Expanding Site-Neutral Payments in Medicare and Addressing Anticompetitive Vertical Integration of Physicians

$12-$24 billion in combined Medicare and commercial savings in one year (0.28%-0.56% of total health spending)

Published: September 2026

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Issue Summary: Medicare typically pays more for outpatient services (e.g., a lower-limb MRI) delivered in a hospital outpatient department (HOPD) than in a physician's office, even when the care is identical. This payment differential costs the Medicare program billions of dollars each year with no apparent difference in patients' quality of care. These payment differentials also raise health spending on the privately insured and have driven hospitals to acquire physician practices (vertically integrate). Congress and CMS have advanced incremental site-neutral payment reforms since 2015, but these policies only cover a small fraction of overall outpatient spending. In addition to increasing Medicare and beneficiary spending, these differentials encourage hospital acquisition of physician practices and spill into commercial rates, raising health spending more broadly.

Policy Recommendation: Federal policymakers should expand site-neutral payment to a wider array of outpatient services, so that Medicare pays the same fee-for-service rate for a given service across ambulatory settings—HOPDs, ambulatory surgical centers, and physician offices—whenever that service can be safely delivered outside a hospital. The budgetary impact of site-neutral payment reform depends on how policymakers define the scope of services implicated, the settings covered, and the target payment rate.

Potential Savings: Proposed site-neutral payment reforms could save Medicare an estimated $190 million (in 2027) to $7.4 billion (in 2026) depending on how broadly the policy is applied. Using the most recent estimate in a year with actual spending data, MedPAC's proposal estimated $6 billion in Medicare savings in 2021, amounting to 0.67% of Medicare spending and 0.14% of total health spending that year. Adding in a rough estimate of commercial spillover savings suggests a one-year total of about $12 billion to $24 billion in 2021.

Related Literature and Evidence:

Cooper, Zack, Elizabeth Jurinka, and Daniel Stern. 2023. "Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program." Tobin Center for Economic Policy, Yale University.

Background

Medicare pays different amounts for the same outpatient service depending on where the service is delivered. Even when the care is identical, Medicare almost always pays more when the service is delivered in a hospital setting than in a physician's office or ambulatory surgical center (ASC). In a physician's office, Medicare pays for services under the Physician Fee Schedule (PFS), covering providers' labor, material, and overhead costs in delivering outpatient services. In a hospital outpatient department (HOPD), Medicare makes the physician payment and a facility fee under the Outpatient Prospective Payment System (OPPS) to cover the facility costs. ASCs are freestanding facilities that perform same-day surgical and procedural care outside a hospital; Medicare pays ASCs under their own rate system which typically falls above physicians' PFS rates and below HOPDs' OPPS rates.

These site-based payment differences are large and appear across clinic visits, imaging, and drug administration, though their size varies by service. For example, in 2023, Medicare paid 194% more for a transthoracic echocardiogram in an HOPD than in a freestanding office (MedPAC 2023). Although reimbursements are higher, there is no peer-reviewed evidence to suggest that services routinely delivered in physicians' offices produce better outcomes when delivered in a hospital instead (Cooper et al. 2023).

Medicare's site-based payment differentials carry three main consequences. First, they increase Medicare spending and beneficiary out-of-pocket spending without commensurate improvements in health outcomes. Because beneficiary cost-sharing is set as a percentage of the payment rate, more expensive care in an HOPD translates into a larger bill for the same service. Second, the gap encourages vertical integration between hospitals and physicians. This occurs because physician practices can earn more money via higher OPPS rates for their services when they are owned by a hospital. The incentive is strongest for high-volume outpatient services with wide site-based payment gaps, such as clinic visits. Third, this payment differential raises commercial spending since commercial insurers often benchmark their payments to Medicare's rates (so this inefficiency diffuses into private insurers' payment rates) and the vertical integration induced by the policy gives hospitals and physicians greater bargaining leverage with payors.

Site-neutral payment policies address this by paying the same rate for the same service regardless of setting. To that end, federal action so far has been narrow. The Bipartisan Budget Act (BBA) of 2015 established site-neutral rates only for newly built, off-campus HOPDs, grandfathering pre-existing off-campus HOPDs and exempting on-campus HOPDs, ASCs, and freestanding emergency departments. As a result, the law reached just 0.8% of OPPS spending (MedPAC 2022). CMS has since incrementally expanded site-neutral payments, extending them to clinic visits at off-campus HOPDs in 2019 and to drug administration at those departments in 2026. The latter is projected to save roughly $290 million combined for Medicare and beneficiaries in 2026, against roughly $101 billion in annual OPPS spending.

Several states have sought to introduce a form of site-neutral billing within their jurisdiction by limiting hospital facility fees in the commercial market: Colorado bars charging patients facility fees for preventive outpatient services, and Connecticut and Indiana restrict them for certain off-campus services. Because commercial prices still benchmark to Medicare's rates, however, broader reform would require federal changes to Medicare payment rules.

Evidence Base

Payment differentials drive vertical integration and raise prices. That physicians can get paid higher rates when they are in hospital-owned practices gives hospitals and physicians an incentive to vertically integrate (Chernew 2021). Exploiting a 2010 change in Medicare's payment methodology, Dranove and Ody (2019) attribute 20% of the rise in hospital employment of physicians and 75% of the shift of procedures to hospital-owned billing sites between 2009 and 2013 to these payment differentials.

Differential payments drive higher health spending in three ways. First, when physicians integrate with hospitals, they receive higher payments from the Medicare program, which mechanically raises health spending. Second, because many private insurers pay providers as a share of Medicare rates, the distortions in payments from the Medicare program ripple through insurers' fee schedules. Clemens and Gottlieb (2017), for example, find that a $1 increase in Medicare reimbursement for physician services raises commercial prices by $1.16. Using commercial claims data, Capps, Dranove, and Ody (2018) find that a physician's prices rise 14.1% on average after hospital acquisition, with about 45% of that increase coming from the switch to hospital facility fee billing. Integration increases commercial prices by 6.7% more than it would if private insurers did not follow Medicare reimbursement rules (Dranove and Ody 2019, crediting Capps, Dranove, and Ody 2018). Third, some vertical transactions have been shown to reduce competition and allow both hospitals and physicians to negotiate higher prices with commercial insurers (Cooper et al. 2025). Cooper et al. (2025), for example, find that vertical integration between hospitals and physicians increases the price of baby deliveries for the privately insured by approximately 5%.

Policy Recommendation

Congress and CMS should expand site-neutral payment to a wider array of outpatient services, aligning Medicare's fee-for-service rates across ambulatory settings so that Medicare pays the same rate for the same service regardless of where it is delivered. For any service that can safely be delivered outside a hospital, its Medicare rate should be aligned across HOPDs, ASCs, and physician offices.

Policymakers will need to make key design choices when designing site-neutral policies, which will influence the magnitude of the savings from reform, including but not limited to:

- The scope of services paid site-neutrally. This could range from a single category (e.g., drug administration) to all services that can be safely delivered outside a hospital (e.g., clinic visits, imaging and diagnostic tests, minor procedures).
- The hospital settings subject to the aligned rate. Reform could focus only on off-campus HOPDs and decide whether pre-existing facilities grandfathered under the BBA of 2015 are folded in or left exempt. More expansive reform could also include services delivered at on-campus HOPDs.
- The target payment rate, or what a given service's aligned rate is across settings. Pegging to the physician office rate—equivalently, roughly 40% of the OPPS rate—yields the largest savings, because it is the lowest of the three ambulatory rates. Pegging to the ASC rate, which sits between the office and OPPS rates, produces more modest savings. MedPAC, for example, has suggested aligning rates based on where a service is most frequently performed. Services primarily done in physicians' offices would get aligned to the office rate; services primarily done in ASCs (e.g., lower-GI, intraocular, certain nerve procedures) would get aligned to the ASC rate.

Critics of site-neutral reform may argue that it would disproportionately harm rural hospitals, which are more financially vulnerable than their urban counterparts (KFF 2025). But the largest group of rural hospitals is exempt by design: critical access hospitals, which account for 59% of all rural hospitals, are reimbursed by Medicare on a cost basis and fall outside the OPPS system that site-neutral reform touches (KFF 2025). Many of the rural hospitals that are paid under the OPPS already receive protective add-ons: CMS pays rural sole community hospitals (SCHs) at 7.1% and rural emergency hospitals (REHs) 5% above standard OPPS rates. Where that proves insufficient, Congress should pair site-neutral payment with targeted financial support for those facilities. Maintaining higher payments and elevated Medicare spending for all hospitals is an inefficient way to protect a vulnerable subset. Finally, CMS and MedPAC should track the effects of site-neutral payment on patient access, quality of care, and hospital finances after implementation, with particular attention to rural areas.

Critics may also argue that hospitals warrant higher payments because they treat sicker patients with more complex conditions in their HOPDs compared to physician offices. While HOPD patients do have somewhat higher average risk scores, they overlap substantially with physician office patients; MedPAC found a negligible link between patient severity and hospital charges for these services (MedPAC 2022, MedPAC 2023). Most services that are candidates for site-neutral payment are low-intensity; where a sicker patient might require more care, the OPPS already allows hospitals to bill separately for added care. For these reasons, MedPAC concluded that no patient-severity adjustment is needed in aligning rates (MedPAC 2022, MedPAC 2023).

Potential Savings

Below is a table of major site-neutral payment proposals, roughly organized from smallest to largest estimated Medicare savings. At the narrow end, aligning payments for a single service, such as drug administration only at off-campus departments, would save Medicare a few hundred million dollars a year or about $4 billion over a decade. On the other end, the broadest proposals that cover services at both on- and off-campus sites would save roughly $7 billion in the first year the policy takes effect and as much as $157 billion over ten years. MedPAC's proposal estimated $6 billion in Medicare savings in 2021, amounting to 0.67% of Medicare spending and 0.14% of total health spending that year.

Because private insurers largely track Medicare payment rates, site-neutral payment proposals would drive spillover savings in the commercial market. The Committee for a Responsible Federal Budget (CRFB) (2021) estimates that broad Medicare site-neutral reform would generate roughly $140-466 billion in private sector spillover savings over ten years, reflecting reductions in private cost-sharing and premiums. The range captures three possible assumptions: 30% adoption of site-neutral payments by commercial insurers and employers, 50% adoption, and full adoption. This implies a rate of about $0.9 to $3.0 of commercial savings per $1 of Medicare savings. Applying that ratio to MedPAC's $6 billion single-year estimate implies commercial spillover of roughly $5.5 billion to $18 billion, for a combined one-year total of about $12 billion to $24 billion in 2021. This serves as a rough approximation, assuming the commercial spillover scales proportionally with Medicare savings; CRFB's ratio also reflects a broader set of services than MedPAC's.

Table 1. Site-Neutral Payment Proposals and Estimated Savings[a]

Source	Source Year	Services Covered	Settings Covered	Target Payment Rate[b]	1-Year Medicare Savings[c] (Savings Year)	1-Year Beneficiary Cost-Sharing Savings (Savings Year)	10-Year Medicare Savings (10-year Window)
CMS, CY27 OPPS proposed rule	2026	Imaging without contrast	Grandfathered off-campus HOPDs	PFS equivalent	$190 million (2027)	$70 million (2027)[d]	—
H.R.5378, Lower Costs, More Transparency Act	2023	Drug administration	Off-campus HOPDs	PFS equivalent (~40% of OPPS)	$212 million (Lou et al. 2025) (2021)	$42 million (Lou et al. 2025) (2021)	$3.7 billion (CBO) (2024-33)
CBO	2024	Drug administration	All off-campus HOPDs	40% of OPPS	$300 million (2026)	—	$5.6 billion (2025-34)
President's FY2019 Budget	2018	All services	Off-campus HOPDs	Physician office rate	$360 million (CBO) (2019)	—	$13.9 billion (CBO) / $34.0 billion (OMB) (2019-28)
CBO	2024	Imaging	All off-campus HOPDs	40% of OPPS	$400 million (2026)	—	$7.6 billion (2025-34)

Source	Source Year	Services Covered	Settings Covered	Target Payment Rate[b]	1-Year Medicare Savings[c] (Savings Year)	1-Year Beneficiary Cost-Sharing Savings (Savings Year)	10-Year Medicare Savings (10-year Window)
Actuarial Research Corporation (ARC)	2024	Drug administration, imaging, diagnostics (12 ambulatory payment classifications)	Off-campus HOPDs	40% of OPPS	$516 million (Lou et al. 2025) (2021)	$103 million (Lou et al. 2025) (2021)	—
President's FY2021 Budget	2020	All services	Off-campus HOPDs	Physician office rate	$890 million (CBO) (2021)	—	$39.1 billion (CBO) / $47.2 billion (OMB) (2021-30)
President's FY2021 Budget	2020	Selected services	On-campus HOPDs	Physician office rate	$2.5 billion (CBO) (2021)	—	$102.3 billion (CBO) / $117.2 billion (OMB) (2021-30)
President's FY2020 Budget	2019	All services	Off-campus HOPDs	Physician office rate	—	—	$28.7 billion (OMB) (2020-29)
S.1869, SITE Act	2023	All services	Off-campus HOPDs	40% of OPPS (70% for off-campus EDs within 6 miles of a hospital)	—	—	$30–40 billion over ten years from removing the 2015 grandfathering provision (CRFB)
MedPAC	2022	Certain services deemed safe to provide outside hospitals	On- and off-campus HOPDs, plus ASCs	Office rate, or ASC rate (by where the service is most commonly performed)	$6.6 billion (2019)	$1.7 billion (2019)	—
MedPAC	2023	66 ambulatory payment classifications deemed safe to provide outside hospitals	On- and off-campus HOPDs, plus ASCs	Office rate, or ASC rate (by where the service is most commonly performed)	$6.0 billion (2021)	$1.5 billion (2021)	—
CBO	2024	Most services commonly supplied in physician's offices	On- and off-campus HOPDs	40% of OPPS	$7.4 billion (2026)	—	$156.9 billion (2025-34)
S.1629, Same Care, Lower Cost Act	2025	MedPAC services + Secretary additions	On- and off-campus HOPDs, plus ASCs	Secretary-determined site-neutral rate, guided by MedPAC	—	—	$150 billion over ten years (CRFB)
Committee for a Responsible Federal Budget	2021	All off-campus services + selected on-campus services	On- and off-campus HOPDs	Office-equivalent rate; ASC-equivalent for selected procedures	—	—	$153 billion (2021-30)

Footnotes

a The rows are ordered by first-year savings where a source published one, and otherwise by the annualized average of the 10-year score. The two MedPAC rows, which reflect the same recommendation across two report years, are shown in report-year order. As noted below, these one-year figures are not a single construct; the ordering is indicative only, and the 10-year column does not increase monotonically.

b Each row states the target rate as its source specifies it. CMS's "PFS-equivalent" rate and "40% of OPPS" refer to the same mechanism: a flat 40% of the OPPS rate that CMS applies to approximate the physician office (PFS) payment. Because the 40% factor is flat, it can differ from the true, service-specific PFS rate.

c One-year figures are reported on different reference years. The CMS entry is its estimate for the first year the policy takes effect; CMS did not publish a multi-year estimate. The CBO entries are the first year of a 10-year window and sit well below the window's average annual savings, as the estimated savings grow over time. The MedPAC and Lou et al. (2025) entries are single-year, fully implemented estimates—the reduction in that reference year's spending had the aligned rates been in effect. Figures are meant to be indicative and not strictly comparable across rows.

d CMS also estimates roughly $70 million in reduced beneficiary premiums for this proposal.

Existing Policy Proposals

The proposals above differ most visibly in how far each reform reaches into on-campus care. The narrower proposals—drug administration alone (H.R.5378), or reforms confined to off-campus departments (the SITE Act, S.1869)—leave on-campus HOPDs untouched, even though on-campus departments account for the bulk of hospital outpatient spending. Only the broadest proposals extend site-neutral payment to on-campus sites and drive the largest ten-year savings, such as the Same Care, Lower Cost Act (S.1629) and CBO's broadest 2024 budget option. A second dimension is what happens to the money each reform saves. Savings can be reinvested in financially vulnerable hospitals, applied to deficit reduction, or returned within OPPS on a budget-neutral basis, and the bills differ in which path they take.

Senators Cassidy and Hassan released a bipartisan framework in November 2024—not yet in legislative text—that proposes site-neutral payment for off-campus HOPDs and for common outpatient services delivered on-campus. The framework would reinvest part of the resulting savings in rural and safety-net hospitals. S.1629 takes a similarly broad approach to settings but does not pair it with a comparable reinvestment provision.

CMS has advanced site-neutral payment reform one service at a time—clinic visits in 2019, drug administration in 2026, and imaging without contrast proposed for 2027—and only at off-campus departments. That authority stops at on-campus HOPDs, where the bulk of outpatient spending sits. Administrative action can keep narrowing the gap service by service, but aligning payment across most outpatient care still requires congressional action.

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