Updated Estimates of Site Neutrality and Evaluation of the Cassidy-Hassan Framework

ACTUARIAL RESEARCH CORPORATION

Tim Bulat, FSA, MAAA (tbulat@aresearch.com)
Ryan Brake, ASA, MAAA (rbrake@aresearch.com)

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SUMMARY

- With a comprehensive expansion of site neutrality, Medicare beneficiaries would save $80 billion over ten years through lower Part B premiums and cost sharing.
- Beneficiaries would average savings of $114 per year. Millions of high-utilizing beneficiaries, such as those receiving chemotherapy, would save several hundred dollars annually.
- Comprehensive site neutrality would reduce federal spending by $148 billion over ten years. Additionally, tax revenue spillover effects from lower employer-sponsored insurance costs would increase federal revenue by $30 billion. A narrower policy focused solely on off-campus HOPDs would reduce spending by $28 billion over the same period.
- The Cassidy-Hassan framework proposes expansion of site neutrality while reinvesting in rural and high-needs hospitals. We estimate 29% of facilities (14% of beds) may qualify for reinvestment. For these hospitals, reinvestment can fully offset revenue losses from site neutrality, though results are sensitive to specific details in how the framework is ultimately implemented.

BACKGROUND

Aligning Medicare payments across settings for similar services, known as site neutrality, continues to draw interest from legislators and regulators. Currently, for an identical service of comparable complexity, Medicare and its beneficiaries often pay two to four times more when the service is provided in a hospital outpatient department (HOPD) than in a physician office.[1,2] Even most off-campus HOPDs, which resemble physician offices and often were standalone offices before being acquired by hospital systems, are paid at the higher rate.

The use of HOPDs is expected to grow rapidly, with the Congressional Budget Office (CBO) projecting Medicare payments to HOPDs will increase by 150% over the next decade, compared to 50% for inpatient services and 23% for physician services.[3] Furthermore, the payment differential between HOPDs and physician offices is increasing faster than inflation on a per-service basis.[4]

Policies implementing limited site neutrality at certain off-campus HOPDs took effect in 2017 and 2019.[5] The 2017 policy only applied to new off-campus HOPDs, grandfathering HOPDs already in existence. The 2019 policy expanded neutrality for evaluation and management (E&M) services to the grandfathered off-campus HOPDs. Together, these policies are narrow, affecting only about 1% of HOPD spending.[6] Consistent with recommendations from the Medicare Payment Advisory

6928 Little River Turnpike
Suite E
Annandale, VA 22003
703-941-7400

10320 Little Patuxent Pkwy
Suite 975
Columbia, MD 21044
410-740-9194

www.aresearch.com

Commission (MedPAC), Congress has considered expanding site neutrality on several occasions, including through a bill which passed in the House of Representatives in December 2023.[7,8]

Recently, Senators Bill Cassidy, M.D. (R-LA) and Maggie Hassan (D-NH) released a framework (the Cassidy-Hassan framework) for legislation to broaden site neutrality.[9] In addition to expanding site neutrality, the framework includes a reinvestment program that would direct a portion of savings to increase payments to certain rural and high-needs hospitals. This reinvestment mechanism addresses a concern among some policymakers that site neutrality may harm less financially stable hospitals.

Actuarial Research Corporation (ARC) has published several policy briefs exploring HOPD and physician office payment differentials, as well as the estimated impacts of site neutrality on various stakeholders.[10] Recognizing the continued legislative interest in site neutrality, we have updated our site neutrality model using newly available claims data and assessed impacts across other insurance segments. In this brief, we present updated savings projections for beneficiaries and the federal budget. Additionally, we evaluate the Cassidy-Hassan framework reinvestment component, estimating the net impact of site neutrality and reinvestment on different cohorts of hospitals.

UPDATED PROJECTIONS OF OFF-CAMPUS AND COMPREHENSIVE SITE NEUTRALITY

Currently, within the Outpatient Prospective Payment System (OPPS), two categories of services are subject to site neutrality: all services performed at non-grandfathered off-campus HOPDs and E&M services performed at all off-campus HOPDs. As we have previously estimated, these categories are narrow, accounting for 19% of off-campus HOPD spending and only 1% of all HOPD spending.

MedPAC has recommended that Congress more closely align payment rates across settings for "services that are safe and appropriate to provide in all settings."[11] MedPAC also provided a list of services that may be suitable for neutrality based on where they are most commonly delivered.

Legislative proposals have included expansions of site neutrality both at off-campus HOPDs and across all HOPDs. In this brief, we discuss two scenarios: (1) expansion of site neutrality to all services provided at off-campus HOPDs and (2) expansion of site neutrality to selected services – that is, those more commonly performed in physician offices or ambulatory surgical centers – when delivered at on-campus HOPDs. We refer to the combination of these two expansions as comprehensive site neutrality.

Tables 1 through 3 present projected savings from both scenarios. Table 1 presents total projected out-of-pocket savings for all Medicare beneficiaries. Table 2 presents annual per-beneficiary savings for cohorts affected by proposed site neutrality policies. Table 3 provides ten-year projections of federal budget savings.

TABLE 1: SITE NEUTRALITY OUT-OF-POCKET SAVINGS TO MEDICARE BENEFICIARIES (2025-2034, $ BILLIONS)

	Off-Campus HOPD (All Services)	On-Campus HOPD (Selected Services)	Comprehensive (Sum)
Part B Premiums	$8.3	$34.9	$43.2
Cost Sharing	$7.0	$29.7	$36.7
Total	$15.3	$64.6	$79.9

Notes: From ARC's site neutrality simulation model, calibrated to the 2023 Medicare 5% sample Limited Data Set (LDS). Projections are calibrated to the 2024 Medicare Trustees Report. Neutrality is assumed to be implemented with a relativity adjuster which is updated to reflect differences in OPPS and PFS increases. OPPS and PFS increases are assumed to converge to projected medical inflation over the 10-year period.

We project that comprehensive site neutral expansion would save Medicare beneficiaries $79.9 billion over ten years (2025-2034). These savings reflect reductions in both Part B premiums and cost sharing. Most Medicare beneficiaries would experience lower premiums, with annual savings averaging $61.78 over the ten-year period. When including cost sharing, average annual savings rise to $114.29 per beneficiary, though this amount varies widely depending on whether and how intensively beneficiaries use services that would be affected by site neutrality. Table 2 illustrates this variation: 10.4 million high-utilizing beneficiaries would save over $250 per year, primarily due to reduced cost sharing. Patients receiving chemotherapy are particularly high users of HOPD services. We estimate that 1.3 million of these beneficiaries would save about $475 annually under comprehensive site neutrality.

TABLE 2: SITE NEUTRALITY OUT-OF-POCKET SAVINGS TO COHORTS OF BENEFICIARIES (ANNUALLY PER BENEFICIARY)

	Off-Campus HOPD			Comprehensive		
Cohort	**Beneficiaries** (millions per year)	**Part B Premium Savings** (annual)	**Cost Sharing + Premium Savings** (annual)	**Beneficiaries** (millions per year)	**Part B Premium Savings** (annual)	**Cost Sharing + Premium Savings** (annual)
All Medicare Beneficiaries	69.9	$11.83	$21.88	69.9	$61.78	$114.29
All Impacted Medicare Beneficiaries	7.0	$11.83	$111.25	27.6	$61.78	$193.52
High-Utilizing Beneficiaries	2.8	$11.83	$170.22	10.4	$61.78	$259.08
Beneficiaries Receiving Chemotherapy	0.5	$11.83	$369.95	1.3	$61.78	$474.17

Notes: All Medicare Beneficiaries includes all beneficiaries with Part B benefits, either through original Medicare or Medicare Advantage. Impacted beneficiaries are those with at least one claim that would be impacted by the site neutrality scenario, based on 2023 utilization patterns. High-utilizing beneficiaries are those with total Medicare spending in the highest quartile. Projections are from ARC's site neutrality simulation model, calibrated to the 2024 Medicare Trustees report.

From a federal budget perspective, we project that comprehensive site neutrality expansion would reduce federal spending by $147.6 billion over ten years (2025-2034), as shown in Table 3.[12] This projection reflects reductions in fee-for-service (FFS) Medicare spending, lower Medicare Advantage benchmarks and spending, decreased Medicaid spending on dually eligible Medicare beneficiaries, and reduced federal spending on Affordable Care Act (ACA) Marketplace premium subsidies. Not included in this total are increases in federal tax revenues, resulting from lower employer-sponsored insurance (ESI) costs, which we estimate to be approximately $30 billion over ten years. Changes in Marketplace and ESI premiums stem from the influence of Medicare payments on commercial provider contracting and the expectation that Medicare site neutrality would prompt similar changes in private-sector contracts.[13] We have not estimated impacts to Medicaid (beyond dual-eligible beneficiaries) and other segments, given the less direct influence of Medicare payments in those areas.

TABLE 3: SITE NEUTRALITY REDUCTIONS TO FEDERAL SPENDING (2025-2034, $ BILLIONS)

	Off-Campus HOPD (All Services)	On-Campus HOPD (Some Services)	Comprehensive (Sum)
Medicare	$24.1	$102.0	$126.1
Medicaid (Duals)	$0.8	$3.5	$4.4
ACA Marketplaces	$3.3	$13.8	$17.0
Total	**$28.3**	**$119.3**	**$147.6**

Notes: From ARC's site neutrality simulation model, calibrated to the 2023 Medicare 5% sample Limited Data Set (LDS). Projections are calibrated to the 2024 Medicare Trustees Report. Neutrality is assumed to be implemented with a relativity adjuster which is updated to reflect differences in OPPS and PFS increases. OPPS and PFS increases are assumed to converge to projected medical inflation over the 10-year period.

EVALUATION OF CASSIDY-HASSAN FRAMEWORK REINVESMENT

A frequently raised concern about expanding site neutrality is its impact on revenues of rural and other financially at-risk hospitals.[14] Although our previous analysis indicated that off-campus spending associated with rural hospitals is limited, expanding site neutrality to on-campus services would have a larger effect.[15] To address this concern, the Cassidy-Hassan framework includes a reinvestment program for certain hospitals. Under this program, facilities may be classified as rural or high-needs, with hospitals in these classifications receiving an increase to base Medicare payments.

In this section, we evaluate the reinvestment proposal, estimate the share of hospitals that may be categorized as rural or high-needs, and quantify the net effect of site neutrality and reinvestment on those hospitals under several reinvestment scenarios. The Cassidy-Hassan framework does not precisely define the parameters for rural and high-needs identification. For our analysis, we adopt existing definitions within the Inpatient Prospective Payment System (IPPS) to define rural hospitals.[16] We then define high-needs hospitals as those in the top five percent of metrics related to low-income patients contained in the Centers for Medicare and Medicaid Services (CMS) cost reports.[17]

As shown in Table 4, we estimate that 29% of facilities, accounting for 14% of hospital beds, would be categorized as either rural or high-needs under the framework. There is limited overlap between these categories – in contrast to rural hospitals, high-needs hospitals are often larger urban facilities with a high proportion of Medicaid patients. Using a database developed by the Agency for Healthcare Research and Quality (AHRQ) to identify hospital ownership,[18] we estimate that nearly two-thirds of rural and high-needs hospitals belong to multi-hospital chains. Additionally, 16% of rural hospitals are part of one of the largest (top 10) hospital chains, slightly below the share of all hospitals in large chains.

Our analysis is limited to short-term acute care facilities. Critical access hospitals, rural health clinics, and other facilities not paid under the OPPS are excluded.

TABLE 4: COUNTS OF RURAL AND HIGH-NEEDS FACILITIES

	Neither Rural nor High-Needs	Rural	High-Needs	Rural or High-Needs
Facilities (% by Facilities)	2,283 (71%)	770 (24%)	170 (5%)	919 (29%)
% by Bed Count	86%	8%	6%	14%
Average Beds	200	70	235	101
Portion in a Multi-Hospital Chain	79%	64%	57%	64%
Portion in a Top-10 Hospital Chain	24%	16%	15%	16%

Notes: Categorization based on ARC modeling intended to reflect the Cassidy-Hassan framework. Uses designations from the 2024 IPPS final rule. Uses data on hospital beds and public payer information from 2021-2024 CMS cost reports. Hospital chain data is from the 2023 AHRQ Compendium of U.S. Health Systems. Includes short-term acute facilities only.

Table 5 shows the annualized net impact of site neutrality and reinvestment by hospital categorization, assuming comprehensive site neutrality expansion, under four reinvestment scenarios. The Cassidy-Hassan framework illustrates reinvestment as an increase to base hospital payments. Legislation following this framework would need to specify whether the increase applies to inpatient or outpatient payments, as well as how the payment adjustment is calculated. The scenarios shown below represent a reasonable range of reinvestment options, including two where the increase applies to IPPS payments and two where it applies to OPPS payments. In each scenario, the reinvestment consists of a base percentage increase, which varies by scenario, plus an additional 1% for each of five designated "core lines of service" provided by the hospital.[19]

In scenarios 1 and 2, reinvestment increases IPPS and OPPS payments, respectively, by 10% plus the additional 1% per core line of service. At this percentage, the overall size of the reinvestment is greater when applied to IPPS ($1.5 billion compared to $0.8 billion) because acute hospitals paid through prospective payment systems receive more revenue through IPPS than OPPS.

In scenario 3, the IPPS reinvestment percentage is solved such that the net impact of reinvestment and site neutrality is at least break-even for both rural and high-needs hospitals. In this scenario, 12% IPPS reinvestment is needed for rural hospitals to break even. However, with this reinvestment, high-needs hospitals do meaningfully better than break-even (net impact of +$0.5 billion), because rural hospitals derive a larger share of revenue from outpatient services which are negatively impacted by site neutrality. By contrast, hospitals designated as high-needs rely more heavily on inpatient services, which benefit from the reinvestment.

In scenario 4, the OPPS reinvestment percentage is solved such that the net impact of reinvestment and site neutrality is at least break-even for both rural and high-needs hospitals. Here, 15% OPPS reinvestment results in both rural and high-needs hospitals having approximate break-even net impacts.

Taken together, this modeling shows that the net impact to hospital revenue is sensitive to how the reinvestment program is defined. Especially important are differences in outpatient and inpatient proportions in rural and high-needs hospitals, which can lead to directional differences in the net impact of site neutrality and reinvestment.

TABLE 5: ANNUAL HOSPITAL REVENUE NET IMPACT OF SITE NEUTRALITY AND REINVESTMENT SCENARIOS ($ BILLIONS)

	Neither Rural nor High-Needs	Rural	High-Needs	Rural or High-Needs	Total
Site Neutral Impact	-$6.8	-$1.0	-$0.2	-$1.2	-$8.0
Scenario 1: IPPS 10% Reinvestment					
Reinvestment Impact	$0.0	$0.9	$0.6	$1.5	$1.5
Net Impact	**-$6.8**	**-$0.1**	**$0.4**	**$0.3**	**-$6.5**
Scenario 2: OPPS 10% Reinvestment					
Reinvestment Impact	$0.0	$0.7	$0.1	$0.8	$0.8
Net Impact	**-$6.8**	**-$0.3**	**-$0.1**	**-$0.4**	**-$7.2**
Scenario 3: IPPS 12% Reinvestment					
Reinvestment Impact	$0.0	$1.0	$0.7	$1.8	$1.8
Net Impact	**-$6.8**	**$0.0**	**$0.5**	**$0.6**	**-$6.3**
Scenario 4: OPPS 15% Reinvestment					
Reinvestment Impact	$0.0	$0.9	$0.2	$1.1	$1.1
Net Impact	**-$6.8**	**$0.0**	**$0.0**	**$0.0**	**-$6.9**

Notes: Site neutrality impacts consider neutrality at off-campus and on-campus HOPDs and are from ARC's site neutrality simulation model, calibrated to the 2023 Medicare 5% sample Limited Data Set (LDS). Values are shown here on an annual what-if 2023 retrospective basis. Impacts reflect Medicare FFS only, and we have not estimated spillover impacts on contracting in other segments.

CONCLUSION

The expansion of site neutrality continues to be a topic of significant interest among various stakeholders. Senators Bill Cassidy, M.D. (R-LA) and Maggie Hassan (D-NH) have introduced a framework for site neutrality legislation that considers the potential risk to some hospitals by reinvesting a portion of savings into rural and high-needs hospitals.

In this brief, we have re-estimated the federal budgetary impacts of off-campus site neutrality expansion ($28.3 billion over ten years) and comprehensive site neutrality ($147.6 billion over ten years). We have also demonstrated that the net revenue impact to hospitals that may be classified as rural or high-needs under the Cassidy-Hassan framework could be break-even, though this result is sensitive to how the reinvestment is structured. Specifically, reinvestment through IPPS payments benefits high-needs hospitals more than rural hospitals.

We have also calculated the impact of site neutrality on beneficiaries, including reductions in both Medicare Part B premiums and cost sharing ($79.9 billion over ten years). On a per-beneficiary, per-year basis, the impact of lower Part B premiums would average $62 per year. Additionally, lower cost sharing would average $53 per year, with several million higher-utilizing beneficiaries saving hundreds of dollars per year.

APPENDIX – SITE NEUTRALITY IMPLEMENTATION APPROACH

The site neutrality estimates throughout this brief assume that CMS would implement expanded site neutrality using a uniform multiplier applied to OPPS rates. This approach is consistent with the "relativity adjuster" CMS currently uses to implement site neutrality. We assume the value of the adjuster decreases over time because the gap between OPPS and Physician Fee Schedule (PFS) rates has been growing faster than inflation, as discussed in our November 2024 brief.[20]

CMS has used the relativity adjuster approach due to the complexity of aligning PFS and OPPS rates. Often, when a service is performed in an HOPD, the total payment includes a facility component determined by the OPPS and a physician component determined by the PFS. By contrast, the same service performed in a physician office only generates a single payment. Adding complexity, OPPS payment for supporting services is often bundled with the primary facility payment.

In addition to the relativity adjuster approach, we also estimated impacts of site neutrality using a more precise implementation. Under this approach, the sum of the OPPS payment and PFS payment (when there is a physician component) would be set for each APC at the average rate paid for the same mix of services in a physician office setting, adjusted for the additional cost of bundled services. This estimate was consistent with the one derived using the relativity adjuster. This consistency confirms that estimating impacts using the relativity adjuster is a reasonable simplification for considering, and potentially implementing, expanded site neutrality.

DISCLOSURES

This work was supported by Arnold Ventures. ARC maintains full editorial and analytical control.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all communications with respect to actuarial services. Tim Bulat and Ryan Brake are members in good standing of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this brief.

NOTES

[1] Bulat T, Brake R. Actuarial Research Corporation. *Potential Impacts of Medicare Site Neutrality on Off-Campus Drug Administration Costs*. October 18, 2023. https://www.arnoldventures.org/resources/drug-admin-off-campus-site-neutrality-report-oct-18-2023.

[2] Cooper Z, Jurinka E, Stern D. *Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program*. October 30, 2023. https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf.

[3] Congressional Budget Office. June 2024. Baseline Projections. Medicare. https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf

[4] Bulat T, Brake R. Actuarial Research Corporation. *Without Site Neutrality, the Differential in HOPD and Office Medicare Payments is Growing Faster than Medical Inflation*. November 14, 2024. https://assets.arnoldventures.org/uploads/Site-Neutrality-Growing-Differential-2024.11.14.pdf.
[5] Site neutrality was first implemented in OPPS at non-excepted off-campus HOPDs in the 2017 OPPS payment rule as a result of the Bipartisan Budget Act of 2015. Site neutrality was expanded to all off-campus HOPDs for evaluation and management services (HCPCS G0463) in a two-year phase-in from 2019 to 2020. These existing site neutrality rules do not apply to OPPS payments at on-campus HOPDs and excepted off-campus HOPDs for all other services.
[6] Bulat T, Brake R. Actuarial Research Corporation. *Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals*. January 3, 2024. https://assets.arnoldventures.org/uploads/Sizing-Medicare-Off-Campus-HOPD-Site-Neutrality-Proposals-2024.01.03.pdf.
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[9] Cassidy B, Hassan M. U.S. Senate. *Lowering Health Costs for Seniors Framework*. October 2024. https://www.cassidy.senate.gov/wp-content/uploads/2024/10/Site-Neutral-Policy-Framework-Final.pdf.
[10] Bulat and Brake, *Potential Impacts of Medicare Site Neutrality*; Bulat and Brake, *Sizing Medicare Off-Campus HOPD Proposals*; Bulat and Brake, *Without Site Neutrality, the Differential in HOPD and Office Medicare Payments is Growing*.
[11] MedPAC, *Chapter 8 Aligning fee-for-service payment rates.*
[12] CBO estimated savings from a comprehensive site neutrality policy at $156.9 billion over 2025–2034 (CBO, *Options for Reducing the Deficit: 2025 to 2034*, December 2024). While this estimate is similar to ours, there are likely offsetting differences in underlying methodologies and assumptions. Potential sources of variation include how impacts on non-Medicare segments are modeled, assumptions about how site neutrality would be implemented, and differing expectations for the relative growth of PFS and OPPS reimbursement rates.
[13] Clemens J, Gottlieb JD. *In the Shadow of a Giant: Medicare's Influence on Private Physician Payments*. J Polit Econ. 2017;125(1):1-39. doi:10.1086/689772.
[14] American Hospital Association. *Fact Sheet: Medicare Hospital Outpatient Site-Neutral Payment Policies*. Updated January 2025. https://www.aha.org/fact-sheets/2023-03-21-fact-sheet-medicare-hospital-outpatient-site-neutral-payment-policies.
[15] The Cassidy-Hassan framework also suggests linking reinvestment with Medicare Alternative Payment Models (APMs) by increasing APM payments or benchmarks. While we have not directly modeled this approach, given the lack of specificity in the framework and the relatively straightforward nature of increasing IPPS or OPPS payments directly, an APM approach could be specified to achieve similar impacts.
[16] CMS. FY 2024 IPPS Final Rule Home Page. Last modified September 30, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page.
[17] CMS. Medicare Cost Reports. Last modified January 16, 2025. https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports.
[18] Agency for Healthcare Research and Quality (AHRQ). Compendium of U.S. Health Systems, 2023. Last modified December 2024. https://www.ahrq.gov/chsp/data-resources/compendium-2023.html.
[19] The Cassidy-Hassan framework lists five essential services that reinvestment should incentivize: Level I or Level II Trauma Center, Obstetrics Department, Burn Unit, Neonatal Intensive Care Unit, and Emergency Psychiatric Services.
[20] Bulat and Brake, *Without Site Neutrality, the Differential in HOPD and Office Medicare Payments is Growing Faster than Medical Inflation*.