Site Neutrality: Impact of Payment Differentials and Updated Savings Estimates

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SUMMARY

- In most states, payment rates that vary by site-of-service incentivize performing care in high-cost hospital outpatient departments (HOPDs) rather than lower-cost physician offices and ambulatory surgical centers (ASCs). The alternative payment system used in Maryland reverses these incentives. Comparing site-of-service patterns nationwide to those in Maryland allows for estimation of the impacts of payment differentials.
- Across the services MedPAC has suggested for site neutral payment reform, the share provided in HOPDs was 10 percentage points higher nationwide than in Maryland in 2024, and this gap has grown from 7 percentage points in 2017. Maryland's experience offers a directional benchmark for a lower-cost pattern of care achieved without adverse outcomes.
- Between 2017 and 2024, HOPD utilization of certain services increased nationwide and decreased in Maryland. For example, the HOPD share of drug administration increased nationally from 37% to 39% while falling in Maryland from 26% to 23%. For other services, such as imaging, HOPD utilization remained flat nationwide yet was lower and continued to decline in Maryland. This divergence suggests that clinical and technological advances have allowed more services to be delivered safely in physician offices and ASCs, but payment differentials have muted this cost-saving progress outside of Maryland.
- We identified 16 additional service categories beyond the widely cited MedPAC list that are performed more frequently in office or ASC settings than in HOPDs in Maryland. These services, which include imaging with contrast and some endovascular procedures, may warrant consideration for site neutral payment policies.
- CMS recently finalized site neutral payment for off-campus HOPD drug administration effective in 2026. We project CMS's expansion of site neutrality for off-campus HOPD drug administration will save $5 billion in federal spending and $3 billion for Medicare beneficiaries over the next decade.
- CMS is considering further expansion of site neutral payments, and this brief includes our updated savings estimates for expansion scenarios. Including off-campus HOPD imaging would save an additional $6 billion in federal spending and $3 billion for beneficiaries over ten years. Including on-campus HOPD clinic visits would save an additional $24 billion in federal spending and $13 billion for beneficiaries. These amounts represent a small share of potential upper-bound savings from comprehensive site neutrality, which could exceed $200 billion for the federal government and $100 billion for beneficiaries over ten years.

BACKGROUND

Many medical services can be safely performed in multiple settings, including physician offices, ambulatory surgical centers (ASCs), and hospital outpatient departments (HOPDs), but payment rates vary widely by setting. For identical services, HOPD payment is often two to four times higher than physician offices or ASCs.[1] [2] These differentials

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create strong financial incentives for hospitals and physicians to shift services into higher-paid settings. Consistent with these incentives, hospitals have increasingly acquired physician practices and converted them into hospital outpatient departments.[3] [4]

Site neutral payment reform, which aligns payments for similar services across settings, has long been proposed by MedPAC and other stakeholders as a policy strategy to reduce spending growth driven by site-of-service differentials.[5] CMS has introduced site neutrality in limited steps – first for newly established (non-grandfathered) off-campus HOPDs in 2017 and then removing the grandfathering exception for off-campus clinic visits in 2019. These changes were narrow, however, affecting about 1% of HOPD spending.[6]

In 2026, CMS is taking another modest step by removing grandfathering for off-campus drug administration.[7] CMS presented evidence that the share of drug administration performed in HOPDs has increased over time and linked these trends to its statutory responsibility to "control unnecessary increases in the volume of outpatient services." CMS also signaled potential future expansion by soliciting comments on extending site neutral payment to additional services, including imaging and on-campus clinic visits.

In this brief, we examine the extent to which hospital outpatient payment policy is associated with site-of-service utilization patterns, using Maryland as a benchmark. Maryland operates under a unique hospital global budget payment model that incentivizes care in non-hospital settings, in contrast to volume-driven incentives that exist in the rest of the country. A recent study published in *Health Affairs* found substantially lower outpatient utilization in Maryland than elsewhere,[8] suggesting Maryland may serve as a benchmark for "what could have been" in the absence of site-of-service payment differentials. Here, we build on that study by comparing changes in service-level site-of-service mix in Maryland with the rest of the country between 2017 and 2024. This framing shifts the policy question from whether HOPD utilization volume has increased in absolute terms to whether it remains higher than necessary.

Using this framework, we also identify a broader set of services than those previously highlighted by MedPAC for which site neutral payment may be appropriate. We also update projections of potential reductions in federal health care spending under various site neutral expansion scenarios. These scenarios include the 2026 expansion for off-campus drug administration services, potential extension to imaging and on-campus clinic visits, and more comprehensive reforms.

COMPARING NATIONAL HOPD UTILIZATION TO MARYLAND

Maryland Global Budgets

The state of Maryland has a long history of testing unique payment models to incentivize efficient hospital care, beginning in 1977 with an inpatient hospital all-payer rate setting system. To better incentivize coordination of care across inpatient and outpatient settings, Maryland introduced global budgets, covering all hospital spending, in the 2014-2018 Maryland All-Payer Model (MDAPM), and retained global budgets in the 2019-2026 Total Cost of Care (TCOC) Model. Under global budgets, Maryland hospitals are exempt from the Medicare Inpatient and Outpatient Prospective Payment Systems (IPPS and OPPS). Instead, combined inpatient and outpatient revenue is set prospectively each year by the Maryland Health Services Cost Review Commission (HSCRC).[9] [10] [11]

Global budgets create fundamentally different incentives for outpatient care delivery than the OPPS. Under global budgets, hospitals do not receive additional revenue for providing more outpatient services. Because each additional service still incurs a cost, incremental volume results in a financial loss. In contrast, services delivered in non-hospital settings such as physician offices and ASCs are not included in the global budget framework, so

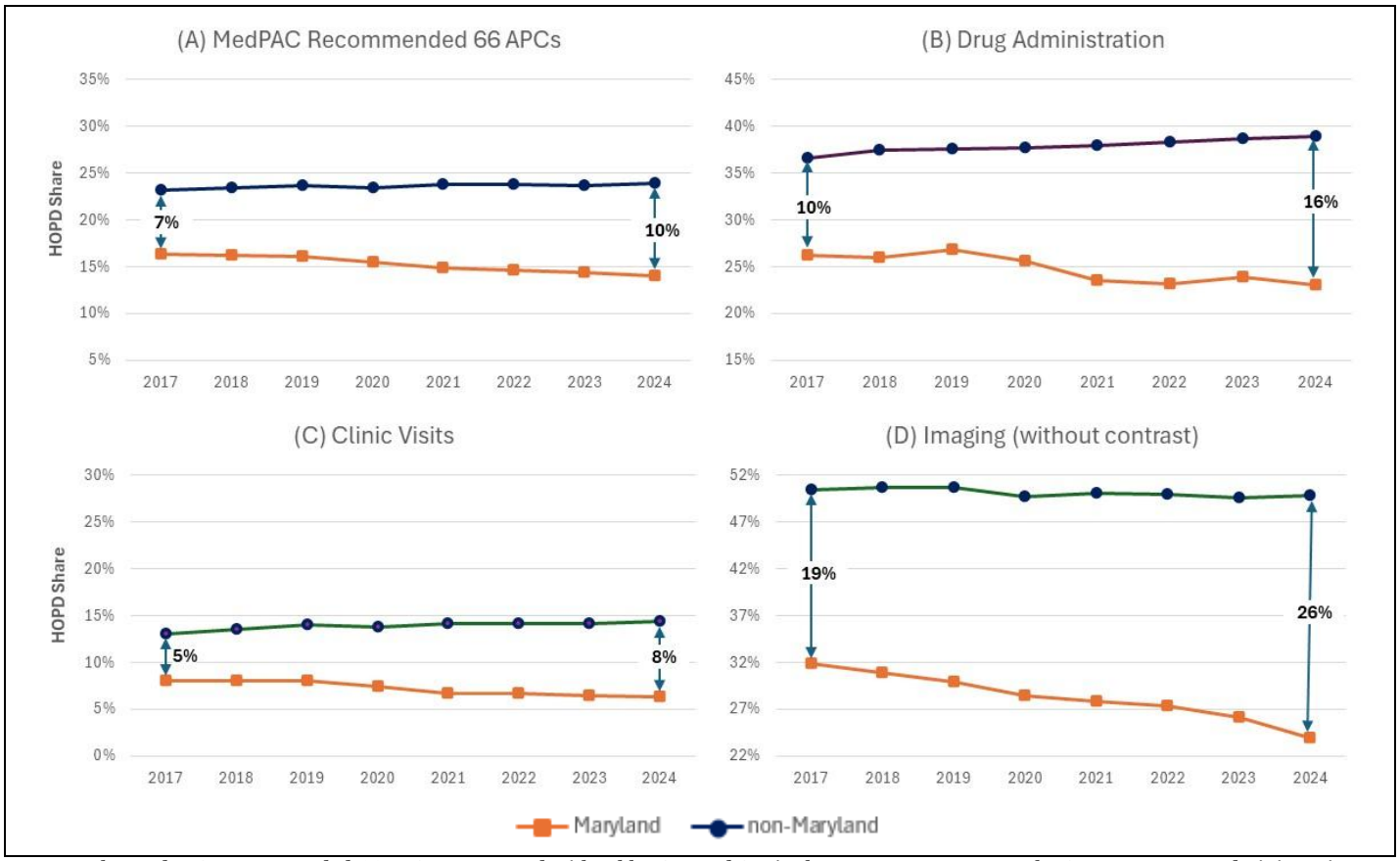
additional volume in these settings results in higher revenue. This creates a strong financial incentive to keep services that can be safely and appropriately delivered outside of hospitals in non-hospital settings, rather than shifting to HOPDs. Outside of Maryland, incentives operate in the opposite direction, with hospitals receiving full payment under the OPPS for each outpatient service provided, such that incremental revenues exceed incremental costs, encouraging the provision of additional services in HOPDs.[12]

Given these contrasting incentives, Maryland provides a real-world counterfactual, illustrating how a different payment structure is associated with a lower-cost site-of-service mix. We compared nationwide HOPD utilization to Maryland in order to quantify the extent to which payment incentives are associated with both levels and trends in HOPD utilization. Importantly, evaluations of Maryland payment models have not found adverse impacts to clinical outcomes or patient experiences.[13] [14] This suggests that the observed site-of-service mix in Maryland is consistent with clinical and technological capabilities that enable safe care delivery outside acute settings.

Results

Exhibit 1 presents four panels comparing the regression-adjusted share of services delivered in HOPDs in Maryland with the rest of the nation. See Appendix 1 for a description of the methodology.[15]

EXHIBIT 1: COMPARING PORTION OF SERVICES IN HOPDS, MARYLAND VERSUS NON-MARYLAND, 2017-2024



Notes: The MedPAC Recommended 66 APCs correspond with tables 8-2 and 8-3 in the June 2023 Report to the Congress. Drug Administration are services which map to APCs 5691 through 5694. Clinic visits are APC 5012, or services with an outpatient office visit HCPCS code. Imaging (without contrast) are services which map to APCs 5521 through 5524. The HOPD Share metric reflects unique service instance counts taking place at any on or off-campus HOPD in the numerator divided by unique service instance counts taking place at any HOPD, ASC, or physician office in the denominator. See Appendix 1 for additional results, measures of statistical significance, and statistical methods.

Panel A shows utilization for all services in the 66 APCs that MedPAC has identified as candidates for site neutral payment.[16] Outside of Maryland, the share of these services provided in HOPDs remained roughly flat from 2017 to 2024, at about 24%. In contrast, Maryland began with an HOPD share 7 percentage points below the national level in 2017, and this declined further to a 10pp gap by 2024.

Panel B focuses on drug administration services, corresponding to the APCs for which CMS expanded site neutral payment to all off-campus HOPDs in the 2026 OPPS rule. Outside of Maryland, the share of these services delivered in HOPDs increased from 37% in 2017 to 39% in 2024, a pattern directionally consistent with CMS's discussion in the final rule. In Maryland, HOPD use declined over the same period, widening the gap between Maryland and the rest of the nation from 10pp to 16pp.

Panel C focuses on clinic visits. In the 2026 OPPS rule, CMS indicated it is considering expanding site neutrality for clinic visits to on-campus HOPDs. For these services, the share delivered in HOPDs increased slightly outside of Maryland from 13% in 2017 to 14% in 2024, while declining in Maryland from 8% to 6%. Over this period, the gap between Maryland and the rest of the nation increased from 5pp to 8pp.

Panel D focuses on imaging services (without contrast), another category often discussed in the context of site neutrality. Outside of Maryland, the share delivered in HOPDs remained flat at 50% from 2017 to 2024. However, in Maryland, the share of imaging in HOPDs was lower and declined meaningfully, from 32% to 24%, leading to the gap between Maryland and the rest of the nation widening from 19pp in 2017 to 26pp in 2024.

Additional results for all APCs that have been proposed for site neutrality, in graphical and tabular format, including measures of significance are in Appendix 2.[15]

Interpretations

Our analysis found consistent, meaningful, and widening differences in HOPD utilization between Maryland and the rest of the country. Maryland's global budget model strongly incentivizes reductions in service provision in HOPDs, while site-of-service differentials elsewhere incentivize HOPD utilization. Site neutral payment reform falls between these two extremes, reducing but not eliminating the marginal revenue associated with providing incremental services in HOPDs. Despite the strong incentives under global budgets to keep care out of hospitals, and the correspondingly lower HOPD utilization observed in Maryland, evaluations of the Maryland model have not identified adverse effects on patient experiences or outcomes.[13] [14] Therefore, Maryland may serve as a useful benchmark for the share of care that can be safely delivered outside of hospitals.

For many services, the share delivered in HOPDs declined in Maryland while remaining flat nationally. One interpretation of this is that broad trends, such as technological innovation and clinical advances, have enabled more services to be safely delivered in physician offices. In Maryland, where global budgets remove the incentives favoring higher-paid sites-of-service, these advances have translated into shifts in utilization toward physician offices and ASCs. Outside of Maryland, by contrast, the effects of these advances may have been offset by site-of-service payment differentials that continue to favor HOPDs. This dynamic is particularly plausible for imaging services: technological progress has been well-documented and a growing share of physician offices maintain in-house imaging capacity, yet the share of imaging in higher-cost HOPDs remains high outside of Maryland.[17] [18] [19] [20]

In the 2026 OPPS rule, CMS focused on services, like drug administration, that have experienced absolute increases in the share of services in HOPDs, reflecting a conservative and service-specific interpretation of the statutory requirement to control for "unnecessary increases" in HOPD volume. Maryland's experience, however, illustrates how utilization patterns may differ in the absence of site-of-service payment differentials. This evidence suggests

that the relevant policy question may not be whether HOPD utilization has increased for a specific service in absolute terms, but whether HOPD utilization for some services has remained higher than necessary.

ADDITIONAL SERVICES TO CONSIDER FOR SITE NEUTRAL REFORM

MedPAC identified 66 APCs as candidates for site neutral payment reform in its June 2022 and June 2023 reports to Congress.[16] [21] This set of 66 APCs has become a commonly cited reference for comprehensive site neutrality among stakeholders interested in site neutral reforms.[22] [23]

MedPAC has defined a site neutral payment principle that payment should be based on the most efficient clinically appropriate setting. To identify APCs which are candidates for meeting this standard, MedPAC identified services for which ASCs or physician offices accounted for the largest share of utilization from 2016 through 2021.[24] This assumes that a plurality of utilization in non-hospital settings serves as a potential indicator that the service can be safely furnished outside of HOPDs. MedPAC also emphasized that CMS should retain ultimate discretion in determining which services are subject to site neutral payment to ensure clinical appropriateness is considered.

Because site-of-service payment differentials have existed for many years, relying on 2016–2021 utilization patterns to identify candidate services for site neutrality may be overly conservative – that is, physician office and ASC service volumes may be low due to long-standing payment differentials. As an alternative benchmark, Maryland's site-of-service mix can provide additional insight. In Maryland, the absence of site-of-service payment differentials is often associated with a substantially higher share of services delivered outside of HOPDs. For services exhibiting this pattern, the Maryland experience indicates that they can be safely furnished outside of HOPDs and that higher payment for delivery in an HOPD may not be warranted.

Following this logic, we identified 16 APCs for consideration for site neutral payment which are not on the MedPAC list. For four of these APCs, most claims in Maryland were furnished in physician offices. For three APCs, most claims in Maryland were furnished in ASCs. Eight APCs had a share of claims provided in physician offices in Maryland exceeding the national share by at least 10%, with several of these approaching a plurality. We also identified one APC for which physician offices have become the most common site-of-service nationally in 2024 data. Exhibit 2 lists the 16 APCs, and Appendix 4 provides additional methodological detail and supporting data.[15] Site neutral savings estimates in Exhibit 3 include a scenario if site neutral payment was extended to these services.

Our identification of these APCs is based on service volume only, and any final determination regarding site neutral payment reform should also incorporate clinical considerations.

EXHIBIT 2: ADDITIONAL APCS FOR SITE NEUTRAL REFORM CONSIDERATION

APC	Description	Align With	2024 OPPS Amount ($ million)	Explanation
5193	Level 3 Endovascular Procedures	PFS	$1,274	Office share in Maryland at least 10% higher than nationally
5572	Level 2 Imaging with Contrast	PFS	$878	Office most common in Maryland
5594	Level 4 Nuclear Medicine and Related Services	PFS	$861	Office most common in Maryland
5465	Level 5 Neurostimulator and Related Procedures	ASC	$582	ASC most common in Maryland
5301	Level 1 Upper GI Procedures	ASC	$541	ASC most common in Maryland
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	PFS	$526	Office share in Maryland at least 10% higher than nationally
5571	Level 1 Imaging with Contrast	PFS	$522	Office share in Maryland at least 10% higher than nationally
5183	Level 3 Vascular Procedures	PFS	$502	Office most common in Maryland
5194	Level 4 Endovascular Procedures	PFS	$458	Office most common site nationally
5113	Level 3 Musculoskeletal Procedures	ASC	$305	ASC most common in Maryland
5192	Level 2 Endovascular Procedures	PFS	$243	Office most common in Maryland
5591	Level 1 Nuclear Medicine and Related Services	PFS	$85	Office share in Maryland at least 10% higher than nationally
5592	Level 2 Nuclear Medicine and Related Services	PFS	$44	Office share in Maryland at least 10% higher than nationally
5673	Level 3 Pathology	PFS	$44	Office share in Maryland at least 10% higher than nationally
5672	Level 2 Pathology	PFS	$22	Office share in Maryland at least 10% higher than nationally
5661	Therapeutic Nuclear Medicine	PFS	$5	Office share in Maryland at least 10% higher than nationally

Notes: Based on ARC comparison of Maryland and non-Maryland site-of-service mix. OPPS amounts include Medicare-paid and beneficiary cost sharing, and are geographically standardized. See Appendix 4 for supporting data and methodological details.

UPDATED FEDERAL SAVINGS PROJECTIONS FROM SITE NEUTRALITY EXPANSION

Exhibit 3 presents projected federal and beneficiary savings under different site neutral policy alternatives. Projections are generated using ARC's site neutrality simulation model, which we have used for savings projections in several site neutral policy briefs.[1 6 25 26] For this analysis, we updated the underlying claims data to 2024 Medicare administrative data and calibrated projections to the 2025 Medicare Trustees Report and the 2025 National Health Expenditures Accounts projections.

Site neutrality for drug administration services was expanded from non-excepted off-campus HOPDs to all off-campus HOPDs as part of the 2026 OPPS rule. We project that this policy will result in $5.4 billion in federal savings and $2.9 billion in beneficiary savings over the next decade. While meaningful, these savings remain modest in the context of the overall site neutral savings potential. We have previously estimated that the 2017 and 2019 site neutral implementations impacted approximately 1% of total outpatient spending. Adding drug administration at excepted off-campus APCs increases this by 0.2%.

If drug administration were made site neutral in on-campus HOPDs, federal savings would increase to a more substantial $23.8 billion over the next decade. Expanding site neutrality for clinic visits to all HOPDs, as mentioned for consideration in the 2026 OPPS rule, would result in savings of $24.4 billion for the federal government. Site neutrality for imaging (without contrast), also mentioned in the OPPS rule, could save $5.8 billion if applied in off-campus HOPDs and $32.4 billion if applied in all HOPDs.

Expanding site neutrality to all 66 APCs identified by MedPAC would result in ten-year federal savings of $20.6 billion if applied to off-campus HOPDs and $145.8 billion if applied to all HOPDs.

Adding the 16 APCs identified in our analysis would increase savings by an additional $4.3 billion in the off-campus HOPD scenario and $65.8 billion in the all-HOPD scenario. Of this, endovascular procedures contribute 41% of the projected additional savings and imaging (with contrast) another 24% (not shown in table).

Finally, making all services at off-campus HOPDs site neutral, as proposed in the framework put forth by Senators Bill Cassidy, M.D. (R-LA), and Maggie Hassan (D-NH), would generate $6.8 billion in additional federal savings relative to the MedPAC and ARC APC lists. We did not estimate an on-campus HOPD component for this all-APC scenario, as such an approach has not been considered a plausible policy option.

EXHIBIT 3: FEDERAL AND BENEFICIARY SAVINGS FROM SITE NEUTRALITY EXPANSION SCOPES, 2026-2035, $ BILLIONS

($ billions)	**Federal Savings** (a)		**Beneficiary Savings** (b)	
Scenario	**Off-Campus HOPDs**	**All HOPDs**	**Off-Campus HOPDs**	**All HOPDs**
Drug Administration Services	$5.4 (c)	$23.8	$2.9 (c)	$12.8
Clinic Visits	(d)	$24.4	(d)	$13.1
Imaging (without Contrast)	$5.8	$32.4	$3.1	$17.4
Remaining MedPAC APCs (e)	$9.3	$65.3	$5.0	$35.2
Subtotal: MedPAC 66 APCs	**$20.6**	**$145.8**	**$11.1**	**$78.5**
ARC 16 Additional APCs	$4.3	$65.8	$2.3	$35.4
All Other APCs	$6.8	-	$3.7	-
Total: Site Neutral Upper-Bound	**$31.7**	**$211.6**	**$17.0**	**$113.9**

Source: ARC's site neutrality simulation model, calibrated to the 2024 Medicare 5 percent sample Limited Data Set (LDS) and the 2025 Medicare Trustees Report. Notes: (a) Federal savings reflect reductions in traditional Medicare spending, lower Medicare Advantage benchmarks and spending, decreased Medicaid spending for dually eligible Medicare beneficiaries, and reduced federal spending on Affordable Care Act Marketplace premium subsidies; (b) Includes beneficiary cost sharing and Medicare Part B premiums; (c) Newly implemented in 2026; (d) Implemented in 2019–2020; (e) Excludes drug administration, clinic visits, and imaging services without contrast, such that rows in this table are mutually exclusive. Drug administration services are site neutral in 2026 at off-campus HOPDs, and associated projections reflect 2026–2035 savings. All other scenarios reflect 2027–2035 savings, assuming implementation effective in 2027. Site neutrality is assumed to be implemented using a relativity adjuster that reflects differences in OPPS and PFS annual updates, which are assumed to converge to projected medical inflation over the 10-year projection period.

The savings projections here assume site neutrality is implemented across all HOPDs paid under the OPPS. An important consideration in site neutral payment reform is its potential impact on rural and financially vulnerable facilities. CMS has already exempted rural Sole Community Hospitals from site neutral policies, and many rural facilities are not paid under the OPPS and would not be impacted by site neutral policies, such as Critical Access Hospitals, Rural Health Centers, and Federally Qualified Health Centers. The Cassidy-Hassan framework went further, proposing to use site neutral savings to reinvest in high needs hospitals. While this brief does not explicitly model the exclusion of specific facility types, the effect of such exclusions on projected savings is small. As we have previously shown, the overwhelming majority of projected site neutral savings are generated by non-rural facilities paid under OPPS.[6]

CONCLUSION

The expansion of site neutral payment policies continues to represent a meaningful opportunity for cost savings for both the federal government and Medicare beneficiaries. In 2026, for the first time since 2019, CMS expanded the scope of site neutral payments, with the removal of the grandfathering exception for drug administration services at off-campus HOPDs. CMS also outlined considerations for additional site neutral payment reforms in the future.

In this brief, we highlighted the extent to which site-of-service payment differentials are associated with differences in site-of-service mix. We used Maryland as a benchmark given the state's strong economic incentives to deliver care in non-hospital settings. For services under consideration for site neutral payment reform, HOPD utilization is 10 percentage points higher outside of Maryland than in Maryland, a gap that has widened from 7 percentage points over the past eight years.

We also used the Maryland benchmark to identify an additional 16 APCs that warrant consideration for site neutral payment reform. Expanding site neutral payments to all these services, at on- and off-campus HOPDS, would represent a potential upper bound of site neutral payment reform. We estimated ten-year savings associated with this upper bound to exceed $200 billion for the federal government and $100 billion for Medicare beneficiaries.

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.

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