Clinical Trial Site Payment Benchmarks 2026: Fees and Rates

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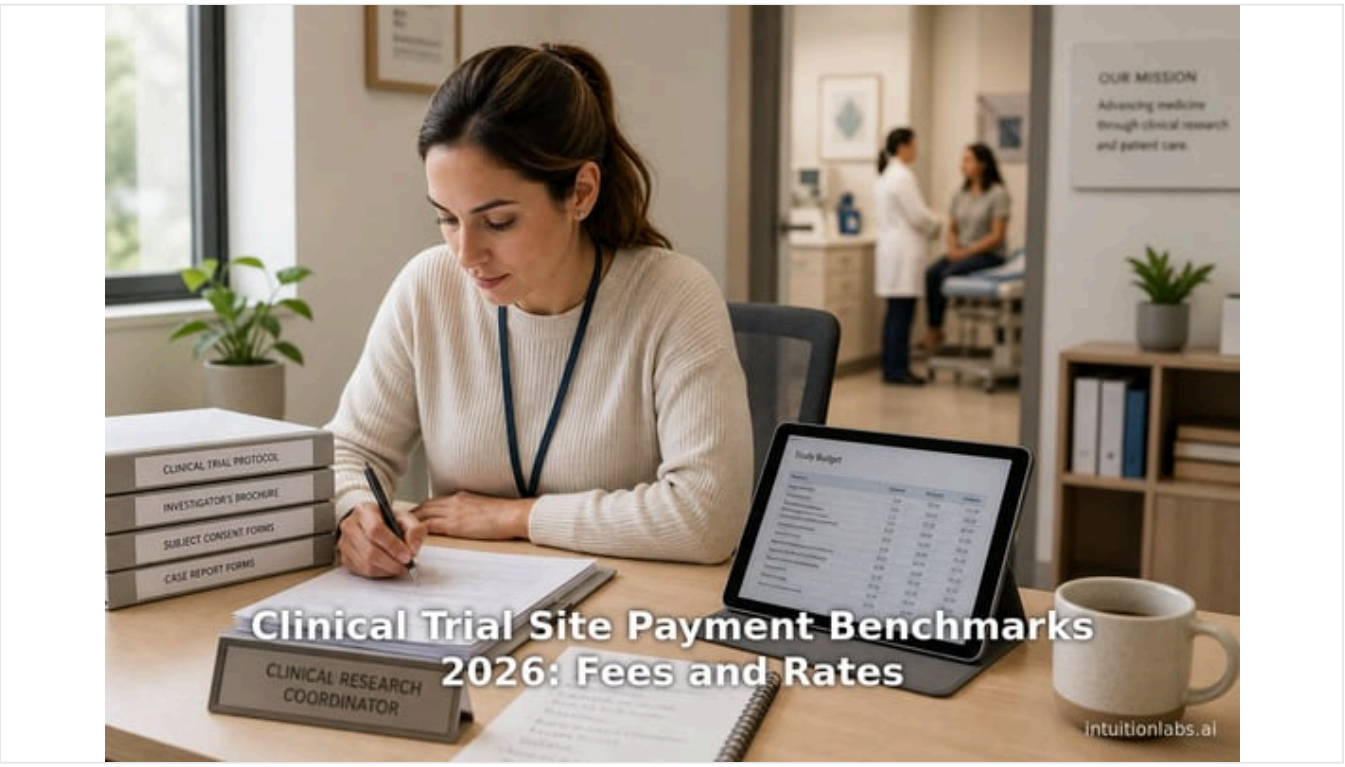


Clinical Trial Site Payment Benchmarks 2026: Fees and Rates

Executive Summary

This article surveys clinical trial site payment evidence available in 2026, including industry surveys of payment terms and timing and public, institution-specific fee examples; it does not provide representative cross-institutional 2026 per-visit or per-procedure rates. The available cash-reserve figures document financial pressure but use different thresholds and therefore do not establish a comparable worsening trend. The **Society for Clinical Research Sites (SCRS)** 2023 Site Landscape Survey found that **38%** of investigative sites experienced a profit decline in 2023 and that nearly **80%** of sites carry less than six months of operating capital (Source: myscrs.org) (Source: myscrs.org). The most current large-sample benchmark, the **2025 WCG CenterWatch Global Site Relationship Survey** (over 12,000 site responses, 19,300+ sponsor ratings, deployed January 20, 2025), found that site satisfaction with "timely payments in accordance with payment schedules" fell from 68.9 in 2023 to 65.3 in 2025, a 3.6 point decline, and satisfaction with "fair overall payment amounts" fell from 67.4 to 63.2, a 4.2 point decline (Source: centerwatch.com).

No single publisher currently reports one clean "average days to payment" figure for the industry as a whole; the most defensible 2026 picture instead comes from converging proxies. SCRS's most recent modeling shows that shifting a site from monthly to quarterly payment terms extends the accounts receivable cycle from an average of **45 days to 137 days** (Source: myscrs.org), and the 2023 Landscape Survey found **23%** of sites already carry 31 to 40% of their invoices more than 90 days past due (Source: myscrs.org). A 2023 industry survey of 189 sponsor and CRO (contract research organization) representatives by **Greenphire** found that paying sites on time is sponsors' single largest self-reported payment challenge, even as 100% of respondents agreed that payment timeliness affects site relationships (Source: suvoda.com). Sponsor/CRO budget negotiation cycles average roughly 100 to 109 days industry-wide according to Advarra and ACRP-published commentary, while automation vendors such as Advarra claim to cut this to 30 to 45 days for outsourced clients, and site-level start-up data from CRIO's SASI benchmark puts the median contract turnaround closer to 9 days once a study is actively moving (Source: advarra.com) (Source: clinicalresearch.io).

On rates, published institutional overhead (indirect cost) policies include Georgetown University Medical Center's **35%** rate, effective February 1, 2025 (Source: clinicaltrials.georgetown.edu); UCLA raised its rate from 26% to **33%** effective October 1, 2024 (Source: ora.research.ucla.edu); and UC Davis and Southern Illinois University report rates of 32% and 31% respectively (Source: research.ucdavis.edu) (Source: siumed.edu). A Journal of Clinical Oncology abstract reviewing more than 170 site budgets found per-patient investigator grant costs for Phase I oncology studies rose from **$30,000 to $40,000 in 2015** to **$70,000 to $110,000 by 2025**, an increase of roughly 133% to 175% (Source: doi.org), a trend consistent with broader analyses of what it costs to bring a drug to market.

The technology response has accelerated in 2025 and 2026: **IQVIA** launched its agentic-AI Clinical Trial Financial Suite in September 2025, projecting up to a 50% reduction in payment processing time and reporting that its underlying platform has already processed over $15 billion in site payments (Source: iqvia.com); **Greenphire**, which merged with Suvoda in April 2025, reports having facilitated over $7 billion in site payments across 80-plus countries (Source: suvoda.com); and **Veeva Systems**, **Medidata**, **Advarra**, and newer entrants such as Ledger Run are competing to automate what remains, by IQVIA's own account, a largely manual, cross-system workflow (Source: clinicaltrialsarena.com), a competitive landscape mirrored in EDC software pricing comparisons of the same vendors. Regulators are also active: HHS's **Office of Inspector General (OIG)** listed a formal Request for Information under June 22, 2026; it was published in the *Federal Register* on June 24, 2026. The RFI asks whether new or modified Anti-Kickback Statute safe harbors are needed for clinical trial participant remuneration, with public comments due August 24, 2026 (Source: oig.hhs.gov). Against a global clinical trials market that Grand View Research estimates at $89.0 billion in 2025, growing at a 7.7% compound annual growth rate (CAGR) to $158.4 billion by 2033, the economics of site payment remain a persistent point of friction between sites and the sponsors and CROs that fund them (Source: grandviewresearch.com).

Introduction and Background

Every clinical trial runs on two parallel currencies: the scientific data a site generates and the cash a sponsor or CRO owes that site for generating it. The second currency gets far less public attention than protocol design or endpoint selection, yet it determines whether a research site can keep its lights on, retain a trained coordinator, or take on the next study at all. This report assembles the clearest available **clinical trial site payment evidence for 2026**: industry evidence on payment timing, terms, and negotiation; institution-specific public examples of overhead and itemized fees; and the changing payment-technology landscape. Its public fee examples are not presented as representative 2026 market rates for visits or procedures.

The stakes are larger than they might first appear. The global clinical trials market was estimated at **$89.0 billion in 2025** and is projected to reach **$94.0 billion in 2026** en route to **$158.4 billion by 2033**, a 7.7% CAGR, according to Grand View Research (Source: grandviewresearch.com). The adjacent global CRO services market was valued at **$92.27 billion in 2025** and is projected to grow to **$99.87 billion in 2026** and **$199.28 billion by 2034** at a 9% CAGR, per Fortune Business Insights (Source: fortunebusinessinsights.com). As of January 2024, **477,346 clinical trials** were registered globally on ClinicalTrials.gov, with roughly 30% (145,575) registered in the United States, per the same Fortune Business Insights market analysis (Source: fortunebusinessinsights.com). Registered studies span multiple recruitment and completion statuses and may use different study designs. Active studies that use investigative sites can incur site-payment obligations for activities such as screening, enrollment, and follow-up. Yet the sites executing this work are frequently thinly capitalized. SCRS's 2023 Site Landscape Survey, drawing on roughly 550 site responses, found that **38%** of sites saw profit decline in 2023 and that nearly **80%** of sites carry less than six months of operating capital (Source: myscrs.org). A separately cited SCRS benchmark, referenced by payment-technology vendor Greenphire, puts the figure even more starkly: roughly half of sites carry three months or less of operating cash (Source: suvoda.com). That fragility makes payment timing, not just payment amount, a material determinant of whether a site network survives. A 2025 Milken Institute analysis of nearly 25,000 U.S. Phase 1 through 4 trials conducted between 2017 and 2024 found that **45% to 60%** of new clinical trial sites closed after hosting only one study in their first year, a failure rate reported as three times higher than that of new U.S. businesses generally (Source: techtarget.com).

Understanding site payment benchmarks requires separating several distinct but related questions: what sites are paid per procedure or visit (the fee schedule), how much of that payment institutions retain as overhead, how quickly sponsors and CROs actually pay once a milestone is hit, what leverage sites have when negotiating a budget, and how technology is changing the mechanics of disbursement. This report addresses each in turn, drawing on primary survey data from SCRS, WCG (formerly CenterWatch), ACRP (the Association of Clinical Research Professionals), Tufts University's Center for the Study of Drug Development (CSDD), university indirect-cost policies, vendor platform data from Greenphire, IQVIA, Medidata, Veeva Systems, and Advarra, and named regulatory and legal actions from 2023 through 2026.

Methodology and the State of Site Payment Benchmarking

No single, universally accepted dataset publishes a definitive "average days to payment" figure across the clinical trials industry, and this report treats that absence as a finding in its own right rather than papering over it with an invented number. Instead, the credible benchmarks come from several distinct, periodically repeated survey programs, each with its own sample and cadence, which this report treats as complementary proxies rather than a single authoritative series.

The **Society for Clinical Research Sites (SCRS)**, a nonprofit representing thousands of investigative sites globally, has run the longest-standing site-payment research program, beginning with a 2012 publication and continuing through a 2016 to 2017 global survey of 760 sites, its 2023 Site Landscape Survey of roughly 550 sites, and a formal **Payment Initiative** with named workstreams on holdback elimination, monthly payment cadence, and screen-failure funding (Source: myscrs.org) (Source: myscrs.org). **WCG**, through its CenterWatch division, has run the **Global Site Relationship Survey** biennially since 1997, with the 2025 edition collecting over 12,000 site responses and 19,300-plus sponsor ratings across attributes that include contracts and budgets (Source: centerwatch.com). **ACRP** published its first national workforce survey, with more than 735 respondents fielded between December 2024 and February 2025, in September 2025 (Source: acrpnet.org). **Tufts CSDD** has periodically surveyed sponsor and CRO start-up timelines, most notably a study of over 400 companies published in 2018 (Source: pubmed.ncbi.nlm.nih.gov). Finally, payment-technology vendors, chiefly Greenphire (now merged with Suvoda) and IQVIA, have published their own market surveys, which this report treats as tier-4 vendor evidence, clearly labeled as such, rather than independent academic research.

Institutional overhead rates, by contrast, are directly documented: individual academic medical centers publish their industry-sponsored clinical trial indirect cost rates as public policy memos, which this report treats as primary, first-party evidence for the specific institution named, though not necessarily representative of the sector as a whole. Where sources disagree, for example on the size of a "typical" negotiation timeline (ACRP-cited figures put it above 100 days industry-wide, while site-level operational data from CRIO's SASI benchmark shows median turnarounds closer to 9 days once a study is in motion), this report presents both figures with their distinct definitions rather than collapsing them into a single misleading number (Source: acrpnet.org) (Source: clinicalresearch.io).

Payment Timing, Terms, and Holdbacks

Delayed payment and holdbacks are prominent site concerns, but available evidence also documents concerns about budget adequacy and the funding of screen failures. ACRP found that 31% of surveyed clinical-research professionals reported that study budgets were sufficient to support good operations, while SCRS reported that 88% of sites said screen failures were not sufficiently covered financially (ACRP (SCRS. SCRS's original 2016 to 2017 global survey of 760 sites, fielded between December 20, 2016 and February 7, 2017, found that **83%** of sites indicated a preference for payment to arrive in 30 days or less (Source: myscrs.org), and that same era of data showed **66%** of sites globally carried less than three months of operating cash (Source: myscrs.org). Nearly a decade later, the underlying dynamic has not resolved. SCRS's 2023 Site Landscape Survey found that only **51%** of sites reported having monthly payment agreements with sponsors or CROs, meaning roughly half of sites are still paid on a slower cadence (Source: myscrs.org), and **23%** of sites reported that 31% to 40% of their invoices were already more than 90 days past due (Source: myscrs.org).

Payment schedule structure matters as much as speed. In the 2023 SCRS survey sample, respondents reported payment arrangements that can include milestones such as startup, enrollment, visits, and closeout, and some arrangements include a **holdback** until study conclusion. Within that survey, the most common reported holdback amount was **10% to 14%** of earned revenue (Source: myscrs.org), a figure consistent with SCRS's more recent economic-impact modeling, which describes typical holdbacks as "often around 10%" of earned revenue, withheld until study completion (Source: myscrs.org). SCRS's own case-study modeling estimates that a single site can lose value equivalent to over **$169,000** as a result of unfavorable payment terms across a study's life cycle (Source: myscrs.org). Perhaps the single clearest cash-flow statistic in the current dataset: SCRS's analysis finds that shifting a site from monthly to quarterly payment terms extends its accounts receivable period from an average of **45 days to 137 days**, nearly tripling the cash-conversion cycle for an operation that, per the same body of research, frequently has only a few months of cash reserves to begin with (Source: myscrs.org).

Table 1 below consolidates the most current and traceable timing and satisfaction benchmarks into a single reference.

METRIC	BENCHMARK VALUE	SOURCE AND SAMPLE	AS-OF DATE
Sites preferring payment within 30 days	**83%**	SCRS/Greenphire global survey, 760 sites (Source: myscrs.org)	2017
Sites with monthly payment agreements	**51%**	SCRS 2023 Site Landscape Survey, roughly 550 sites (Source: myscrs.org)	2023
Sites with 31 to 40% of invoices >90 days late	**23%**	SCRS 2023 Site Landscape Survey (Source: myscrs.org)	2023
Most common holdback amount	**10 to 14%** of earned revenue	SCRS 2023 Site Landscape Survey (Source: myscrs.org)	2023
AR cycle, monthly vs. quarterly terms	**45 days vs. 137 days**	SCRS economic impact analysis (Source: myscrs.org)	Dec 2025
Sites with <6 months operating capital	**roughly 80%** (2023) vs. **66%** (2016)	SCRS Landscape Survey and Global Perspective white paper (Source: myscrs.org)	2023 / 2016
Site satisfaction: "fair overall payment amounts"	**63.2** (2025) vs. **67.4** (2023), down 4.2 pts	WCG CenterWatch Global Site Relationship Survey, 12,000+ sites (Source: centerwatch.com)	2025
Site satisfaction: "timely payments per schedule"	**65.3** (2025) vs. **68.9** (2023), down 3.6 pts	WCG CenterWatch Global Site Relationship Survey figures cited above	2025
Sites believing study budgets are sufficient	**31%**	ACRP national workforce survey, 735+ respondents (Source: acrpnet.org)	Sept 2025

The table shows that, in the WCG survey, satisfaction with payment fairness and timeliness declined between 2023 and 2025, while SCRS data documents continuing cash-flow fragility and invoice aging. These findings coexist with continuing investment in payment technology, but the cited surveys do not measure automation adoption or isolate its effect on payment satisfaction.

Per-Visit Rates, Overhead, and Fee Schedules

Clinical trial budgets are built from two structurally different components: the direct, procedure-level costs a site bills for conducting specific study activities, and the indirect overhead rate that a site's parent institution (typically an academic medical center or health system) applies on top as a markup for administrative support. Published institutional examples document changes in certain overhead rates, while a 2026 Journal of Clinical Oncology conference abstract reports higher direct costs within its proprietary oncology sample.

On the indirect cost side, academic medical centers publish industry-sponsored clinical trial overhead rates as institutional policy. The following examples document the policies at the named institutions; they do not establish a sector-wide trend. **Georgetown University Medical Center** set its indirect cost rate at **35%** of direct costs effective February 1, 2025 (Source: clinicaltrials.georgetown.edu). **UCLA** raised its rate from 26% to **33%** of total direct costs effective October 1, 2024 (Source: ora.research.ucla.edu). **UC Davis** applies a **32%** facilities and administrative (F&A) rate to total direct costs, effective January 1, 2021 (Source: research.ucdavis.edu), and **Southern Illinois University School of Medicine** applies a **31%** rate effective July 1, 2024, further describing an indirect cost rate of 31% as "consistent with the current standard rate charged to all pharmaceutical/device companies" for clinical trials (Source: siumed.edu). These are institution-specific examples, not a representative sector-wide benchmark. Overhead can vary materially by institution, therapeutic area, and the applicable cost base. For example, a 2026 Journal of Clinical Oncology conference abstract reported 40% to 50% overhead at 20 U.S. oncology academic centers in 2025; this proprietary-data finding is limited to the abstract's oncology sample and is not a sector-wide benchmark. One additional line item sites must weigh: the University of Iowa's negotiation guidance warns that if a sponsor routes central Institutional Review Board (IRB) fees through the university rather than paying the IRB directly, the sponsor incurs an additional **25% to 40%** institutional markup on that fee alone (Source: dsp.research.uiowa.edu).

Direct, line-item fees show similar granularity where institutions publish them openly. A University of Iowa negotiation guide dated 2012 lists a non-refundable start-up fee of approximately **$5,000**, noting that some studies were **$8,000 to $11,500**; it does not establish a current market range, and the guide does not state that the higher amounts are additional to the approximately $5,000 figure (Source: dsp.research.uiowa.edu). The University of Utah publishes a detailed, standardized invoiceable fee schedule for fiscal year 2026 that includes items such as an IRB amendment fee of **$3,350** per occurrence (Source: qualitycompliance.research.utah.edu). At the procedure level, the University of Southern California's Clinical Trials Unit publishes an industry chargemaster that prices a single 12-lead electrocardiogram (EKG) without interpretation at **$109.40** and a first-tube intravenous blood draw at **$36.00**, effective July 1, 2023 (Source: sc-ctsi.org). These published chargemasters are dated, institution-specific reference points for itemized fees. They do not establish typical 2026 market rates or validate ranges in commercial FMV (fair market value) benchmarking databases.

Where sites lack institutional fee transparency, they typically rely on commercial FMV benchmarking. **Medidata's** Grants Manager platform draws on the PICAS database, which the company describes as containing over **30,000 protocols**, 2,300 indications, and more than **350,000 negotiated investigator agreements** compiled over nearly 30 years, positioned as the industry's most extensive objective source for per-procedure and per-visit rate benchmarking (Source: medidata.com). A 2026 Journal of Clinical Oncology conference abstract from Premier Research, based on a proprietary review of more than 170 oncology site budgets, reported that per-patient investigator grant costs rose approximately **133% to 175%** between 2015 and 2025, with average Phase I oncology per-patient grant costs rising from **$30,000 to $40,000 in 2015** to **$70,000 to $110,000 by 2025** (Source: doi.org). This conference-abstract finding is limited to the reviewed oncology budgets and does not establish general clinical-trial site-payment rates. The same analysis found oncology principal investigator (PI) salaries rose an average of **24%** from 2021 to 2025, clinical research coordinator salaries rose approximately **33%** over the same period, and **81.5%** of oncology trials undergo at least one protocol amendment, each of which typically triggers additional site fees (Source: doi.org).

Wage pressure independently pushed budgets upward across the broader site landscape, not just oncology. IQVIA's clinical operations white paper reports that post-pandemic site staff attrition climbed from a pre-pandemic range of **10% to 37%** up to **35% to 61%**, and that to recruit and retain staff, sites have needed **30% to 50%** staffing budget increases (Source: iqvia.com). WCG's budget commentary notes that sites are increasingly restructuring one specific line item, archiving fees, from a one-time flat fee into a recurring yearly fee, sometimes covering records-retention periods as long as **25 years**, reflecting both regulatory retention requirements and the recognition that archiving was chronically underpriced in older budget templates (Source: wcgclinical.com).

Table 2 summarizes representative overhead rates and fee benchmarks gathered from public institutional and vendor sources.

ITEM	RATE OR FEE	EFFECTIVE / AS-OF	SOURCE
Georgetown University overhead rate	**35%** of direct costs	Feb 1, 2025	Georgetown (Source: clinicaltrials.georgetown.edu)
UCLA overhead rate	26% raised to **33%** of total direct costs	Oct 1, 2024	UCLA (Source: ora.research.ucla.edu)
UC Davis F&A rate	**32%** of total direct costs	Jan 1, 2021	UC Davis (Source: research.ucdavis.edu)
SIU School of Medicine overhead rate	**31%** of direct costs	Jul 1, 2024	SIU (Source: siumed.edu)
University of Iowa start-up-fee guidance	**approximately $5,000**; some studies **$8,000 to $11,500**	2012 guide	University of Iowa; illustrative guidance, not a current market benchmark (Source: dsp.research.uiowa.edu)
IRB amendment fee (per occurrence)	**$3,350**	FY2026	University of Utah (Source: qualitycompliance.research.utah.edu)
Single 12-lead EKG, no interpretation	**$109.40**	Jul 1, 2023	USC / SC-CTSI chargemaster (Source: sc-ctsi.org)
Phase I oncology per-patient investigator grant, 2015 vs. 2025	**$30k to $40k** rising to **$70k to $110k** (+133 to 175%)	2025	JCO conference abstract / Premier Research proprietary review of 170+ oncology site budgets (Source: doi.org)

This table compiles institution-specific examples rather than a representative academic-center or industry benchmark. Overhead varies by institution, therapeutic area, and rate base; a 2026 Journal of Clinical Oncology conference abstract reported 40% to 50% overhead at 20 U.S. oncology academic centers in 2025, but that proprietary-data finding is limited to its oncology sample. The same abstract reported rising direct per-patient costs in its reviewed oncology budgets; it does not establish broader clinical-trial payment trends.

Budget Negotiation and Sponsor/CRO Payment Performance

Budget negotiation is where payment terms are actually set, and the data suggests both that negotiations are slow and that outcomes vary enormously depending on whether a site negotiates alone or through an intermediary. Commentary published in ACRP's Clinical Researcher in April 2025 states that the average time to negotiate a clinical trial contract now exceeds **100 days**, that sites often wait up to 90 days for compensation once terms are set, and that **80%** of sites have less than six months of operating cash on hand, a negotiating-power problem as much as a cash-flow one (Source: acrpnet.org). **Advarra**, which offers an outsourced site budget negotiation service, states that the industry average negotiation timeline is **109 days**, and that its own process reduces this to 30 to 45 days, a reduction of up to 72% (Source: advarra.com). Advarra further reports that while the industry average budget increase it observes sites secure independently is just **8%** per patient and **17%** for startup costs, its own negotiations consistently secure increases of **50%** per patient and **150%** for startup costs, a claim that, if representative, implies most individual sites negotiating alone leave substantial value on the table (Source: advarra.com). This report treats Advarra's specific percentages as a vendor claim rather than an independently audited statistic, though the direction (intermediary-assisted negotiation outperforming solo negotiation) is consistent with broader survey findings about sites' limited negotiating leverage.

Once a study is actively underway rather than in initial contract formation, negotiation cycles appear to move faster. Site operations platform CRIO's SASI (Site Activation Speed Index) benchmark reports a median budget negotiation turnaround of **9 days**, with top-quartile studies closing in 5 days and bottom-quartile studies taking 23 days, alongside a median time from site activation to first patient screened of **20 days** (Source: clinicalresearch.io). The apparent contradiction between this figure and the 100-plus day contract-negotiation statistics cited above is best explained

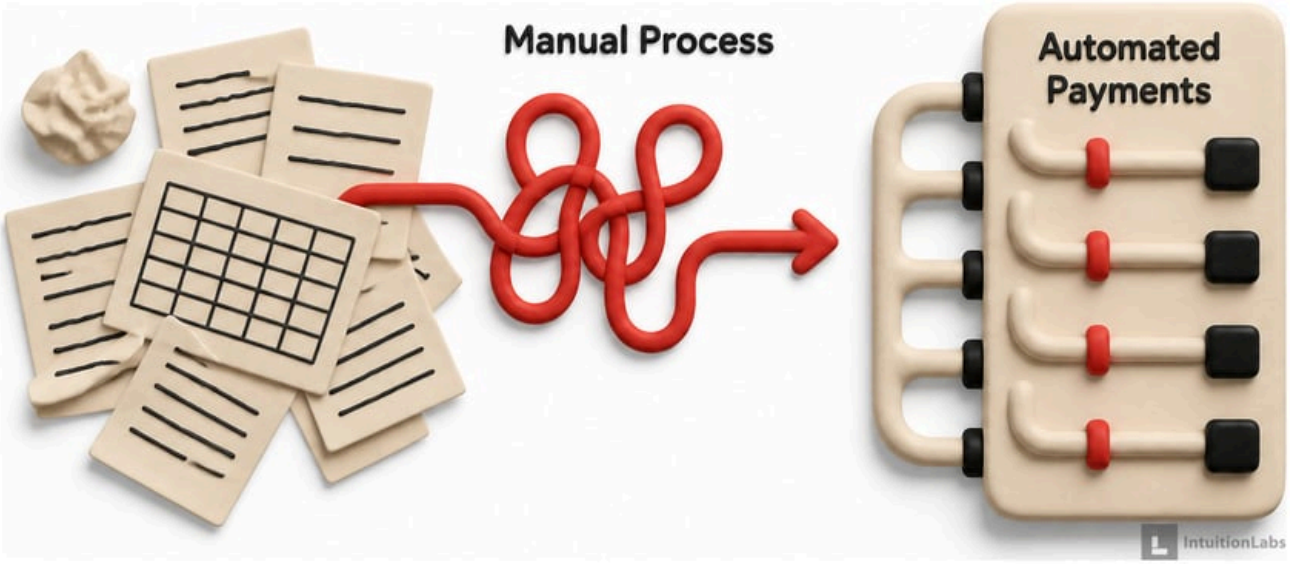
by definitional differences: the longer timelines describe the full cycle from initial protocol receipt through executed contract, while the SASI figure describes a narrower budget-revision turnaround once a study is already active. Sites and sponsors interpreting negotiation benchmarks should be explicit about which stage of the process a given statistic measures.

Sponsors and CROs themselves acknowledge the strain their own payment practices create. In Greenphire's 2023 survey of 189 sponsor and CRO representatives, **100%** of respondents agreed that the timeliness and accuracy of site payments affects their relationship with research sites, and sponsors' single largest self-identified challenge with the payment process was simply "paying sites on time," while CROs' top challenge was managing varying site and country requirements (Source: suvoda.com). That same survey found **93%** of sponsors and CROs agreed that lengthy budget negotiation cycles negatively affect site relationships (Source: suvoda.com). A more recent 2025 Suvoda commentary put a specific figure on one of the slowest categories, noting that sites and sponsors can spend **100-plus days** negotiating oncology study budgets specifically, consistent with oncology's disproportionately complex per-patient cost structure documented in the prior section (Source: suvoda.com).

The broader financial picture explains why negotiation leverage matters so much to sites. SCRS's 2024 Site Finances Whitepaper found that **88%** of sites report screen failures, patients who are screened but do not qualify for or complete enrollment, are not sufficiently covered financially by sponsors, a direct, quantified negotiation gap (Source: myscrs.org). To address these systemic gaps, SCRS maintains standardized negotiation tools, including a Site Invoiceables Toolkit built on a principled-negotiation methodology that scores site performance across ten dimensions rather than relying on ad hoc bargaining (Source: myscrs.org), and a formal Site Payments workstream that advocates for monthly payment cadence to match ongoing site expenditures such as staff salaries, rent, and participant payments (Source: myscrs.org).

Payment Technology and the Move Toward Automation

Recent vendor launches, product investment, and consolidation illustrate continued development in clinical trial site-payment technology. Vendor and survey evidence also indicates that manual, spreadsheet-based payment processes remain a material bottleneck for some organizations. Greenphire's own 2023 survey found that **20%** of sponsor and CRO respondents still managed site payments manually via email and spreadsheets, and only **24%** of that group reported being satisfied with the process (Source: www.suvoda.com). A Clinical Trials Arena op-ed by an IQVIA engineering lead, published in July 2026, makes the same point from the technology vendor side: "activities such as budget negotiations, invoice processing and payment distributions are often done manually and across disparate systems," a description that motivates the current build-out of integrated platforms (Source: clinicaltrialsarena.com).



Greenphire, which completed a merger with clinical trial technology company Suvoda on April 24, 2025, unifying trial randomization and consent technology with site financial management under common ownership, released its latest Site Payments platform upgrade in June 2024 following a multiyear investment of over **$20 million** in research and development (Source: prnewswire.com) (Source: clinicalresearchnewsonline.com). The platform, as of its 2024 relaunch, had supported more than **1,300 studies** and executed more than **7.6 million payments** across nearly 80 countries, and the company cited a survey finding that **82%** of sites report payment delays have a negative impact on their business operations as the rationale

for the investment (Source: clinicalresearchnewsonline.com) (Source: clinicalresearchnewsonline.com). By a separate account, Greenphire's Site Payments product has facilitated **$7 billion** in payments across 80-plus countries and delivers an **80%** reduction in time customers spend supporting site payment inquiries (Source: suvoda.com) (Source: suvoda.com).

IQVIA launched its agentic-AI-driven Clinical Trial Financial Suite (CTFS) on September 10, 2025, with general availability targeted for the first quarter of 2026, projecting up to a **50%** reduction in payment processing time for customers (Source: iqvia.com), a projection independently reported, and attributed to IQVIA, by Fierce Biotech (Source: fiercebiotech.com). The CTFS Site Payments module is described by IQVIA as built on a foundation that has already processed over **$15 billion** in site payments (Source: iqvia.com), while its companion CTFS GrantPlan budgeting module draws on **38 million** negotiated data points and is reportedly used by **90%** of top pharmaceutical companies (Source: iqvia.com). A Frost & Sullivan survey commissioned by IQVIA in May 2025 found that **58%** of sponsor executives already used IQVIA as their clinical trial financial management technology vendor (Source: iqvia.com).

Veeva Systems entered the site payment category earlier than most, introducing **Veeva Vault Payments** in January 2020 as an add-on to its Vault CTMS (Clinical Trial Management System) platform, explicitly framing the product around the industry's manual-process problem: "manual processes and fragmented systems often delay payments, leading to high dissatisfaction among clinical research sites," per the company's own launch announcement (Source: ir.veeva.com). The product, now marketed as Veeva Payments, automatically generates payment requests tied to specific visits and procedures and tracks them to completion (Source: veeva.com). CRO Ora, in a published customer story, reported that within several months of adopting Veeva Payments it had managed more than **$1 million** in site payments more efficiently than under its prior process (Source: veeva.com).

Advarra, better known for institutional review board and CTMS services, offers **CCPay**, a tool integrated with its Clinical Conductor CTMS that automates participant payment tracking and gives sites real-time financial visibility (Source: advarra.com), alongside its budget negotiation service discussed above. **Medidata's** Grants Manager applies AI-driven forecasting on top of its dynamic FMV benchmarks to model how changes in study timeline, region, or design affect projected site costs (Source: medidata.com). Newer entrant **Ledger Run**, which markets an AI-powered payments platform called ClinRun used, per the company, by three of the top ten pharmaceutical companies and two of the top five CROs across roughly 17,000 sites, argues that absent automation, "many organizations spend as much as 70% of their time manually tracking and processing site invoices" (Source: prnewswire.com).

Table 3 summarizes the primary named platforms competing in this category as of mid-2026.

PLATFORM	VENDOR	CORE CAPABILITY	REPORTED SCALE OR IMPACT
Site Payments	Greenphire (merged with Suvoda, April 2025)	Automated multi-rail site payment disbursement	$7B+ in payments facilitated across 80+ countries; 80% reduction in time spent on payment inquiries (Source: suvoda.com)
CTFS Site Payments	IQVIA	Agentic AI-driven payment processing within the Clinical Trial Financial Suite	Built on infrastructure processing $15B+ in payments; up to 50% projected reduction in processing time (Source: iqvia.com)
CTFS GrantPlan	IQVIA	AI-assisted investigator grant and budget benchmarking	38 million negotiated data points; used by 90% of top pharma companies, per IQVIA (Source: iqvia.com)
Grants Manager (PICAS)	Medidata	FMV benchmarking database with AI-driven cost forecasting	30,000+ protocols, 350,000+ negotiated investigator agreements (Source: medidata.com)
Veeva Payments	Veeva Systems	Vault CTMS add-on automating visit/procedure-based payment requests	Launched Jan 2020; CRO Ora managed $1M+ in site payments post-adoption (Source: veeva.com)
CCPay / Budget Negotiation	Advarra	Participant payment tracking; outsourced budget negotiation service	Reports cutting the 109-day industry-average negotiation timeline to 30 to 45 days (Source: advarra.com)
ClinRun	Ledger Run	AI-powered invoice and payment automation	Used across an estimated 17,000 sites; claims up to 70% of manual invoice-tracking time can be eliminated (Source: prnewswire.com)

Every figure in this table is a vendor-reported claim rather than an independently audited benchmark, and this report presents them as such. Even so, the consistency across competing vendors, all describing manual, fragmented, multi-week processes as the baseline they are displacing, corroborates the independent survey evidence of chronic payment friction documented in the preceding sections. The practical implication is that process redesign, not merely tool selection, tends to determine whether a payment automation investment closes the gap between vendor-projected and realized cycle-time improvements.

Data Analysis and Evidence

Stepping back from individual platforms and institutions, several quantitative threads recur across the independent survey data collected by SCRS, WCG, ACRP, and Tufts CSDD, and they are worth isolating as a distinct evidentiary base.

First, sample sizes and survey cadence matter for how much weight a given statistic should carry. The WCG CenterWatch Global Site Relationship Survey is the largest and longest-running site-satisfaction instrument identified in this research, having run biennially since 1997, with the 2025 edition, deployed beginning January 20, 2025, alone collecting over **12,000** site responses worldwide, yielding more than **19,300** individual sponsor ratings (Source: centerwatch.com). That survey found that site ratings on both "fair payment amounts" and "overall flexibility in contract and budget negotiations" declined approximately **5% to 6%** from 2023 to 2025, a broad-based erosion rather than an isolated metric. SCRS's 2023 Site Landscape Survey, drawing on roughly 550 sites, is the second-largest recurring instrument and the primary source for the cash-flow and holdback statistics cited throughout this report (Source: myscrs.org). ACRP's first national workforce survey, fielded from December 2024 to February 2025 and published in September 2025, adds a third independent lens specifically on operational sufficiency: only **31%** of the more than 735 respondents believed study budgets were sufficient to support good operations (Source: acrpnet.org).

Second, sponsor and CRO operational speed differs measurably, and the most rigorous available comparison, a Tufts CSDD study surveying more than 400 companies, found that CROs complete all site-related study start-up activities **6 to 11 weeks faster** than sponsors managing the process directly, with the overall site start-up process averaging **5 to 6 months** in total duration industry-wide (Source: pubmed.ncbi.nlm.nih.gov) (Source: pubmed.ncbi.nlm.nih.gov). Separately, Tufts CSDD data cited by clinical trial matching vendor PSI-CRO found that across the industry, **37%** of sites

enroll poorly and **11%** never enroll a single patient, underscoring that payment friction is one symptom of a broader site-performance variance problem rather than its sole cause (Source: psi-cro.com). Separate Tufts CSDD data indicates that the average time between protocol approval and first patient visit increased **45%** between 2015 and 2021, a lengthening of the overall trial start-up funnel independent of payment terms specifically (Source: iqvia.com).

Third, the regulatory and compliance backdrop against which all of this rate and timing data sits is itself active in 2026. The **FDA's** long-standing financial disclosure regulation, dating to a 1998 final rule, requires sponsors to certify or disclose specified clinical-investigator financial interests and compensation arrangements that could affect the reliability of study data (Source: fda.gov). This disclosure requirement is a relevant compliance consideration, not a federal framework that mandates FMV benchmarking or determines Anti-Kickback Statute compliance. Separately, FDA guidance on payment and reimbursement to research subjects (as distinct from payment to sites and investigators) states that reimbursing a subject's travel expenses does not itself raise concerns about undue influence, and that a small completion bonus is acceptable provided it is not coercive (Source: fda.gov) (Source: fda.gov). Most significantly for 2026 planning, HHS's Office of Inspector General listed a formal Request for Information under June 22, 2026; it was published in the *Federal Register* on June 24, 2026. It seeks public input on whether new or modified Anti-Kickback Statute safe harbors or Beneficiary Inducements Civil Monetary Penalty exceptions are needed specifically for remuneration provided to clinical trial participants, with comments due August 24, 2026 (Source: oig.hhs.gov). OIG guidance separately clarifies that compliance with an Anti-Kickback Statute safe harbor is voluntary, meaning failure to satisfy a safe harbor does not automatically render a payment arrangement illegal, a nuance relevant to how sponsors structure investigator and site compensation (Source: oig.hhs.gov). Under the federal Physician Payments Sunshine Act, manufacturers reporting research-related payments must identify the physician principal investigator and report the total aggregate research payment amount, including costs associated with patient care and professional time, obligations that indirectly reinforce FMV discipline in site contracting (Source: duanemorris.com). IQVIA describes FMV methodology as an industry standard in light of regulations and statutes including the Sunshine Act, False Claims Act, and Anti-Kickback Statute (Source: iqvia.com). That vendor description is not a legal safe harbor or an independent determination that a specific arrangement complies with the Anti-Kickback Statute.

Finally, on the technology adoption trend that connects payment benchmarks to broader industry AI investment, the IQVIA Institute's Global R&D Trends 2026 report found that the Phase I clinical success rate for AI-enabled emerging biopharma programs reached **75%**, described as a substantial advantage over comparable non-AI-enabled programs, with Phase II success rates roughly on par with industry peers (Source: iqvia.com). While that statistic concerns clinical development success broadly rather than payment operations specifically, it is directly relevant context for why sponsors and vendors alike are willing to invest tens of millions of dollars in AI-driven financial infrastructure: the same organizational capability building AI into trial design and operations is, in parallel, being applied to the financial plumbing connecting sponsors to sites.

Case Studies and Real-World Examples

The following five named, documented cases illustrate how site payment dynamics play out in practice across technology vendors, site networks, and dispute resolution.

Greenphire's 2024 Site Payments Relaunch

Facing survey data showing that **82%** of sites report payment delays negatively affect their business operations, Greenphire released a substantially upgraded Site Payments platform in June 2024, backed by a multiyear investment exceeding **$20 million** in research and development (Source: clinicalresearchnewsonline.com). By that point the underlying platform had already executed more than **7.6 million** payments across nearly 80 countries and supported over **1,300 studies**, illustrating both the scale of the payment-processing problem and the degree of capital now flowing into solving it (Source: clinicalresearchnewsonline.com). Less than a year later, on April 24, 2025, Greenphire completed a merger with clinical trial technology company Suvoda, consolidating site financial technology with trial randomization and consent management under one ownership structure, a consolidation move consistent with the broader trend of clinical technology platforms bundling previously siloed functions (Source: prnewswire.com).

IQVIA's Clinical Trial Financial Suite Launch

On September 10, 2025, IQVIA formally launched its agentic-AI-powered Clinical Trial Financial Suite, with the Site Payments and GrantPlan modules built on a base that has already processed over **$15 billion** in payments and **38 million** negotiated budgeting data points, respectively (Source: iqvia.com) (Source: iqvia.com). The company projected the suite could cut customer payment processing time by up to **50%**, a figure Fierce Biotech's independent trade coverage attributed directly to IQVIA's own estimate rather than presenting it as an independently verified outcome (Source:

fiercebiotech.com). The launch is notable as a case study because it represents one of the first instances of a major clinical technology vendor explicitly branding a site-payment product around agentic AI (AI systems capable of autonomously executing multi-step workflows) rather than simple workflow automation, with general availability targeted for the first quarter of 2026.

Veeva Payments and CRO Ora

Veeva Systems entered the site payment category with Veeva Vault Payments in January 2020, framing the launch explicitly around the industry-wide manual-process problem this report documents throughout (Source: ir.veeva.com). The company's published customer story with CRO Ora provides one of the few concrete before-and-after figures available in this category: within several months of go-live, Ora reported it had managed more than **$1 million** in site payments more quickly and easily than under its prior, presumably manual or spreadsheet-based, process (Source: veeva.com). This case illustrates a smaller, mid-sized CRO's experience with payment automation, distinct from the platform-scale statistics reported by Greenphire and IQVIA, both of which serve much larger customer bases.

Elligo Health Research's Growth Financing

Illustrating the capital dynamics on the site-network side of the payment relationship, integrated site network operator Elligo Health Research received a **$40 million** venture loan facility from Horizon Technology Finance in October 2023, financing intended to support continued growth of its combined health-system and site-network model (Source: ir.horizontechfinance.com). A comparable network, Javara, reported **52%** year-over-year revenue growth from the first quarter of 2025 to the first quarter of 2026 as it expanded into oncology and added new health-system partnerships, growth the company itself attributed to the strength of its "Integrated Research Organization" model (Source: linkedin.com). The Elligo case documents a venture-loan facility. The Javara case documents the company's self-reported revenue growth and expansion, but does not establish outside investment. Together, these cases illustrate different reported growth and financing developments among multi-site network operators; they do not support a broader conclusion about investment trends or sponsor trial-volume allocation.

CytoDyn v. Amarex Clinical Research

Not every sponsor-to-vendor payment relationship in clinical research resolves smoothly, and one dispute offers a rare public window into the dollar figures involved. Biopharmaceutical company CytoDyn's multi-year legal fight with its former CRO, Amarex Clinical Research, over billing disputes settled in July 2024, with Amarex paying CytoDyn **$12 million** in cash and eliminating a separate **$14 million** accounts-payable claim it had asserted against CytoDyn (Source: cytodyn.com). Court filings from earlier in the dispute show Amarex had separately demanded payment of over **$11.5 million** in outstanding invoices from CytoDyn, of which more than **$9.7 million** was described as overdue, illustrating how quickly clinical trial financial disputes between sponsors and their CROs can escalate into eight-figure legal exposure (Source: storage.courtlistener.com). While the dispute centered on the sponsor-CRO relationship rather than a direct site payment dispute, it demonstrates that the payment friction documented throughout this report at the site level exists structurally throughout the clinical trial contracting chain.

Implications and Future Directions

Several converging trends will shape clinical trial site payment practices through the remainder of 2026 and into 2027. The most immediate regulatory development is OIG's RFI, listed under June 22, 2026 and published in the *Federal Register* on June 24, 2026, on whether Anti-Kickback Statute safe harbors or Beneficiary Inducements Civil Monetary Penalty exceptions should be added or modified for remuneration to clinical trial participants; comments are due August 24, 2026 (Source: oig.hhs.gov). The RFI is not a proposed or final rule governing site or investigator payments. Any downstream implications for those arrangements would depend on subsequent agency action and its scope.

Second, the consolidation visible in the payment technology market, most notably the April 2025 Suvoda-Greenphire merger and IQVIA's September 2025 launch of an integrated, agentic-AI-driven financial suite, suggests the market is moving from point solutions (a payments module here, a budgeting tool there) toward unified financial operating systems that span budgeting, negotiation, invoicing, and disbursement (Source: prnewswire.com) (Source: iqvia.com). Whether this consolidation actually closes the satisfaction gap documented in the 2025 WCG survey, where fairness and timeliness scores both declined despite years of automation investment, remains an open empirical question that only the 2027 edition of that survey will be able to answer with comparable rigor.

Third, industry commentary increasingly frames payment practices themselves, not just their speed, as a competitive factor in how sites choose which sponsors to work with, particularly as holdback structures and inconsistent remuneration compound the administrative burden sites already report from protocol amendments and monitoring queries. That framing is consistent with the WCG CenterWatch findings above, where payment fairness

and negotiation flexibility scores both declined even as roughly 80% of sites report holding six months or less of operating cash, a level of financial fragility that turns payment experience into a de facto recruitment and retention factor for sponsors competing for scarce, high-performing site capacity (Source: myscrs.org).

Fourth, the documented rates at Georgetown, UCLA, UC Davis, and SIU show that institutional overhead varies and can change over time, but these examples do not establish an industry-wide trajectory into 2027. The oncology conference abstract reports higher per-patient investigator grant costs in its proprietary sample; it does not establish general overhead-rate movement (Source: doi.org). Sponsors budgeting multi-year studies should confirm the applicable institution's current policy and contractual treatment of any future rate changes. Finally, for organizations advising sponsors, CROs, and health systems on how to modernize the operational and data infrastructure surrounding clinical trial finance, the practical lesson from the technology section above is that platform adoption alone has not yet closed the payment-satisfaction gap; effective modernization appears to require pairing new payment tools with the kind of underlying process redesign and data integration work that spans budgeting, contracting, and disbursement systems, a discipline IntuitionLabs applies within the broader Veeva and life-sciences technology ecosystem as an official Veeva Vault CRM X-Pages Partner supporting enterprise integration across clinical and commercial systems (Source: intuitionlabs.ai).

Frequently Asked Questions (FAQs)

What are typical clinical trial per-visit payment rates in 2026?

No representative, publicly available cross-institutional 2026 rate exists. Rates vary by institution, region, therapeutic area, protocol, and applicable cost base. USC's 2023 Clinical Trials Unit chargemaster, for example, lists **$109.40** for a single 12-lead EKG without interpretation and **$36.00** for a first-tube intravenous blood draw; these are institution-specific examples, not typical market rates (Source: sc-ctsi.org). Medidata states that its proprietary PICAS database contains more than 350,000 negotiated investigator agreements, but that vendor-reported scale does not make its underlying rates publicly verifiable 2026 benchmarks (Source: medidata.com).

What is a typical clinical trial site overhead rate?

There is no defensible single typical rate. Georgetown (35%), UCLA (33%), UC Davis (32%), and SIU School of Medicine (31%) are institution-specific examples. A 2026 Journal of Clinical Oncology conference abstract also reported 40% to 50% overhead at 20 U.S. oncology academic centers in 2025, but this proprietary-data finding is limited to that oncology sample (Source: clinicaltrials.georgetown.edu) (Source: ora.research.ucla.edu). Overhead varies by institution, therapeutic area, and rate base, so parties should confirm the specific site's policy during budget negotiation.

What is the average number of days to payment for clinical trial sites?

No single publisher currently reports a definitive, industry-wide average days-to-payment figure. The closest available proxy is that **83%** of sites prefer payment within 30 days (Source: myscrs.org); yet, as detailed above, only 51% of sites report monthly payment agreements and 23% of sites already carry over 30% of invoices more than 90 days past due, underscoring the gap between preference and practice.

How should a site negotiate a clinical trial budget?

Available guidance points to three consistent levers: use principled, data-driven negotiation frameworks rather than ad hoc bargaining, such as the SCRS ten-dimension performance-scoring toolkit described above; push explicitly for monthly rather than quarterly payment cadence, given the documented 45-day versus 137-day accounts receivable gap between the two (Source: myscrs.org); and consider outsourced negotiation support, since vendors such as Advarra report securing materially larger budget increases than sites achieve negotiating independently (Source: advarra.com).

What are typical clinical research site payment terms?

Payment arrangements can use milestones such as startup activation, per-patient enrollment, per-visit completion, and study closeout rather than a flat retainer. Some arrangements include a holdback until study conclusion; in SCRS's 2023 survey, **10% to 14%** of earned revenue was the most commonly reported holdback amount (Source: myscrs.org). SCRS's Payment Initiative, described above, actively advocates for eliminating holdbacks entirely and standardizing monthly payment cadence across the industry.

How do CROs and sponsors compare on study start-up speed?

A Tufts CSDD study found that CROs completed site-related study start-up activities **6 to 11 weeks faster** than sponsors managing the process directly (Source: pubmed.ncbi.nlm.nih.gov). This is a study start-up finding, not evidence that CROs pay sites faster than sponsors; this article identifies no direct comparative payment-timing benchmark.

What does a 2026 clinical trial site fee schedule typically include?

Published institutional examples can include a non-refundable start-up fee, per-occurrence charges such as an IRB amendment fee (**$3,350** at the University of Utah), per-procedure charges such as a 12-lead EKG (**$109.40** at USC), and archiving fees. A University of Iowa guide dated 2012 lists approximately **$5,000** for a start-up fee and notes that some studies were **$8,000 to $11,500**; those figures are institution-specific illustrative guidance, not a common 2026 market range (Source: dsp.research.uiowa.edu) (Source: qualitycompliance.research.utah.edu) (Source: wcgclinical.com).

Conclusion

Clinical trial site payment benchmarks in 2026 describe an industry with documented institution-specific rates and technology responses, but persistent structural friction that neither has fully resolved. Published academic policies provide examples of overhead rates, not a representative sector-wide benchmark. A 2026 Journal of Clinical Oncology conference abstract reported 40% to 50% overhead at 20 U.S. oncology academic centers in 2025 and reported higher per-patient investigator grant costs in its proprietary oncology-budget review; neither finding establishes general site-payment rates. Vendors also report substantial payment-processing volumes and, in Greenphire's case, a specific multiyear R&D investment, but these figures do not establish aggregate industry investment. Yet WCG's 2025 CenterWatch Global Site Relationship Survey found that satisfaction with payment fairness and timeliness both declined from 2023 to 2025, and SCRS's most recent data shows nearly 80% of sites still operate with less than six months of cash reserves.

Technology development and declining site satisfaction coexist in the available evidence, but the cited WCG survey does not measure automation adoption or its causal effect on payment outcomes. It therefore cannot establish whether automation alone resolves negotiation asymmetries, holdback structures, or site-specific overhead policies. OIG listed its request for information under June 22, 2026; it was published in the *Federal Register* on June 24, 2026. The RFI asks whether to add or modify Anti-Kickback Statute safe harbors or Beneficiary Inducements CMP exceptions for remuneration to clinical trial participants. It is an information-gathering action, not a proposed or final rule, and does not itself change the rules for participant, site, or investigator payments (Federal Register public-inspection document. For organizations evaluating clinical-trial financial operations, the benchmarks assembled in this report offer a source-traced starting point for 2026 budget planning, vendor evaluation, and site negotiation strategy.

Tags: clinical trial site payments, clinical trial budget negotiation, site payment benchmarks, clinical research overhead rate, fair market value clinical trials, clinical trial fee schedule, SCRS site payment survey, clinical trial financial management

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Contact founder Adrien Laurent and team at intuitionlabs.ai/contact for a consultation.

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