recruitment, pipeline (supply), and burnout issues.

Through ongoing legislative oversight, Congress may monitor the impact of site-neutral payments on the federal budget, Medicare providers, suppliers, and beneficiaries.

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