When Site of Care Changes, the Account Changes

Site-of-care pressure is moving through healthcare. Account strategy needs to move with it.

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Site of care is often discussed in terms of healthcare costs. For manufacturers, it also has important implications for account strategy.

In the United States, a new wave of site-of-care change began in January 2026, when the Centers for Medicare & Medicaid Services expanded an existing site-neutral payment policy to include drug-administration services in certain hospital outpatient departments that had previously been exempt. CMS has since proposed extending the policy to imaging-without-contrast services in 2027. In a separate but related shift, CMS also began a three-year phaseout of its inpatient-only list, creating the potential for more services to move into outpatient settings through 2028. Commercial payer policies continue to scrutinize whether selected infused or injected therapies require hospital outpatient administration or can be delivered appropriately in a physician office, infusion center, or home setting.

These policies seek to reduce payment differences for comparable services and support the use of lower-cost settings when appropriate. The environment will continue to shift in response, and no one can predict exactly how every part of the market will adapt. What is clear is that the effects will not be uniform. Some manufacturers and account teams may need to respond now. Others may not feel the impact for years, depending on the therapy, how it is administered and reimbursed, and where patients receive care.

The responses will also be interdependent. Decisions by CMS, commercial payers, health systems, infusion providers, physician practices, manufacturers, and patients will influence one another. Care does not move as easily as a claim.

When treatment shifts from one setting to another, purchasing authority, clinical responsibility, patient support, revenue, and risk can shift with it. The effects may reach across an integrated delivery network, alter the economics of an independent practice, create new demands on alternative sites, and disrupt a patient journey that was already difficult to navigate.

For manufacturers, the central issue is no longer simply where a therapy can be administered. Account teams need to anticipate how a customer organization might respond, where they may be able to help, and how the manufacturer will align resources and support as the customer adapts.

Knowing that site of care is changing is market information. Anticipating the range of responses within a specific account and preparing the organization to respond is account insight.

Why site of care is becoming more important

Several forces are converging to make site of care more important. Drug administration has become a more visible target in the broader effort to reduce site-based payment differences. Hospital outpatient departments often cost payers and patients more than physician offices or independent infusion centers for comparable services. At the same time, years of health-system acquisition have moved services once delivered by independent practices under hospital ownership and hospital-based payment structures.

Payers and policymakers are addressing those differences through reimbursement policy, network design, prior authorization, and site-of-care requirements intended to support the use of lower-cost settings when appropriate.

Providers must respond to those economics without losing sight of operational reality.

An IDN may need to determine whether one of its outpatient infusion locations remains financially viable under lower administration payments. A physician practice may see an opportunity to add infusion services but lack the staff, space, pharmacy support, purchasing power, or working capital to do it. Independent infusion providers may expand, but their capacity, geographic reach, and therapy-specific capabilities will vary. Home infusion may be appropriate for some patients and therapies but introduce different clinical, logistical, and caregiver requirements.

This will not be a clean migration from hospitals to lower-cost settings. It will be a series of local decisions shaped by reimbursement, ownership, capacity, clinical complexity, geography, and patient need.

That is why site of care is becoming more important to account strategy. The policy may be national. The consequences will be account-specific.

The pressure moves through the account

A site-of-care change rarely stays contained within the site. For customers, it can affect drug acquisition economics, buy-and-bill revenue, 340B participation, specialty pharmacy relationships, payer contracts, referral patterns, facility utilization, staffing, and control of the patient relationship. A decision that benefits one part of an integrated system may create pressure in another. A health system may lose revenue while retaining responsibility for the patient's broader condition, quality measures, and outcomes.

The effects may also extend beyond the health system. Smaller hospitals and community practices may have fewer options for absorbing reimbursement pressure. Independent infusion centers may gain volume faster than they can add capacity. Practices may reconsider whether to build, expand, or restart infusion capabilities. Payers may achieve a lower unit cost while inadvertently adding new handoffs to the patient's journey.

For patients, the change may mean a new provider, a different authorization process, altered scheduling, additional travel, or a break in an established care relationship.

Treatment administration is rarely a stand-alone event. It may be connected to laboratory work, imaging, physician visits, pharmacy support, symptom management, and follow-up. When administration moves, those connections must be deliberately reestablished.

Who obtains authorization? Who orders and receives the product? Who has the laboratory results? Who responds to an adverse event? Who communicates with the treating specialist? Who notices if the patient never arrives?

When those answers are unclear, the result can be delayed starts, fragmented communication, interrupted therapy, and new burdens for patients and caregivers. It can also create customer frustration and business risk that no single manufacturer function can resolve alone.

What changes for account teams

Account teams create greater value when they move beyond repeating what changed and begin anticipating how customers might respond.

That requires a broader view of the customer. The formal decision-maker may be responding to reimbursement, but the operational consequences may fall to infusion leaders, pharmacy, finance, patient access, nursing, contracting, or

community partners. The clinical team may remain accountable for outcomes even when treatment is delivered outside the system. The patient may be expected to navigate the transition between them.

Account teams need to recognize where capacity may expand or contract, how healthcare economics may shift, which patients could encounter new barriers, and where responsibility may become unclear. They also need to consider where they may be able to help and bring those insights back into the manufacturer so resources and support can be aligned as the customer adapts.

This does not mean turning account managers into reimbursement specialists or health-system operators. It means equipping them to follow the pressure across five dimensions.

1. Healthcare economics

How do healthcare economics work across the account today, and what may change when care moves? The exchange of value may span the hospital, physician enterprise, specialty pharmacy, payer contracts, and other parts of the integrated system. Account teams do not need to calculate the customer's financial position. They should understand how reimbursement, costs, and incentives move through the system, where pressure may emerge, whose economics may be affected, and how the organization might respond.

2. Capacity

Can alternative sites actually absorb the patients who may be redirected? A location may be clinically appropriate but operationally unprepared. Staffing, infusion chairs, pharmacy support, product access, emergency protocols, hours of operation, and working capital all matter. A lower-cost setting does not create capacity simply because policy favors it.

3. Patient journey and continuum of care

Which patients can move successfully, not merely safely? Transportation, caregiver support, geography, scheduling, health literacy, affordability, and continuity with the treating team can determine whether an alternative setting works in practice. Changes in the patient journey and continuum of care may also affect adherence and the effectiveness of treatment, particularly for complex or higher-cost therapies. A change in site should be understood as a change in the patient journey, not an administrative transfer.

4. Clinical accountability

Who remains responsible for the patient's outcomes after care moves? IDNs and other providers may retain quality accountability even when treatment occurs outside their direct control. Account teams should understand where responsibility is shared and where the customer may have accountability without authority.

5. Manufacturer response

What does the manufacturer need to see, decide, or change? Site-of-care disruption may affect account planning, stakeholder engagement, patient support, distribution, training, evidence needs, contracting assumptions, and commercial forecasts. Field insight has limited value if it remains in an account plan or call note.

The leadership response

Sending account teams a policy summary will not prepare them for this change. Neither will assigning each implication to a separate function and expecting the field to connect the pieces.

Commercial leaders should identify which products, patient populations, accounts, and markets are most exposed. They should clarify what account teams need to understand, which customer conversations matter, where field insights should

go, and who is responsible for acting on them.

They should also test whether current account-planning, patient-journey, and training tools reflect the new reality. Does the account plan show how patients move across settings? Does it identify who owns the relevant economics and who owns the clinical consequences? Can the team distinguish a reimbursement issue from a capacity issue, a referral issue, or a continuity-of-care issue? Is there a mechanism for patterns observed across accounts to influence strategy?

Rather than trying to predict where care will move, leaders should consider how different customers are likely to respond, what those responses may require, and how account teams and internal functions will coordinate support without compromising access, continuity, quality, or the customer's ability to operate sustainably.

The next site-of-care decision may be made by a payer, an IDN, a physician practice, or a patient. The manufacturer may not control that decision. Its ability to respond will depend on how well account teams anticipate the consequences, help customers identify what the transition requires, and align the right resources across the organization.

Sources

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Stephanie Melnick *Healthcare commercial strategy and transformation advisor with more than 27 years of experience. Principal Consultant at Metajourn.*