CAPITOL STREET

November 23, 2025

Hospital Outpatient Pay Up +3.3% in 2026

Price Transparency, Site-Neutral for Drugs, IPO List Eliminated Over 3 Years

Relevant Companies

UHS, ArdentHealth, HCA Healthcare, Tenet Health, CHS Community Health Systems

Our Take & Next Up

Final outpatient hospital pay rates will be +3.3% (up from proposed +2.6%) while transparency and site neutral reform are headwinds that Congress may try to utilize (for savings). See final rule here, released Nov 21 after the close. New payments and policies that start Jan 1, 2026. CMS is reverting the 340B remedy offset percentage for non-drug items and services back to the original 0.5% point instead of 2%, and hospitals will be dinged by 2% in 2027 instead. Site-neutral policies for drug administration and the elimination of the IPO list are also finalized.

Key Points

HOPD 2026

For-profit hospitals will see a +3.3% (up from +2.6% proposed) update in 2026 (UHS, THC, HCA, ARDT, others). Voluntary hospitals would see a **+2.5%** increase (up from +2% proposed), and government hospitals would see an increase of **+2.1%** (up from +2% proposed) in 2026.

Hospital outpatient departments will see an overall update of +2.6% in 2026. This is based on the proposed inpatient hospital market basket increase of +3.3% (vs proposed +3.2%), reduced by a final productivity adjustment of 0.7% point. Urban hospitals would see an increase of 2.6% (vs, proposed +2%) and rural hospital outpatient departments would see an increase of 2.3% (up from proposed +2%).

These final policies are estimated to increase OPPS payments to providers by +2.4% for services (compared to +1.9% proposed), to ~3,600 facilities. These include general acute care hospitals, children's hospitals, cancer hospitals, and community mental health centers (CMHCs). This increase is expected to raise total OPPS payments by ~$1.77 B compared to CY 2025, excluding any changes in enrollment, utilization, or case-mix. For providers subject to the 340B remedy offset, payments will be reduced by an estimated $275 M in CY 2026.

There will be a larger (-2% cut) in 2027 pay per 340B Final Remedy rule. For 2026, CMS will apply the previously final 0.5% reduction to the OPPS conversion factor for non-drug items under the 340B Final Remedy rule, delaying any increase to 2% until future years. The proposed rule proposed an increase to the annual offset percentage for non-drug items and services from 0.5% to 2%, but the final rule returns to the original 0.5%, to restore hospitals gradually without undue burden, considering utilization changes and stakeholder feedback.

INPATIENT ONLY (IPO) LIST

CMS is finalizing a 3 year phase out of the Inpatient Only (IPO) list starting with removal of 285 musculoskeletal procedures. Eliminating the list shifts responsibility to physicians to decide the most appropriate care setting-inpatient or outpatient-for the beneficiary. The agency believes this will allow more procedures to be performed on an outpatient basis. CMS claims elimination of the list allows greater patient flexibility to seek care and lower out-of-pocket costs for beneficiaries. Examples of the musculoskeletal procedures removed include anesthesia for radical facial bone surgery (00192), removal of cervical total disc arthroplasty (0095T), fibula bone graft with microvascular anastomosis (20955), open treatment of depressed frontal sinus fracture (21343), deep thoracic bone incision for osteomyelitis (21510), and partial sternum ostectomy (21620) (full list on p. 465 of the proposed rule).

CMS finalized its policy that exempts procedures removed from the IPO list from certain medical reviews under the two-midnight rule (as seen in the 2021 final rule). The two-night rule is a policy that hospital stays expected to last at least two midnights are generally considered inpatient admissions. Removed IPO procedures are temporarily exempt from site-of-service denials, beneficiary and family centered care quality improvement organization (BFCC-QIO) referrals, recovery audit contractor (RAC) reviews, and patient status audits until data show they are more commonly performed outpatient. This exemption, first established in 2021, will remain in place for CY 2026 and beyond until the Secretary determines the procedure is primarily outpatient for Medicare patients.

SITE-NEUTRAL REFORM BEGINS

CMS is finalizing site-neutral payments for drug administration in grandfathered off-campus provider-based departments (PBDs), paying the same rate as the physician fee schedule (PFS). This policy aims to prevent higher payments in off-campus PBDs compared with physician offices and to control unnecessary increases in service volume. CMS expects the volume of these services to decrease and estimates the policy will reduce OPPS spending by $290 M in CY 2026, with $220 M saved by Medicare and $70 M by beneficiaries through lower coinsurance.

The policy is the camel's nose under the tent as Congress looks to implement additional site neutral policies. CBO proposed site neutral for drug administration as a policy option for reducing the deficit here (saves $5.6 B over 10). The Trump executive order (EO) on drug prices also explicitly mentions site-neutral drug reform as a regulatory priority.

OTHER – PRICE TRANSPARENCY & NON-OPIOID PAIN

CMS is finalizing a market-based approach for Medicare severity diagnosis related group (MS-DRG) payments by requiring hospitals to report median negotiated rates with Medicare Advantage plans for

each DRG. Using data from hospital price transparency files, CMS aims to reduce reliance on hospital-set prices, update inpatient payment calculations starting in 2029, and explore ways to apply market-based methods to other Medicare fee-for-service (FFS) payment systems.

CMS is finalizing new hospital price transparency rules for CY 2026, requiring hospitals to report allowed amounts, attest to data accuracy, include national provider identifiers (NPIs), and follow updated penalty policies. Hospitals must report actual allowed amounts for each service, including the median, 10th percentile, and 90th percentile, using EDI 835 or an equivalent data source, replacing previously estimated amounts. Hospitals must also have a senior official certify that the data is complete and accurate, and include their organizational type 2 NPI in the machine-readable file to improve comparability across hospitals. The rules take effect January 1, 2026, with enforcement delayed until April 1, 2026, to give hospitals time to update and post accurate data.

CMS will continue providing temporary additional payments for certain non-opioid pain treatments in HOPD and ASC settings through 2027. Five drugs and 11 devices have been identified for separate payment, supporting reduced opioid use and prevention of opioid use disorder. CMS may also create a more frequent pathway to add new qualifying products to the program and welcomes public input on expanding the list.

CMS is updating Medicare payment rates for intensive outpatient program (IOP) services in HOPDs and community mental health centers (CMHCs). The existing rate structure, two ambulatory payment classifications (APCs) per provider type for days with three services and four or more services, will be maintained, and hospital rates will continue to use OPPS data, while CMHC rates will be set at 40% of hospital costs to correct cost inversions and stabilize payments.

AMBULATORY SURGERY CENTERS

Surgery centers (ASC) will see a pay update of +2.6% (up from 2.4% proposed) in 2026. This is based on the IPPS MB increase of 3.3% reduced by 0.7% for productivity adjustment. In the final rule, CMS is using the hospital market basket to update ASC payments, increasing them by 2.6% to about $9.2 B. CMS is also revising the covered procedures list, adding 276 procedures and moving 271 from the IPO list to the CPL.

Genitourinary sees an increase of +**12%** (down from proposed +18%) in 2026, **cardio +5%** (down from +12% proposed) increase, and **eye procedures** +4% (up from proposed -2%). The total change for specialty groups is **+3%** (up from proposed +2%).

CMS will unpackage skin substitute products from application procedures and create APCs based on product characteristics rather than price, aligning payment with FDA regulatory status. A single payment rate will apply in 2026 to reflect resource use, with differentiated rates planned in future years. This policy, applied in both hospital outpatient and physician office settings, aims to recognize clinical differences, encourage innovation, and reduce Medicare costs.

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