New Analysis: CMS Site-Neutral Proposal Would Cut Hospital Imaging Payments by $256 Million - With Total Medicare Exposure Potentially Exceeding Half a Billion Dollars in 2027

WASHINGTON – August 31, 2026 - A new hospital-level analysis of the Centers for Medicare & Medicaid Services' proposed CY 2027 site-neutral payment policy for outpatient imaging finds that the proposal would reduce Traditional Medicare payments to hospitals by approximately **$256.2 million** in its first year, with more than 1,100 hospitals experiencing payment reductions. The proposal is part of CMS' proposed CY27 Outpatient Prospective Payment System (OPPS) rule.

- Click here for the hospital-specific impact (Excel File).
- Click here for the methodology used by Dobson|DaVanzo, the firm contracted to conduct the analysis.

The analysis also suggests that the ultimate impact on hospitals could be substantially larger because Traditional Medicare now accounts for less than half of the Medicare population. Medicare Advantage covers approximately 55% of Medicare beneficiaries eligible for the program. Although Medicare Advantage plans negotiate their own provider contracts and do not automatically adopt every Medicare fee-for-service payment change, many contracts reference Medicare payment methodologies. If the proposed reductions are substantially replicated in Medicare Advantage contracts, total Medicare-related hospital revenue reductions could exceed $500 million annually.

CMS has characterized the proposal as a cost-saving measure designed to ensure that Medicare and its beneficiaries do not pay more for the same imaging service simply because it is provided in a hospital outpatient department rather than a physician office or other freestanding setting. CMS estimates the provision would reduce Medicare Part B expenditures by approximately $260 million in 2027 and reduce beneficiary cost-sharing by approximately $70 million.

Does lowering the government reimbursement rate actually lower the cost of providing the care?

Reducing the price Medicare pays for an MRI, X-ray or other imaging service does not necessarily reduce the underlying cost of performing that service. The patient still receives the care. The imaging equipment must still be purchased, operated and maintained. Technologists and other clinical personnel must still be employed. Hospitals must continue to support the infrastructure, regulatory compliance and other operating requirements associated with hospital outpatient departments. Unless those costs are actually eliminated, a reduction in Medicare reimbursement is primarily a payment reduction rather than an equivalent reduction in the resources required to provide care.

The analysis produces several significant findings:

1. The hospital-level data essentially confirms CMS's national estimate.
Across 3,104 hospitals in the analysis, current Traditional Medicare payments for the imaging services studied total approximately **$2.94 billion**. The proposed site-neutral adjustment reduces those payments by approximately **$256.2 million**, or **8.7%**, closely matching CMS's stated national estimate of approximately $260 million.

2. More than one-third of hospitals in the analysis would experience a direct payment reduction.
Of the 3,104 hospitals analyzed, **1,126 hospitals - approximately 36%** - would lose Medicare imaging revenue under the proposal. Among hospitals affected by the policy, the aggregate reduction equals approximately **14.2%** of their current Medicare payments for these imaging services.

3. For hundreds of hospitals, this is not a marginal payment adjustment.
The proposed policy would reduce current imaging payments by:

- At least 10% at 487 hospitals;
- At least 20% at 231 hospitals;
- At least 30% at 90 hospitals;
- At least 40% at 26 hospitals; and
- At least 50% at six hospitals.

These figures demonstrate that the national average masks substantially greater exposure at individual hospitals.

4. The reductions are heavily concentrated among a relatively small number of hospitals and states.
The 50 hospitals facing the largest reductions would absorb approximately **$84.2 million** in Traditional Medicare cuts - **32.9%** of the entire **$256.2 million** national reduction. In other words, fewer than 2% of the hospitals analyzed would bear nearly one-third of the total payment reduction.

The geographic concentration is also significant. Five states alone account for nearly 40% of the estimated Traditional Medicare reduction:

- Pennsylvania - $26.6 million
- New York - $23.3 million
- Ohio - $19.6 million
- California - $17.0 million
- Florida - $14.3 million

The 10 states with the largest reductions account for approximately 61% of the entire $256 million national impact.

5. The $256 million figure may significantly understate the hospital impact.
Medicare Advantage now enrolls approximately **55%** of eligible Medicare beneficiaries, compared with roughly 45% in Traditional Medicare.

Medicare Advantage payment effects cannot simply be assumed to equal Traditional Medicare because MA plans generally have flexibility to negotiate provider payment rates. Nevertheless, where hospital contracts establish payments as a percentage of Medicare rates or otherwise incorporate Medicare payment methodologies, the site-neutral policy could flow through to MA reimbursement.

Using Medicare enrollment shares simply as an illustration, a Traditional Medicare reduction of $256 million could correspond to approximately **$313 million** of additional Medicare Advantage exposure, producing a potential combined Medicare impact of roughly **$569 million annually**. Actual MA effects will depend on individual payer-provider contracts.

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