CAPITOL STREET

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Hospital Payment & Regulatory Oversight This Month

Committees Look Under The Hood As They Tee Up Site-Neutral & Other Reforms

Relevant Companies

Our Take & Next Up

House oversight starts this month: Congress is looking to convene health system and trade associations (such as American Hospital Association) to understand how federal dollars are being used. In mid-March, we expect the House Committee on Energy & Commerce (Chair Guthrie, R-KY) to hold a hearing featuring trade associations (e.g., AHA, America's Essential Hospitals, others) and the House Committee on Ways & Means (Chair Smith, R-MO) may also bring in hospital systems to testify.

Hospitals are emerging as a target in the broader health care cost debate that likely starts after the mid-term election. We don't expect major reform in 2026 given midterm elections, but more comprehensive reform is likely coming. Lawmakers are concerned about vertically aligned systems (as they are with health insurers), site-neutral payments, 340B program oversight, graduate medical education (GME), charity care practices, and the use of AI in billing and utilization management, among other items.

Key Points

While sweeping reform remains unlikely before the midterms, targeted hospital policies could advance in a year-end package. Concerns around vertical integration are running high on a bipartisan basis as scrutiny of insurer-provider-PBM-GPO entities takes place (our take here). Congress is nervous about hospital consolidation and business practices that are impacted by reimbursement and policy in Medicare, Medicaid, and 340B.

Hospitals are criticized by other stakeholders (insurers, drugmakers) as the primary driver of health care spending and growth. There is a focus on executive compensation, tax-exempt (nonprofit) status, pricing differentials between sites of care, 340B, and operating margins. During a January hearing before the House E&C Committee (Chair Guthrie, R-KY), the nation's largest insurers – ELV, CVS, UNH, CI – pointed to hospital pricing and volumes as key drivers of rising consumer premiums (see our take here).

Site-neutral payment policy remains the eye on the prize as health systems' acquisition of clinics and providers continues to reshape care delivery and federal spending.

- According to a 2025 GAO review, 47% of physicians were employed by or affiliated with hospital systems in 2024, up from less than 30% in 2012.
- Corporate employment is also rising, with 23% of physicians working for companies in 2024 (up from 15% in 2019) including 6.5% in PE–owned practices (up from 4.5% in 2022).
- PE ownership exceeded 30% in specialties such as gastroenterology, dermatology, and ophthalmology.
- In 2025, HHS reported acquisitions of physician practices can raise physician service prices by roughly 14%, partly because services can be billed as hospital outpatient care with higher facility fees. Stakeholders argue these financial incentives - differences between hospital outpatient and physician office payments - encourage consolidation and contribute to higher spending.
- Policymakers have debated reforms such as site-neutral payment policies (our take here) and greater transparency and antitrust enforcement (our take here) to address the trends in hospital business practices & consolidation.

BACKGROUND

Hospitals face near-term headwinds with the expiration of ACA enhanced premium tax credits (EPTCs) compounded by OBBBA Medicaid provisions set to start in 2027/28. EPTC expiration will likely result in shrinking enrollment in Obamacare plans and increasing financial pressure on providers with high marketplace exposure. OBBBA Medicaid provisions will begin to come into play.

- Provider-tax reforms are phased in over the next several years, with full implementation in 2027–2028. Beginning October 1, 2026, Medicaid provider-tax financing rules tighten (saving $191 B/ten) with statutory phase-down from 6% to 3.5% starting in fall 2027
- States must also implement Medicaid work requirements by December 31, 2026 (saving $326 B/ten)
- State-directed payments would be capped at 100% of Medicare rates in Medicaid expansion states and 110% in non-expansion states, with existing arrangements phased down by 10% annually starting in 2028 (saving $149 B/10)

Recall CMS finalized (for 2026) limited site-neutral payment reforms (our take here), starting with drug administration services in grandfathered off-campus provider-based departments (PBDs). Under the 2026 final OPPS rule, services are now reimbursed at the same rate as the physician fee schedule (PFS), eliminating the higher pay hospital outpatient departments previously received relative to the office setting. CMS framed the change as a step to curb payment differentials that can encourage hospital acquisition of physician practices and drive unnecessary increases in service volume.

CMS may take another baby step towards hospital site neutrality in a 2027 payment rule, as a part of annual rulemaking, while Congress evaluates its options. CMS may look to implement additional site-neutral policies, as CBO scored site neutral for drug administration as a policy option for reducing the deficit here (saves $5.6 B over 10). 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.

Graduate medical education (GME) funding: Medicare spends billions annually to support physician training and it largely flows to a limited # of states. The GAO found federal GME spending was $21.2 B in FY2023, while MedPAC's 2025 report found that Medicare spent ~$19 B on GME in 2022 through indirect and direct payments, which largely flow to teaching hospitals. In 2024, The National Conference of State Legislatures found that states such as NY, PA, NC, FL, OH, IL, MO, TX and CA receive a disproportionate share of Medicare-supported residency funding. Because Medicare graduate medical education payments are tied to

residency positions at teaching hospitals, funding tends to concentrate in states with the largest training programs. MedPAC has recommended restructuring these payments to better align with workforce needs, while Senator Grassley (R-IA) has raised concerns about potential overpayments and transparency. In 2024, CBO estimated that reducing and restructuring Medicare GME could lower federal spending by about $94–$103 B over ten years (2025–2034).

Policymakers are questioning the level of charity care provided by nonprofit hospitals and whether their community benefit justifies the scale of the tax subsidies they receive. At a recent House W&M oversight hearing last fall (Chair Smith, R-MO), lawmakers and witnesses noted that nonprofit hospital tax exemptions are valued at over $37B annually, with some analyses suggesting hospitals received $28 B in tax benefits while providing roughly $10 B less charity care between 2020-2022. Witnesses also highlighted gaps in IRS Form 990 reporting that limit effective oversight. Similar concerns have been raised by Sens Grassley (R-IA) and Warren (D-MA) who have argued that some nonprofit hospitals receive more in tax breaks than they provide in community benefit and have urged stronger transparency and enforcement of tax-exempt requirements.

Ipsita Smolinski
Managing Director I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

CAPITOL STREET
