Site-Neutral Payment for Ambulatory Care: A Medicare Policy Framework

SEPTEMBER 2025

JOHNS HOPKINS UNIVERSITY | Center for Health Systems and Policy Modeling

JOHNS HOPKINS UNIVERSITY | Center for Health Systems and Policy Modeling

TABLE OF CONTENTS

LIST OF FIGURES 1

INTRODUCTION: What is Site-Neutral Payment? 2

SECTION 1: Traditional Medicare's Payment Systems for Ambulatory Care 3

SECTION 2: Site-Neutral Policy Framework 7

SECTION 3: Site-Neutral Payment Policy Spending Impacts, 2024 12

CONCLUSION: Implementing Site-Neutral Policy 14

CONTACT INFORMATION 15

FUNDING ACKNOWLEDGEMENT 15

REFERENCES 16

Cover image: iStock

Credits: iStock

LIST OF FIGURES

Figure 1. How Medicare pays for ambulatory care: Office vs. HOPD

Figure 2. Payments for services paid under PFS reflect three cost components

Figure 3. Payment for large joint injection without ultrasound guidance, 2024: Office vs. HOPD

Figure 4. Key milestones in Medicare's limited site-neutral payment policy for ambulatory care

Figure 5. Site-neutral policy framework

Figure 6. Key site-neutral policy design questions and examples

Figure 7. CMS's determination of site-neutral payment rates

Figure 8. OPPS, applicable PFS, and 40 percent relativity adjuster rates for select services, CY 2024

Figure 9. Compare policies using the site-neutral framework

Figure 10. Spending on select HOPD services under two site-neutral payment scenarios, 2024

Figure 11. Medicare spending on select HOPD services under two site-neutral payment scenarios by hospital type, 2024

Figure 12. Medicare spending on select HOPD services under two site-neutral payment scenarios by patient type, 2024

INTRODUCTION: What is Site-Neutral Payment?

When payments for health care services are site-neutral, payment is based on the service provided, regardless of the setting. In contrast, with narrow exceptions, Traditional Medicare's payment systems for ambulatory care are site-specific, meaning that payment is based on the location where the service is delivered. Medicare's site-specific payments for ambulatory care result in higher costs to the Medicare program and beneficiaries for services provided in hospital outpatient departments (HOPDs) when they could be provided safely in a physician's office or other setting for less. Higher payments in HOPDs have also contributed to hospital acquisition of physician practices,[1, 2, 3] and an increase in the share of ambulatory services provided in HOPDs.

Researchers and policymakers have released numerous site-neutral policy options that would align payments across settings, with the goal of reducing program and beneficiary costs and reducing incentives for further integration of hospitals and providers. Savings estimates for these policies have varied and are a function of differences in key design features.[4] This chartbook provides background to understand site-neutral payment for ambulatory care, a policy framework for site-neutral payment policy that arrays key design features, and analysis of estimated payments and savings under different site-neutral payment scenarios for select services. As site-neutral policy continues to develop, this framework offers a way to understand and compare site-neutral policies and develop policies to achieve their intended outcomes.

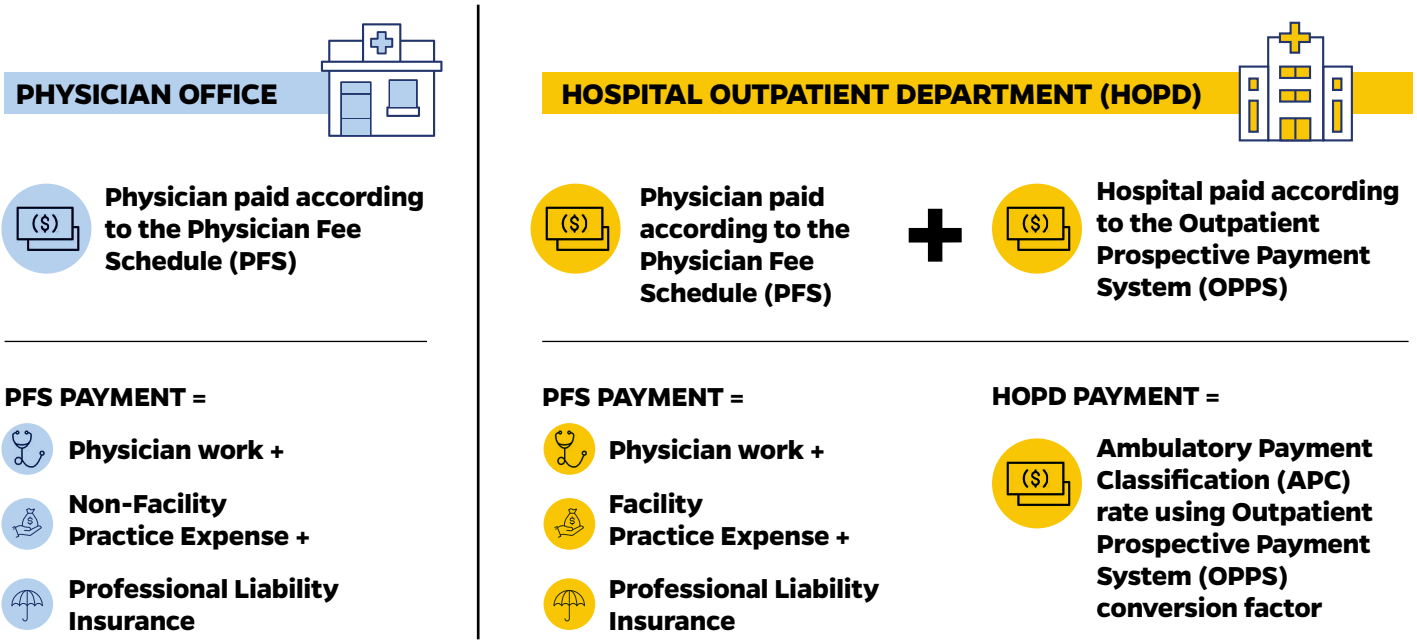
Credit: iStock

SECTION 1: Traditional Medicare's Payment Systems for Ambulatory Care

In Traditional Medicare's site-specific payment systems, the type of provider rendering a service and the location of that service determine which of Medicare's prospective payment systems apply and how much traditional Medicare and beneficiaries pay.

Physicians' services paid under the physician fee schedule (PFS) are furnished in a variety of settings, including physician offices, hospitals, and ambulatory surgery centers (ASCs). Medicare pays a single rate for most physicians' services provided in the office. When a service is provided in a facility, such as an HOPD, Medicare pays the physician under the PFS and makes a separate payment (sometimes called the "facility fee") to the HOPD for its costs such as nursing, supplies and equipment, and rooms, using the outpatient prospective payment system (OPPS).* Under the OPPS, Medicare pays hospitals a fixed rate for services grouped into Ambulatory Payment Classifications (APCs). Each APC includes services, identified by Health Care Common Procedure Coding System (HCPCS) codes, which are similar clinically and in cost to the facility. Payments for items and services that are essential to a procedure or service are bundled, or "packaged," with the primary service for purposes of payment.

Figure 1. How Medicare pays for ambulatory care: Office vs. HOPD



Notes: PFS = Physician Fee Schedule; APC = Ambulatory payment classification; HOPD = Hospital outpatient department; OPPS = outpatient prospective payment system. OPPS payment to HOPDs is sometimes called the "facility fee.

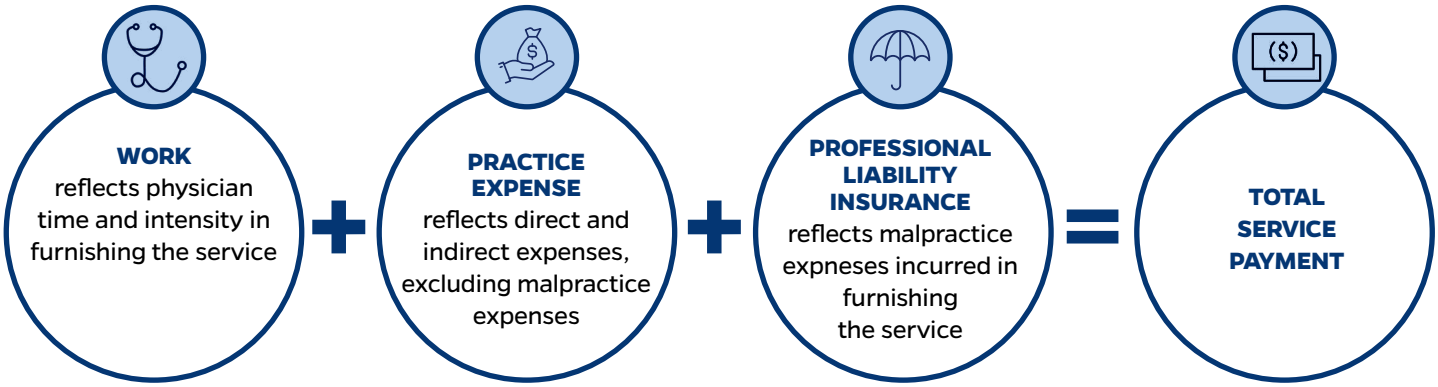
*Outpatient department services can be provided at critical access hospitals and rural emergency hospitals, but these services are not paid under Medicare's OPPS.

Medicare payment systems: Physician fee schedule

Medicare pays for services provided by physicians and other health professionals using the Medicare PFS. The PFS assigns rates to each service provided, identified by HCPCS codes. PFS rates compensate physicians and other health professionals for three components of the cost of providing the service—physician work, practice expense, and professional liability insurance (**Figure 2**).

For some services paid under the PFS, such as diagnostic tests and radiology services, the PFS sets separate rates for the technical and professional components when different providers deliver them. Facilities like diagnostic testing or imaging centers may bill for the technical component when they provide the equipment, facilities, and staff to deliver a service. A physician or other eligible practitioner may bill for the professional component when they supply only the work and expertise required to deliver a service. When billed separately under the PFS, the two components together equal the full PFS rate for the service.

Figure 2. Payments for services paid under PFS reflect three cost components



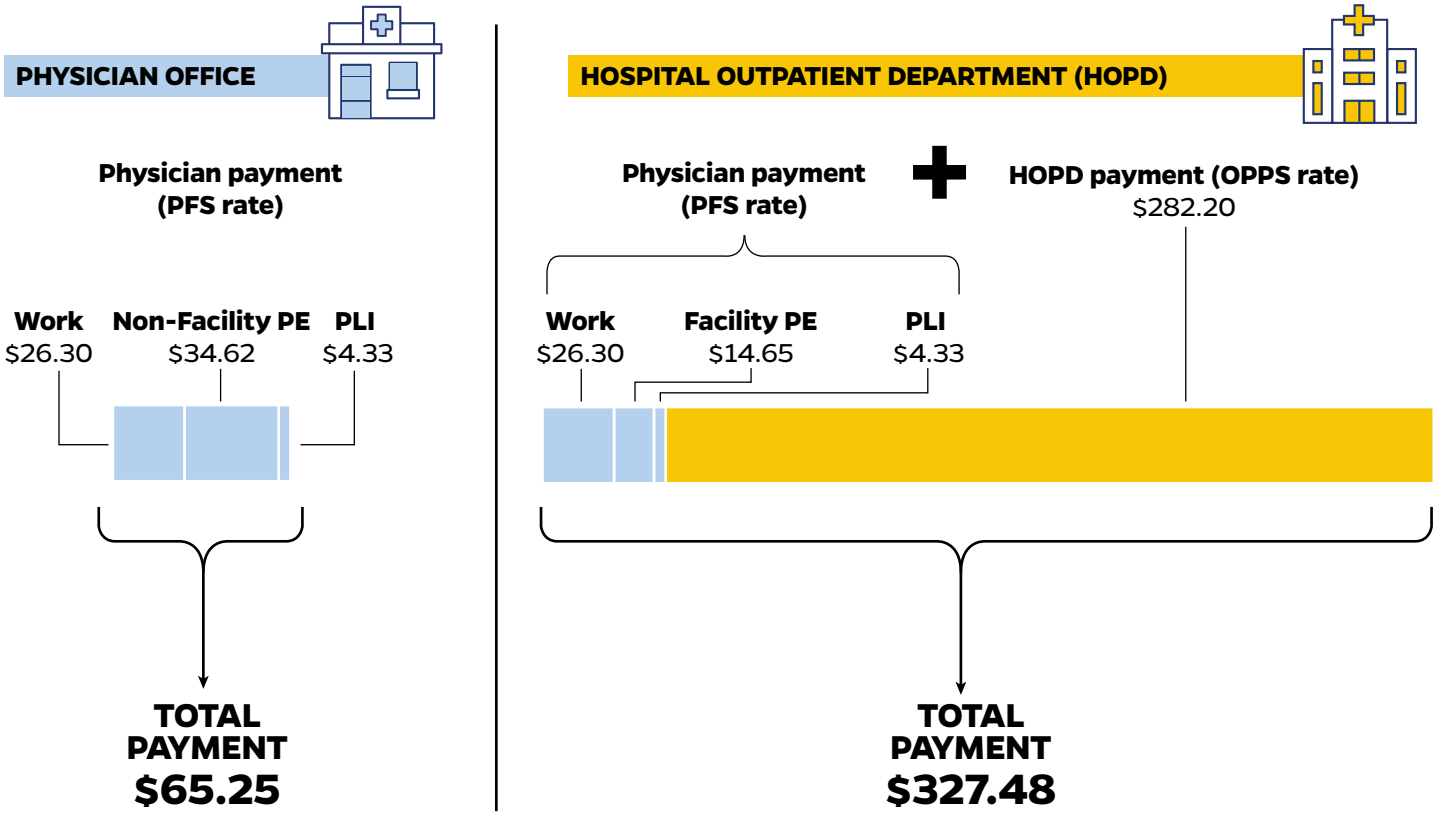
Notes: PFS = Physician Fee Schedule. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses.

Credit: iStock

Medicare program payments for the same service may vary based on the setting

For many services furnished in an HOPD, the payment to the physician is lower than it is when the service is provided in an office because the office-based physician payment includes the higher non-facility practice expense, while the HOPD physician payment reflects the typically lower facility practice expense. However, when adding in the facility fee, Medicare's total payment (physician + facility) is typically higher in the HOPD setting. For example, **Figure 3** shows Medicare's payment rates for a large joint injection without ultrasound guidance provided in an office and in an HOPD. Medicare paid 5 times more for this service in the HOPD than in a physician office in 2024. That year, 89 percent of these procedures were provided in a physician office.

Figure 3. Payment for large joint injection without ultrasound guidance, 2024: Office vs. HOPD

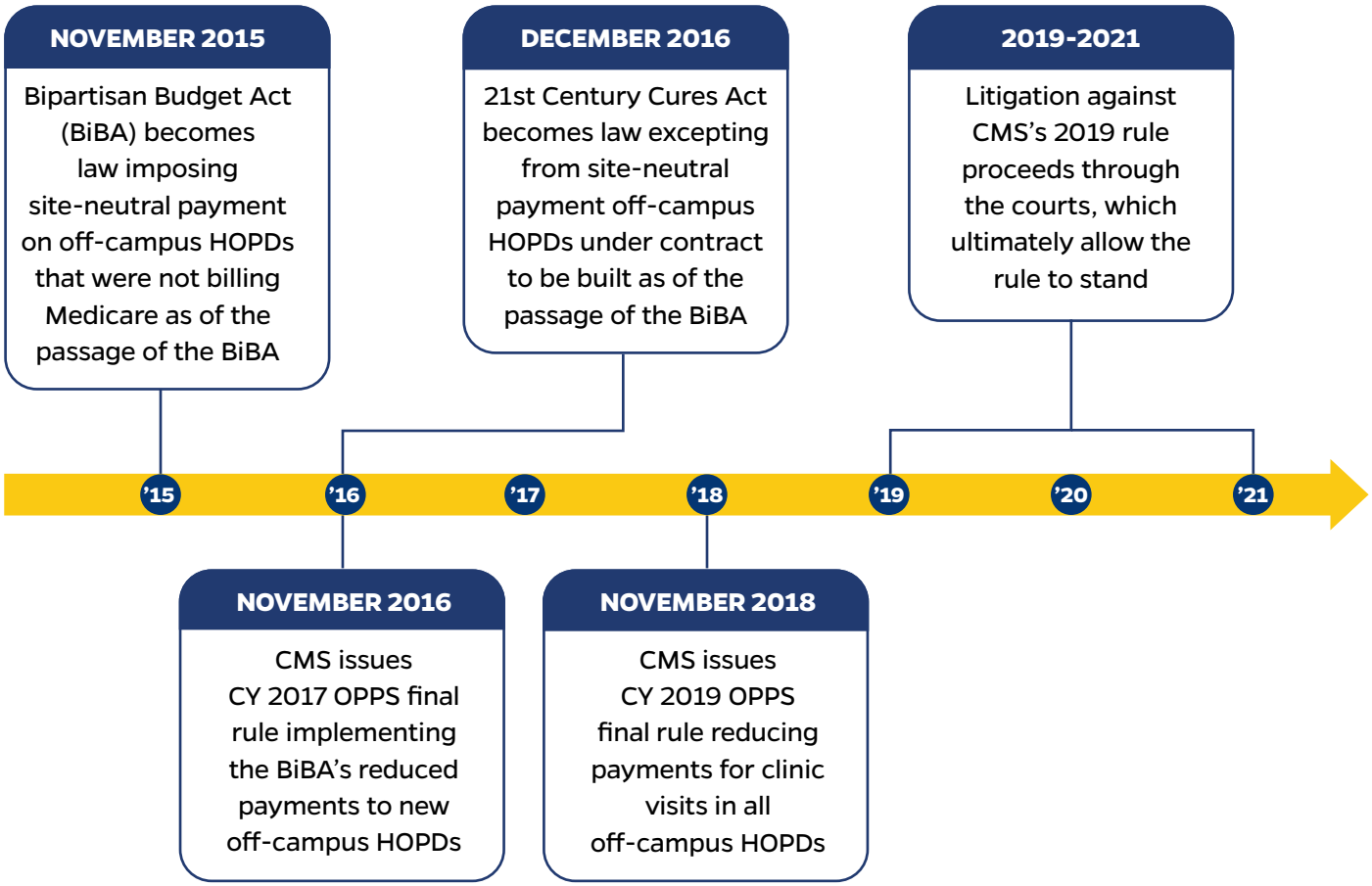


Notes: OPPS = outpatient prospective payment system; PE = Practice expense; PFS = Physician Fee Schedule; PLI = Professional liability insurance. Payments are from the October 2024 release for HCPCS code 20610/APC 5441.

Medicare's current site-neutral policy is narrow and has many exceptions

Medicare has a narrowly applicable site-neutral policy that applies only to non-exempt services at off-campus HOPDs that began construction after November 2, 2015, pursuant to the Bipartisan Budget Act of 2015 (BiBA), as amended by the 21st Century Cures Act.* These are referred to as non-excepted off-campus HOPDs. Because most HOPDs are exempt, just 1.5 percent of all OPPS services were subject to the amended BiBA's site-neutral provisions.[5] Research found that the BiBA site neutral policy has "done little to reduce Medicare spending or hospital-physician integration, suggesting that site-neutral legislation could be strengthened by reducing exceptions."[6] In the final OPPS rule for 2019, CMS also extended site-neutral policy to all clinic visit services at all off-campus HOPDs 9also called "provider-based departments").[7] After litigation against the rule worked its way through the appeals process, CMS's rule to pay a site-neutral rate for clinic visits was permitted to stand.[8] Key milestones in the establishment of Medicare's limited site neutral policy are shown in **Figure 4**. In July 2025, CMS proposed to apply site-neutral payment rates to drug administration APCs in excepted off-campus HODPs in 2026, but at the time of this writing that proposal had not yet been finalized.[9]

Figure 4. Key milestones in Medicare's limited site-neutral payment policy for ambulatory care

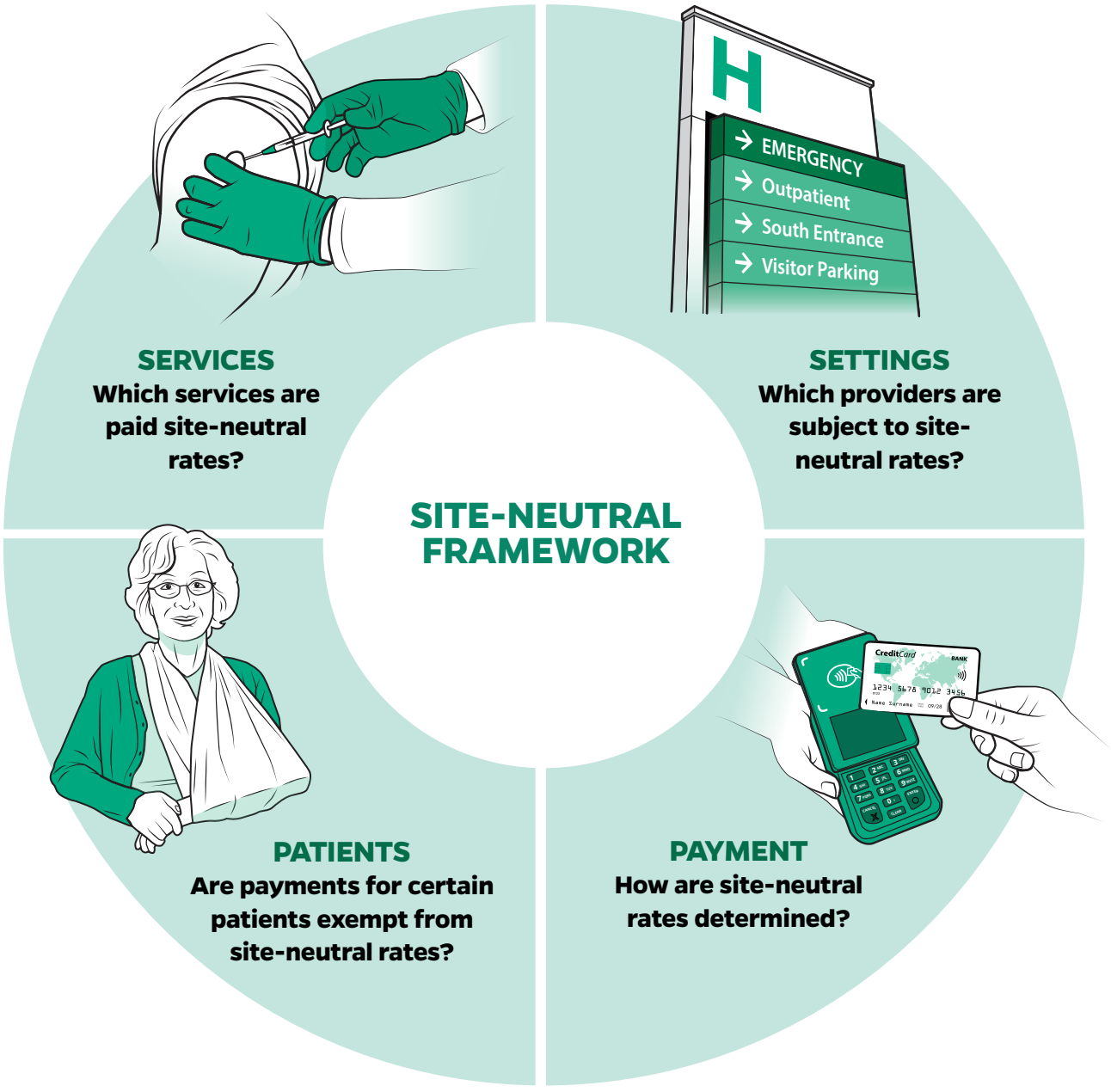


* Off-campus HOPDs (also called "provider-based departments") are located more than 250 yards from the hospital's main campus buildings.

SECTION 2: Site-Neutral Policy Framework

Four key elements are part of all site-neutral policies: (1) the **services** that are paid site-neutral rates, (2) the **settings**, or subgroups of settings, to which those rates apply, (3) the **patients** that are or are not exempt, and (4) the **payment** rates. (See **Figure 5**.)

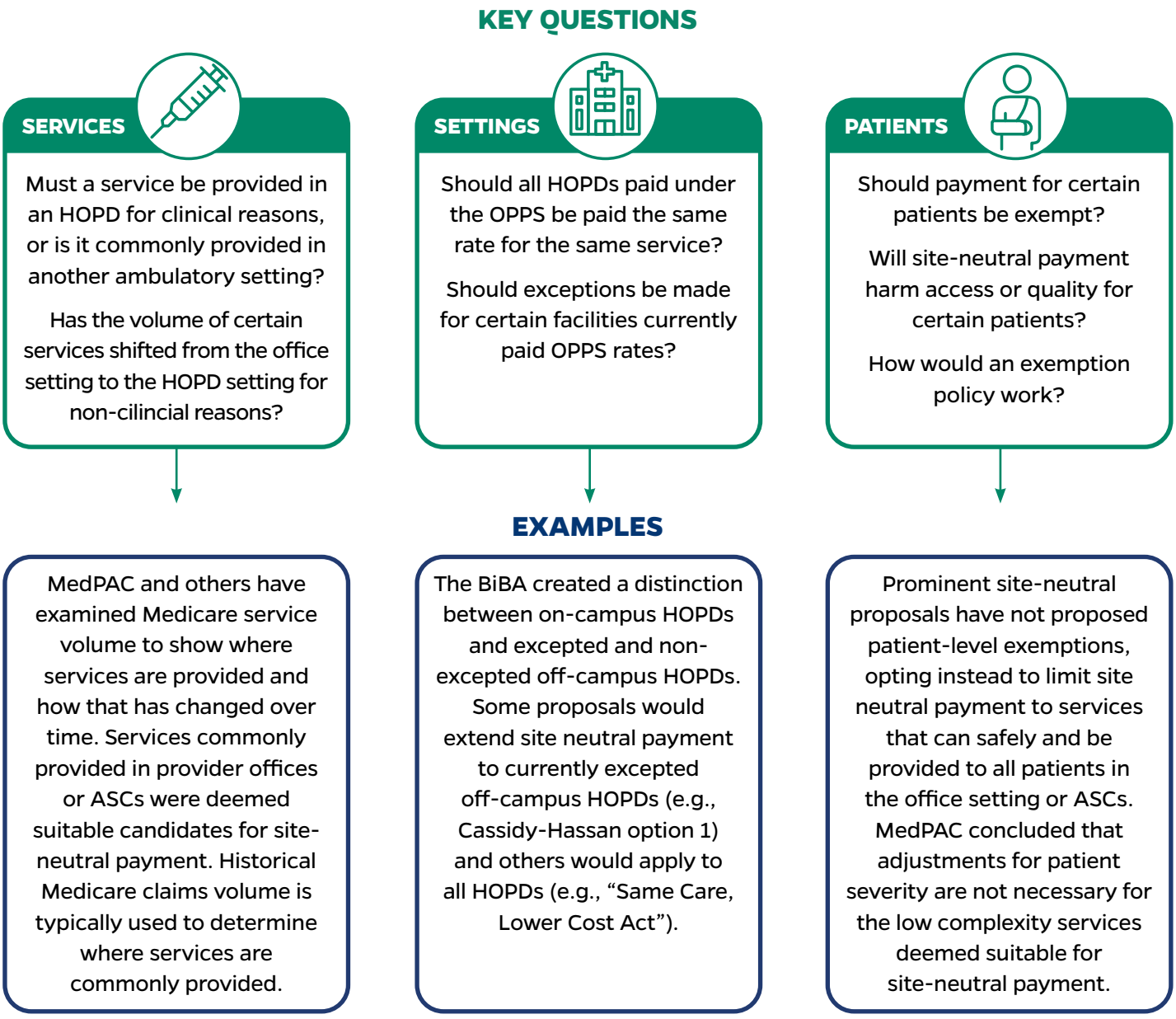
Figure 5. Site-neutral policy framework



Designing site-neutral policy: Options and considerations

Policymakers face key decisions when designing site-neutral policy and their goals can guide these decisions. Generally, site neutral policy proposals have sought to balance achieving program savings, paying providers for the efficient provision of care, and maintaining access, quality, safety, and affordability for beneficiaries. Key site-neutral policy design questions about services, settings, and patients and examples are shown in **Figure 6**. Options and considerations for payments are discussed on page 12.

Figure 6. Key site-neutral policy design questions and examples



Notes: ASC = Ambulatory Surgery Center; BiBA = Bipartisan Budget Act of 2015; HOPD = Hospital Outpatient Department; MedPAC = Medicare Payment Advisory Commission.

Options and considerations for setting payment rates: current policy case study

In setting site-neutral payment rates, policymakers must determine Medicare payments for equivalent services provided in different settings. In practice, determining the site neutral payment amount and paying for HOPD services under another Medicare payment system is not straightforward. When implementing the BiBA's site-neutral policy, CMS was charged with determining payments for services furnished by non-excepted off-campus HOPDs.[10]

Depending on the service, CMS established the applicable payment rate as: (1) the difference between the PFS nonfacility rate and the PFS facility rate, (2) the technical component of the payment for the service from the PFS, or (3) the full non-facility PFS rate as shown in **Figure 7**.[11]

However, Medicare does not pay for services subject to site-neutral rates using the PFS due to claims processing system limitations and concerns about the costs of packaged items and services provided by HOPDs. Instead, for CY 2017, CMS established site-neutral rates by applying a 50 percent "relativity adjuster" to the OPPS rate.[12] CMS reduced the adjustment to 40 percent in CY 2018 and subsequent years.[13] In essence, the OPPS rate is "discounted" by 60 percent to roughly reflect the average PFS rate for a select group of services. Under this administratively simpler approach, the site-neutral rate as a share of the OPPS rate does not vary by service, but the relativity adjuster rate varies as a share of the applicable PFS rate, as shown in **Figure 8**.

Figure 7. CMS's determination of site-neutral payment rates

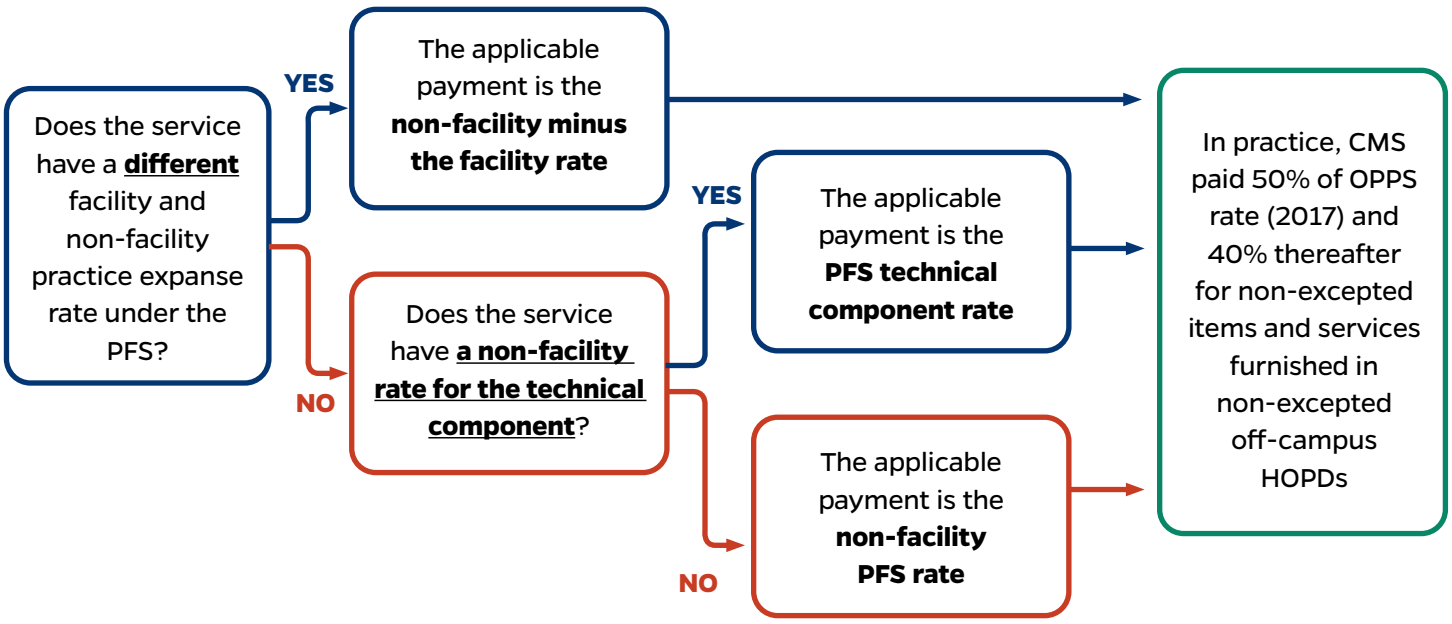
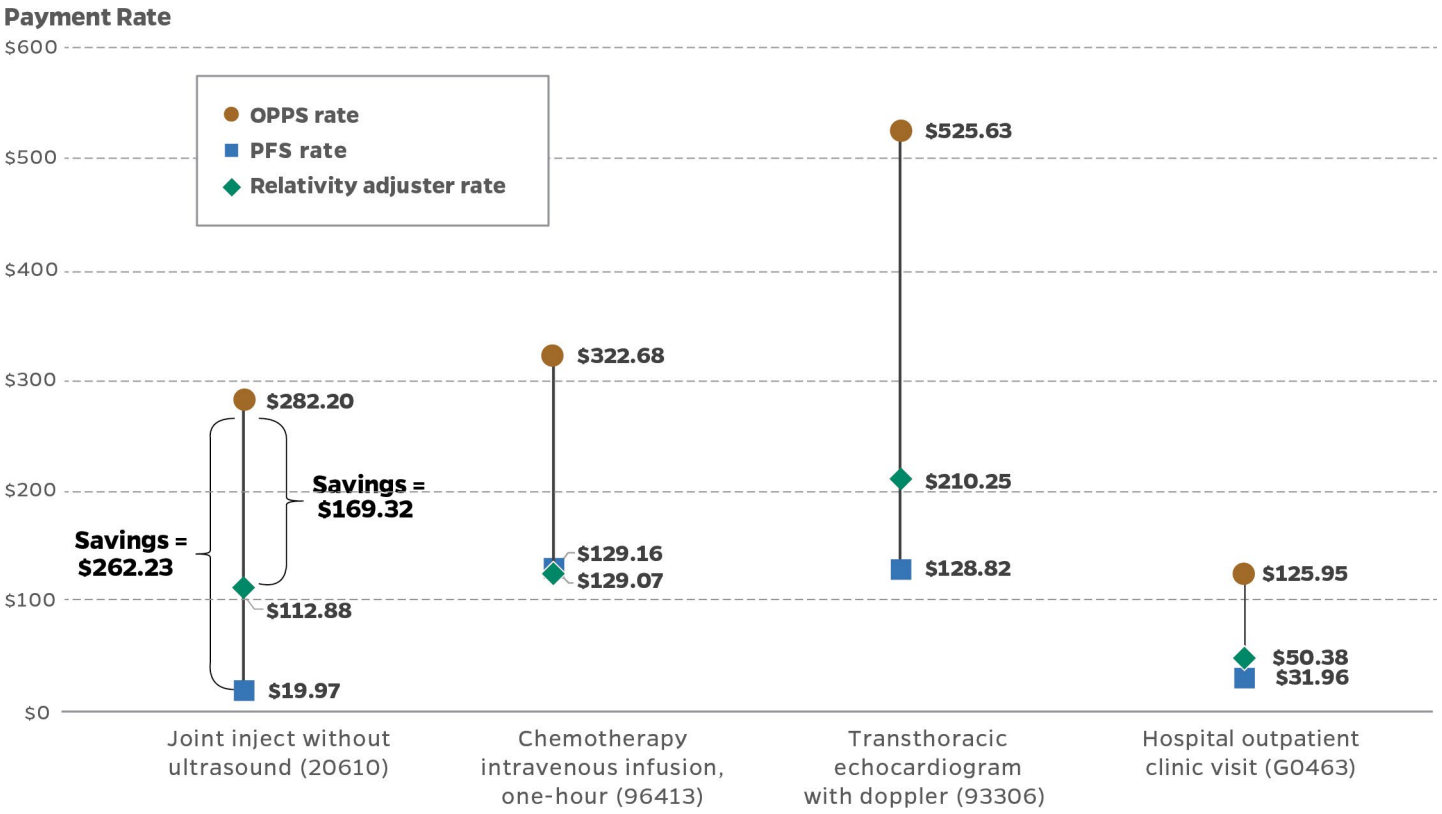


Figure 8. OPPS, applicable PFS, and 40 percent relativity adjuster rates for select services, CY 2024



Notes: HCPCS codes shown in parentheses. Code G0463 is billed only by HOPDs and does not have a direct analog in the PFS. PFS rates used here for G0463 are for evaluation and management code 99214.

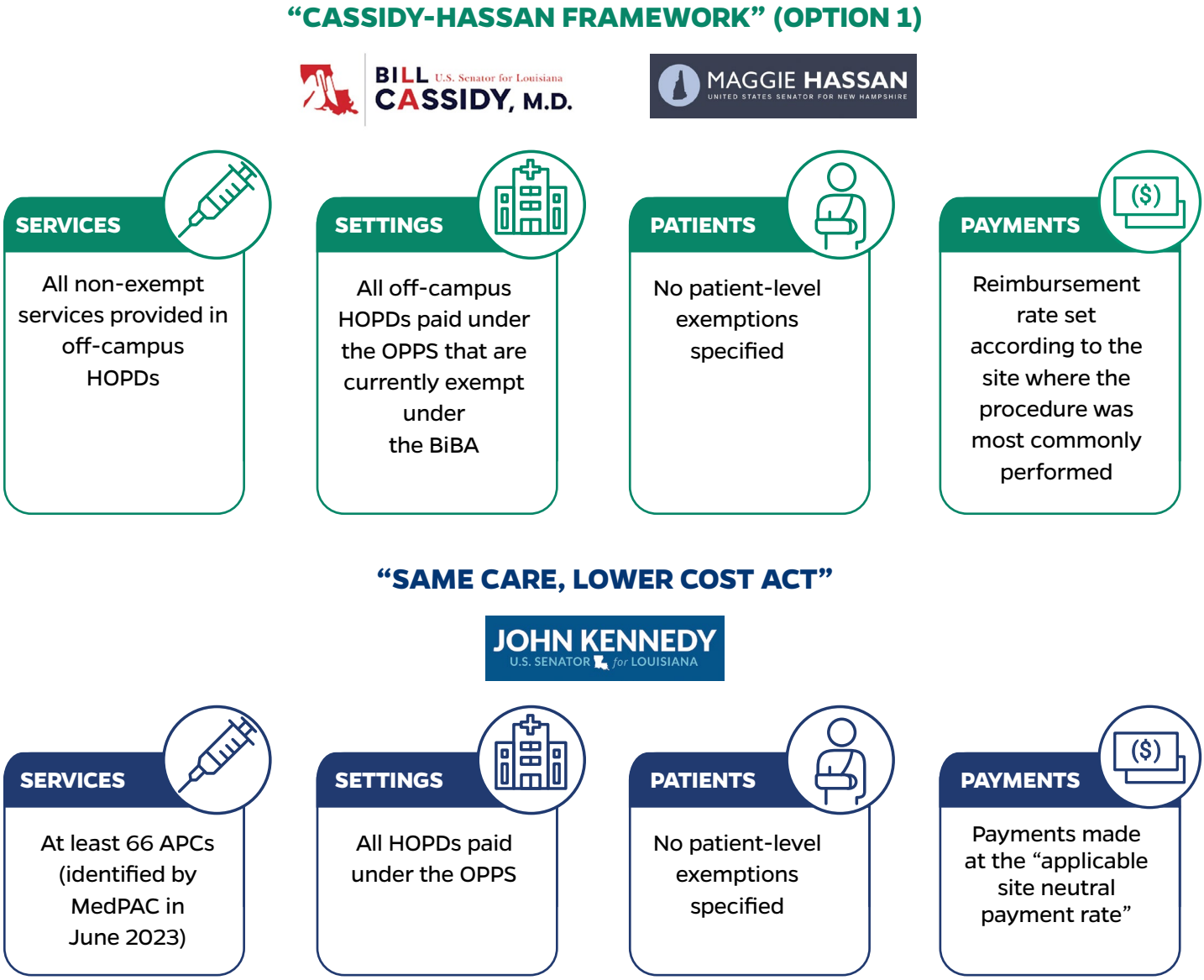
Source: CHSPM analysis of Medicare's OPPS and PFS rates for 2024.

Credit: iStock

Comparing policy design using the site-neutral framework

In November 2024, Senators Bill Cassidy (R-LA) and Maggie Hassan (D-NH) released a legislative framework for Medicare site-neutral payment reform.[14] In May 2025, Senator John Kennedy (R-LA) introduced the "Same Care, Lower Cost Act," which would direct the Secretary of Health and Human Services to make the 66 APCs (out of approximately 170 total service APCs) identified in MedPAC's report eligible for site-neutral payments.[15] **Figure 9** summarizes the features of these policies using the site-neutral framework.

Figure 9. Compare policies using the site-neutral framework

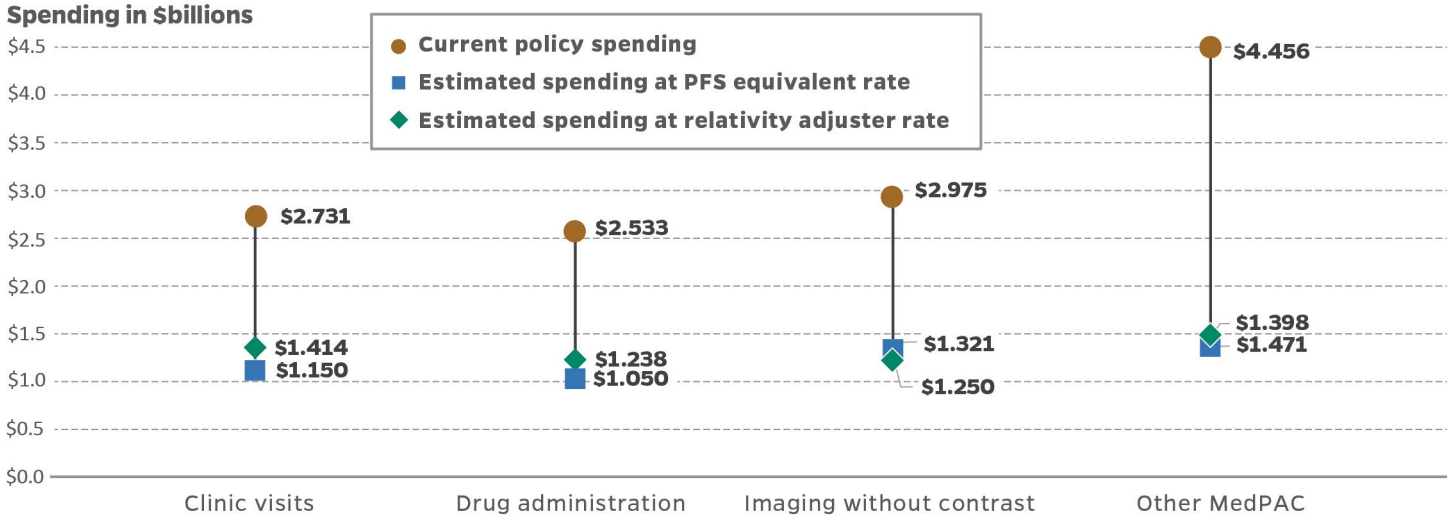


SECTION 3: Site-Neutral Payment Policy Spending Impacts, 2024

To illustrate the effects of the policy choices, we calculated Medicare spending on clinic visits, drug administration, imaging without contrast, high-volume, low-intensity services commonly included in recent site neutral policy proposals, as well as other 48 APCs MedPAC identified as candidates for being paid PFS-equivalent rates.[16] Spending for these services is shown in **Figure 10** at current rates, at estimated PFS-equivalent rates using CMS's protocol, and at relativity-adjuster rates equal to 40 percent of the OPPS rate. For all APCs shown in **Figure 10**, estimated spending under a site-neutral policy that paid PFS equivalent rates would be $4.9 billion ($7.8 billion in savings compared to OPPS payments) and spending under the relativity adjuster rate would be $5.3 billion ($7.3 billion in savings compared to OPPS payments) in 2024. Payments under site-neutral scenarios are calculated using applicable multi-procedure discounts and do not include estimated payments for packaged items or adjustments for geographic differences in wages.

Figure 11 and **Figure 12** on page 13 show estimated Medicare spending on the same services included in **Figure 10** by hospital and beneficiary groups. In this example, and other services examined, under both PFS-equivalent rates and relativity adjuster rates, reductions in spending are generally proportional to the share of spending under current policy in hospital and beneficiary groups.

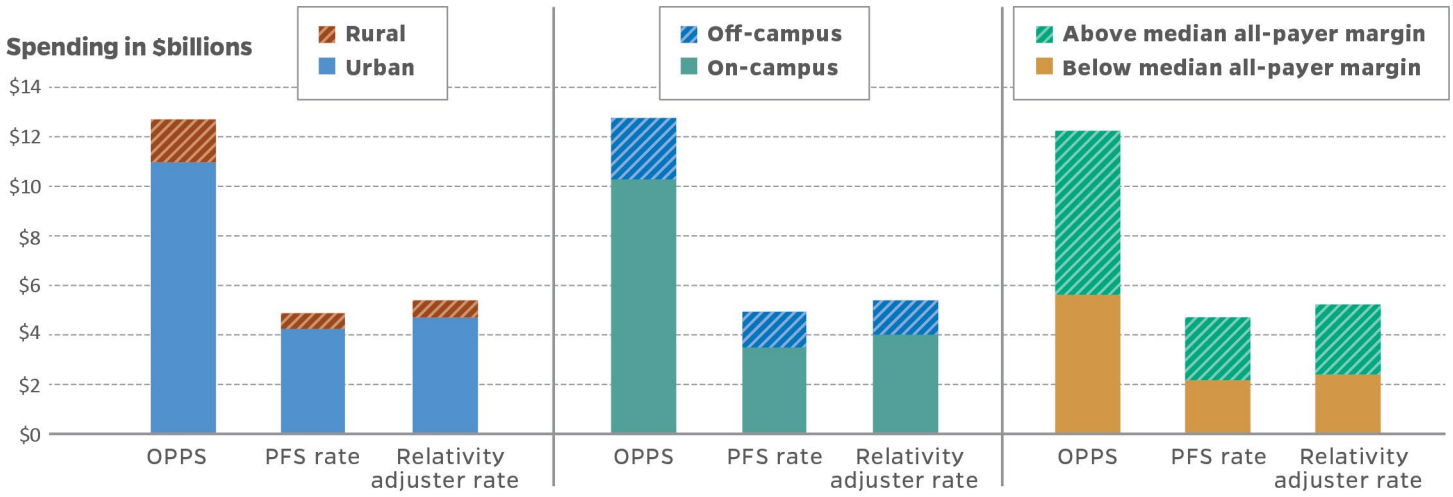
Figure 10. Spending on select HOPD services under two site-neutral payment scenarios, 2024



Notes: HOPD = hospital outpatient department. PFS = physician fee schedule. Clinic visits are services paid under APC 5012. Drug administration includes APCs 5691 through 5694. Imaging without contrast includes APCS 5521 through 5524. "Other MedPAC" includes the other 48 APCs MedPAC identified as candidates for having outpatient rates aligned with physician fee schedule rates.[17] Spending at the PFS rate does not include payment for packaged services. MedPAC also identified nine services for which the OPPS rate should be aligned with rates paid in ambulatory surgery centers, but those are not included in this figure.

Source: CHSPM analysis of Medicare claims data for 2024.

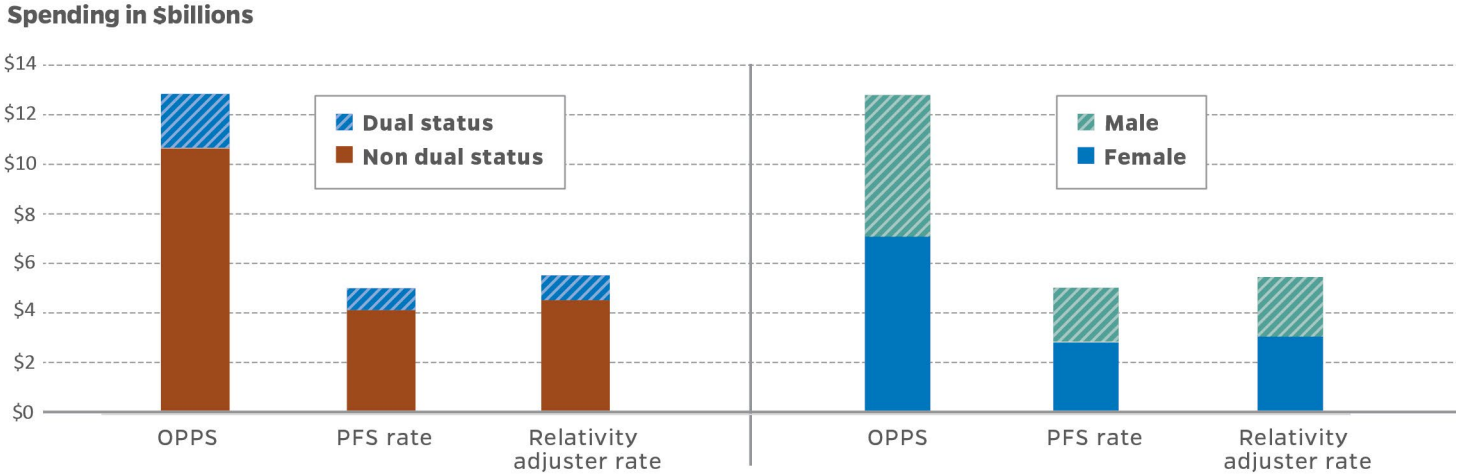
Figure 11. Medicare spending on select HOPD services under two site-neutral payment scenarios by hospital type, 2024



Notes: HOPD = hospital outpatient department. OPPS = outpatient prospective payment system. PFS = physician fee schedule. Includes payment for 57 APCs including clinic visits, drug administration, imaging without contrast and 48 APCs MedPAC identified as candidates for having outpatient rates aligned with physician fee schedule rates.[18] All-payer total margins were calculated from Medicare cost reports for FY 2023 because data for 2024 were not available. Hospitals were stratified into two groups: above and at or below the median all-payer margin. Observations with missing or extreme all-payer margin values were excluded. Spending at the PFS rate does not include payment for packaged services.

Source: CHSPM analysis of Medicare claims and hospital cost report data for 2024.

Figure 12. Medicare spending on select HOPD services under two site-neutral payment scenarios by patient type, 2024



Notes: HOPD = hospital outpatient department. OPPS = outpatient prospective payment system. PFS = physician fee schedule. Includes payment for 57 APCs including clinic visits, drug administration, imaging without contrast and 48 APCs MedPAC identified as candidates for having outpatient rates aligned with physician fee schedule rates.[19] Spending at the PFS rate does not include payment for packaged services.

Source: CHSPM analysis of Medicare claims and Master Beneficiary Summary File data for 2024.

CONCLUSION: Implementing Site-Neutral Policy

Designing a site-neutral policy for ambulatory care requires decisions across four elements—services, settings, patients, and payments. These decisions affect the Medicare program, providers, and beneficiaries. To identify services for site-neutral payment, one common approach, developed by MedPAC, is to target non-emergent, low-complexity services that are frequently performed in office-based settings.[20] When using claims volume to identify where services are performed, policymakers should account for existing incentives that have shifted service volume from the office to the outpatient setting for reasons unrelated to complexity.[21] In selecting the settings to which site neutral rates apply, some proposals have more limited reach, extending site neutral payment to currently excepted off-campus HOPDs (e.g., Cassidy-Hassan Option 1). Others would apply more broadly to on- and off-campus HOPDs (and ASCs) (e.g., MedPAC, Cassidy-Hassan Option 2, and the "Same Care, Lower Cost Act"). Prominent site-neutral proposals have not proposed patient-level exemptions, opting instead to limit the policy to services that can safely and be provided to all patients in the office setting or ASCs. Medicare's experience with its limited site-neutral policy highlights practical considerations in determining and implementing site neutral rates. Estimating equivalent rates under the PFS is complex, and differences in billing rules between the OPPS and the PFS, combined with limitations in Medicare's claims processing systems, have required workarounds to apply PFS-based rates to HOPDs. These challenges underscore the importance of anticipating implementation constraints and developing solutions to ensure site-neutral policy functions as intended.

Credit: iStock

CONTACT INFORMATION

For more information, please contact:

Kathryn E. Linehan

klineha2@jhu.edu

Center for Health Systems and Policy Modeling

https://hbhi.jhu.edu/initiatives/chspm

FUNDING ACKNOWLEDGEMENT

This work was supported by the Peterson Center on Healthcare.

REFERENCES

1 Cory Capps et al., "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001.

2 David Dranove and Christopher Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy* 11, no. 4 (2019): 249–71, https://doi.org/10.1257/pol.20170020.

3 Brady Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," *Health Services Research* 56, no. 1 (2021): 7–15, https://doi.org/10.1111/1475-6773.13613.

4 Klara K. Lou et al., "Medicare Site-Neutral Payment Policies: Effects Of Proposals On Hospitals And Beneficiary Groups: *Health Affairs* 44, no. 6 (2025): 668–76, https://doi.org/10.1377/hlthaff.2024.01501.

5 Brady Post et al., "Site-Neutral Payment Reform: Little Impact On Outpatient Medicare Spending Or Hospital-Physician Integration," Health Affairs, May 21, 2025, 10.1377/hlthaff.2024.00972, https://doi.org/10.1377/hlthaff.2024.00972.

6 Post et al., "Site-Neutral Payment Reform."

7 Centers for Medicare & Medicaid Services, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1695-FC)," Fed. Reg. Vol. 83, No. 225 (November 2018): 58818–9179, https://www.govinfo.gov/content/pkg/FR-2018-11-21/pdf/2018-24243.pdf.

8 Post et al., "Site-Neutral Payment Reform."

9 Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency (1834-P)," Fed. Reg. Vol. 90, No. 135 (July 2025): 33476–865, https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf.

10 Centers for Medicare & Medicaid Services, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital (1656–FC and IFC)," Fed. Reg. Vol. 81, No. 219 (November 2016): 79562–892, https://www.govinfo. gov/content/pkg/FR-2016-11-14/pdf/2016-26515.pdf.

11 Centers for Medicare & Medicaid Services (November 2016)

12 Centers for Medicare & Medicaid Services (November 2016)

13 Centers for Medicare & Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (CMS–1676–F)," Fed. Reg. Vol. 82, No. 219 (November 2017): 52976–3371, https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf.

14 Bill Cassidy and Maggie Hassan, "Lowering Health Costs for Seniors Framework," November 1, 2024, https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-hassan-release-policy-framework-on-medicare-site-neutral-reform-to-lower-health-care-costs/.

15 "Same Care, Lower Cost Act, S.1629," 119th Congress (2025-2026), https://www.kennedy.senate.gov/public/_cache/files/6/0/60b48cd9-ac22-4c45-92a2-6547644aa672/2874DAB163A44F2AB59174C9EBD44BB90323094BFE0CDB2C2AA19A1E48F46D36.site-neutral---bill-text-.pdf.

16 Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System (June 2023): 353-372, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

17 Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System.

18 Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System.

19 Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System.

20 Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System.

21 Lou et al., "Medicare Site-Neutral Payment Policies."

Credit: Shutterstock

Center for Health Systems and Policy Modeling