Not-for-Profit Hospitals & Health Systems Market Update

Industry Specialty Team | Apr 2025

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Consequences of Site-Neutral Payments and Research Infrastructure Caps on U.S. Hospitals

Recent policy proposals are flying fast & furious out of Washington, DC including (but not limited to) reduced Medicaid funding, immigration reform, tariffs, changes to telehealth, changes to the tax-exempt status of hospitals and possibly the loss of the ability to issue tax-exempt debt, among a host of others. This article will focus on two potential changes that could have a major impact on hospitals: implementing site-neutral payments for hospitals and imposing caps on federal research infrastructure funding.

While intended to rein in rising costs, both initiatives could carry significant unintended consequences for the not-for-profit hospital sector. Many hospitals and academic research institutions are already under significant pressure from escalating labor and pharmaceutical costs. Layering additional financial strain through policy changes could trigger ripple effects that reach far beyond the targeted savings, potentially jeopardizing access, innovation, and long-term sustainability across the healthcare system.

Understanding Site Neutral Payments

At first glance, site-neutral payments seem perfectly reasonable: it seems only fair that Medicare would pay hospitals at the same rate as independent physicians & ambulatory surgical centers (ASCs) for the same procedures. The rationale behind this proposal is to reduce costs by eliminating more expensive hospital-based outpatient payments. For example, Sidecar Health reports a hernia repair costs $8,700 in a hospital-based outpatient center in Maryland, compared to $6,000 in an ASC.

This approach has broad bipartisan appeal and is supported by a coalition of consumer advocacy and employer groups. Lawmakers estimate that site-neutral payments could generate up to $150 billion in potential federal savings over the next decade. Medicare beneficiaries could also benefit; they currently pay 20% coinsurance on outpatient visits so inflated hospital charges translate directly to higher out-of-pocket costs. In 2021 alone, Medicare beneficiaries paid an estimated $1.5 billion extra due to the higher hospital-based clinic pricing.

However, these payments are not simply padding hospital profits—they help subsidize other essential services that ASCs and independent physicians do not provide, including:

- **Emergency Departments and Trauma Centers** – Open 24/7 and required to treat all patients, regardless of ability to pay
- **Burn Units** – Specialized care units that require extensive resources
- **NICUs and PICUs** – High-cost care for vulnerable newborns and children
- **Public Health Preparedness** – Capacity to respond to infectious diseases and public health crises
- **Teaching and Training Programs** – Crucial for developing the future healthcare workforce

Hospital-owned clinics also often face more stringent regulatory requirements than independent clinics, which adds to their higher cost structure. These centers benefit from the hospital system without sharing in the financial responsibility of maintaining it. If site-neutral payments reduce hospital revenue without offsetting support, hospitals (particularly those in rural and underserved areas) may struggle to maintain these services likely resulting in further consolidation.

Role of Research Infrastructure Funding

Similarly, proposed caps on federal research infrastructure funding could negatively impact academic medical centers and universities. While direct research grants cover project-specific expenses, indirect cost reimbursements support essential infrastructure such as laboratories, IT systems, equipment, and administrative support. These costs often go unnoticed but are vital for sustaining a research ecosystem.

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Sources: Sidecar Health, American Hospital Association, KFF, Paragon Health Institute, Tradeoffs

Again, at face value it seems inappropriate to pay for “indirect costs” when paying for a research project. In most industries, the cost of infrastructure—things like electricity, water, insurance, administrative staff, compliance systems, and facilities maintenance—is baked into the price of the final product. When a consumer buys a refrigerator, for example, they aren’t billed separately for the factory’s property taxes or its HR department. Those indirect costs are part of the manufacturer’s cost structure and reflected in the price tag.

Research, however, operates differently—particularly when funded by the federal government. Direct research grants cover salaries, lab supplies, and project-specific expenses, but the essential overhead required to house and support those research activities—like maintaining lab facilities, IT infrastructure, security systems, and grant administration—must be reimbursed separately through negotiated indirect cost rates. These rates are often a flashpoint for policymakers seeking savings, but unlike in the private sector, cutting or capping these reimbursements risks hollowing out the very infrastructure that makes research possible. It's the equivalent of asking a manufacturer to build refrigerators without a functioning factory - while still expecting the same product quality and output .

Some leading institutions that rely on indirect cost support include:

- **Children’s Hospital of Philadelphia (CHOP)** – Pediatric genomics research
- **Texas Children’s Hospital** – Global sickle cell initiatives and pediatric oncology research with MD Anderson
- **Johns Hopkins Children’s Center** – Studies on childhood diseases
- **NYU Langone Health** – Advances in pediatric cardiology and oncology
- **Inova Health System** – Population health and care delivery research

Reductions in federal infrastructure funding could delay advances in cancer treatment, disease therapies, and precision medicine. Fewer research opportunities may also discourage future generations of clinicians and scientists

A More Targeted Approach

Rather than the axe, perhaps the scalpel could achieve cost savings while maintaining essential healthcare services and research capabilities. Some suggestions include:

- **Refine site-neutral policies** – Preserve enhanced payments for services with clear community benefit
- **Protect vulnerable hospitals** – Use targeted financial assistance or carve-outs for remote, low-volume hospitals rather than broad exemptions
- **Improve research funding efficiency** – Promote collaboration and cost-effective practices rather than across-the-board reimbursement caps
- **Encourage public-private partnerships** – Leverage industry and philanthropic funding to support infrastructure
- **Incentivize value-based care models** – Expand reimbursement frameworks that reward outcomes and efficiency

Conclusion

The U.S. healthcare system is filled with examples of policies & procedures that seem to be obvious targets for reform, yet many of these practices are deeply embedded in the financial and operational scaffolding of the "system". Abruptly “fixing” them without a broader, thoughtful redesign could have cascading effects—undermining hospital viability, destabilizing payment models thus leading to reduced access to care.

As with site-neutral payments, these inefficiencies may be frustrating but they’re symptoms of years of patchwork policy initiatives and not easy problems with simple solutions. While controlling costs is important, reforms such as site-neutral payments and caps on research infrastructure funding must be carefully designed. A strategic approach that protects essential services and invests in long-term capabilities will strengthen, rather than weaken, the healthcare system. Thoughtful policymaking needs to consider not just short-term savings but also the sustainability of institutions that safeguard public health and innovation.

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