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Payor Pressure and Patient Demand Accelerate Outpatient Shift

Recent data from two healthcare analytics firms quantify the continued migration of hospital services from inpatient to outpatient settings.[1] In June 2026, Vizient, Inc. projected that adult outpatient volumes in the U.S. will grow 20% over the next decade, compared with 7% growth in inpatient discharges.[2] In October 2026, Strata Decision Technology reported that this migration is concentrating higher-acuity patients in the inpatient setting.[3] These findings coincide with efforts by both Medicare and commercial payors to narrow payment differentials between hospital-based and non-hospital sites of care, efforts that further encourage the movement of services out of the hospital.[4] This Health Capital Topics article reviews the recent data on the outpatient shift and the payment policy changes accompanying it.

Forecasted Growth by Site of Care

Vizient's 2026 Impact of Change forecast projects demand for healthcare services from 2026 through 2036, modeling how population, epidemiological, technological, policy, and care delivery factors interact to change utilization.[5] Within the outpatient continuum, the forecast projects 15% growth in hospital outpatient department (HOPD) and ambulatory surgery center (ASC) volumes and 16% growth in office and clinic volumes.[6] Population growth and aging account for most of the projected change in both settings, contributing 14 percentage points to each forecast.[7] For inpatient care, however, Vizient projects that changes in how care is organized and delivered (which it terms "Systems of CARE") will reduce demand by eight percentage points, offsetting more than half of the population-driven growth.[8] Vizient also identifies payor pressure to shift care into lower-cost settings as a driver of outpatient demand.[9]

Patient preferences and clinical advances also contribute. Patients increasingly favor accessible facilities with lower out-of-pocket costs, and innovations such as minimally invasive surgery have made many procedures less expensive to perform in outpatient settings.[10] Outpatient procedures can cost up to 50% less than the same service performed in an inpatient setting.[11]

These trends vary considerably by service line.[12] Vizient projects that orthopedics and spine inpatient volumes will decline 4% over the decade while outpatient volumes grow 17%.[13] For surgery generally, Vizient characterizes the outpatient shift as largely complete, with the remaining inpatient surgical cases more complex.[14]

Acuity Concentrating in the Inpatient Setting

Strata's report on the first half of 2026 draws on data from over 2,200 hospitals.[15] It found that inpatient case mix index (CMI) continues to rise in service lines where over 90% of volume occurs in outpatient settings, which Strata describes as an expected result: as lower-acuity cases leave the hospital, the patients who remain are, on average, more acute and resource-intensive.[16] Gynecology illustrates the pattern, as inpatient gynecology volumes declined 8% in the first half of 2026, which Strata links to the migration of hysterectomy procedures to outpatient settings as minimally invasive and robotic techniques have advanced.[17] The pattern is not universal; breast health inpatient volumes grew 17.2% over the same period, an increase Strata notes its data cannot explain on their own.[18]

Strata's financial data show margins improving but still constrained. Median health system operating margins opened 2026 in negative territory before recovering to 0.7% in June, still below the 1.0% to 1.5% range observed during the second half of 2025.[19] Health systems have invested heavily in outpatient care, and their operating margins have begun to recover as that pivot continues.[20] Revenue mix also varies substantially by hospital size; hospitals with over 500 beds derive nearly half of gross operating revenue from inpatient care, compared with roughly 10% for hospitals with 25 or fewer beds.[21]

Medicare Policy Toward Site Neutrality

Medicare payment policy has reinforced these trends.[22] In its calendar year (CY) 2026 Hospital Outpatient Prospective Payment System (OPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) began a three-year phase-out of the inpatient only (IPO) list, removing 285 mostly musculoskeletal procedures for 2026.[23] CMS also added 289 procedures to the ASC covered procedures list (CPL) under revised criteria, plus 271 codes removed from the IPO list.[24] The same rule extended the site-neutral volume control method that CMS previously applied to clinic visits to drug administration services furnished in excepted off-campus provider-based departments (PBDs), paying those services at the Medicare Physician Fee Schedule (MPFS)-equivalent rate.[25] CMS estimated that this change would reduce OPPS spending by $290 million in 2026.[26]

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The 2027 OPPS proposed rule would continue both policies.[27] CMS proposed to remove 637 additional services from the IPO list and to add 618 codes to the ASC CPL.[28] CMS also proposed to apply the MPFS-equivalent rate to imaging services without contrast furnished in excepted off-campus PBDs, with an exemption for rural sole community hospitals.[29]

Congress has also acted. Section 6225 of the Consolidated Appropriations Act, 2026 (CAA 2026) conditions OPPS payment for items and services furnished by off-campus PBDs on or after January 1, 2028, on each department obtaining a National Provider Identifier (NPI) separate from that of the main hospital and submitting an attestation of compliance with Medicare's provider-based requirements.[30] CMS proposed to codify these requirements in the 2027 OPPS proposed rule.[31]

The requirement addresses billing practices that have grown alongside hospital consolidation, as hospitals acquire independent practices and reclassify them as HOPDs that bill at higher hospital rates.[32] Research has found that hospital-owned outpatient departments charge prices as much as 13.5 times higher than standalone physician offices for some services.[33]

Commercial Payors Follow

On September 29, 2026, Elevance Health announced billing policies, applicable across its commercial, Medicare Advantage, and Medicaid businesses, that will require hospitals to identify the physical location where care was provided, verify that information against hospital addresses, pay certain off-campus hospital services at off-campus rates, and prevent hospital-rate billing for certain lab tests performed elsewhere.[34] Elevance serves approximately 45 million members across its health plans.[35] The insurer plans to implement the policies throughout 2026 and 2027 and describes itself as the first commercial payor to announce an intent to require physical location on billing forms and adjust rates accordingly.[36] Elevance characterized the policies as consistent with growing federal and state attention to outpatient billing, citing the federal off-campus requirements scheduled to take effect in 2028.[37]

The American Hospital Association (AHA) opposes the policy, stating that reimbursement cuts for certain HOPD services "may force hospitals to reduce or even eliminate access to care" at those locations.[38] Hospital groups have long argued that higher hospital outpatient rates reflect costs that physician offices do not bear, including 24-hour operations, greater overhead, and the obligation to treat all patients regardless of ability to pay.[39]

Conclusion

The Vizient and Strata data describe a delivery system in which outpatient settings will absorb most volume growth over the coming decade, while inpatient beds increasingly serve higher-acuity patients. Medicare and commercial payment policy are moving in the same direction, steadily narrowing the reimbursement premium historically attached to services furnished in hospital-based outpatient departments, particularly at off-campus locations. As the 2028 NPI requirement makes the site of service visible on claims, the distinction between on-campus and off-campus care is likely to carry growing financial weight for hospitals that have expanded their outpatient footprint through PBDs.

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