CAPITOL STREET

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Hospitals Up +2.6% (340B Recoupment of -2% Proposed)

Site Neutral for Drugs Proposed, IPO List to Eliminate Over 3 Years, RFI On Additional Site Neutral Reforms

Relevant Companies

ArdentHealth UHS CHS Community Health Systems HCA Healthcare Tenet Health

Our Take & Next Up

Proposed outpatient hospital pay rates of +2.6% for proprietary hospitals (-2% with 340B court case adjustments), while transparency and site neutral reform are headwinds that Congress may try to utilize (for savings). See proposed rules here. Comments are due by Sept. 13, 2025, with the final rule due on or around Nov 1, with new payments and policies that start Jan 1, 2026. Both rural and urban hospital rates see a +2% increase before the 340B remedy offset. We note the CMS is proposing to increase the 340B remedy offset percentage for non-drug items and services from 0.5% to 2%. Site-neutral policies for drug administration and the elimination of the IPO list are also included. However, site neutral for drugs is likely to be taken by Congress as a legislative pay-for (and may not be finalized by CMS).

Key Points

HOPD 2026

For-profit hospitals would see a +2.6% update in 2026 (UHS, THC, HCA, others). Voluntary hospitals would see a **+2%** increase, and government hospitals would see a **+2%** increase in 2025. Final rates will be posted by Nov 1.

Hospital outpatient departments will see an update of +2.4% in 2026, based on the proposed inpatient hospital market basket percentage increase of +3.2%. This is lower than last year's increase of **+2.9%**. Urban and rural hospital outpatient departments both would see a **+2%** increase.

These proposed policies are estimated to increase OPPS payments to providers by +1.9% for services, before accounting for the 340B remedy offset. CMS is proposing to increase the annual offset percentage for non-drug items and services from 0.5% to 2% starting CY 2026 ($1.1 B in payment reductions for impacted hospitals). Payments for services at hospitals subject to the 340B remedy offset (those that began billing Medicare before Jan 1, 2018) will be reduced by 2 percentage points. CMS estimates that 3,270 providers

would be subject to the 340B remedy offset. This offset would remain until the estimated payment reduction reaches $7.8 B, which CMS estimates will occur in 2031.

- **The offset percentage aims to make budget neutral the Final Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 (as a result of the hospital underpayment litigation).** In 2024, CMS made one-time lump sum payments to affected 340B covered entity hospitals to address underpayment to 340B hospitals for CY 2018 through September 2022. This was a result of the ruling from the *American Hospital Association v. Becerra* (see 2022 court case here). These one-time lump sum payments were made to meet budget neutrality requirements through decreases to the non-drug item and services payments, which CMS will implement over the course of several years.

INPATIENT ONLY (IPO) LIST

As previewed in our memo (here) as a distinct possibility, CMS is proposing an elimination of the Inpatient Only (IPO) list over three years starting with musculoskeletal. Eliminating the list shifts responsibility to physicians to decide the most appropriate care setting-inpatient or outpatient- for the beneficiary. Trump did this in his first term. In 2021, the Trump Admin eliminated the IPO list in a final rule. CMS claims elimination of the list allows greater patient flexibility to seek care and lower out-of-pocket costs for beneficiaries.

CMS proposes to continue the two-midnight rule exemption for procedures subject to the IPO list removal (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 that fall under this category are temporarily exempted from site-of-service claim denials, Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractor (RAC), and patient status reviews until claims data shows they're more common in outpatient settings.

SITE-NEUTRAL REFORM

CMS proposes site-neutral payments for drug administration (saves $280 M, less than the $2-3 B in prior CBO scores), in a small negative for hospitals. CMS is proposing to pay for drug administration services furnished at off-campus provider-based departments (PBD) at the same rate as the site-specific PFS payment rate. CMS anticipates that the volume of drug administration services provided in the off-campus PBD setting will decrease. CMS is also soliciting comments on how to control unnecessary increases in services provided in on-campus hospital outpatient departments.

The policy is not necessarily new. 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.

CMS is requesting info on ambulatory services at high risk of shifting to the hospital setting based on financial incentives. CMS wants to develop a more systematic process for identifying ambulatory services that could shift to the hospital setting based on financial incentives. CMS is asking for feedback on which procedures have seen an unnecessary increase in volume, if OPPS payment for certain services should be limited, and if certain services should be exempt from a potentially larger site neutral policy.

OTHER – MA & TRANSPARENCY

The agency proposes requiring hospitals to report median Medicare Advantage MA plan rates to support market-based payments and update inpatient payment calculations. The Medicare Severity Diagnosis-Related Group (MS-DRG) Relative Weight Data Collection and Methodology Proposal aims to have hospitals report MA negotiated prices for each type of MS-DRG as a way to reduce reliance on hospital-set prices and move toward a more market-based Medicare payment system. The data from existing transparency files would also be utilized to update how Medicare calculates inpatient payments starting in 2029.

Hospitals could be subject to detailed transparency requirements, including a wider range of prices and additional datapoints. Starting 2026, hospitals could be required to report the actual price ranges, instead of estimated, for each service using a new payment calculator called EDI 835. Furthermore they must have a senior official to certify data accuracy and include their National Provider Identifier (NPI).

AMBULATORY SURGERY CENTERS

Surgery centers (ASC) would see a pay update of +2.4% in 2026. This is based on the proposed IPPS MB increase of 3.2% reduced by 0.8% for productivity adjustment.

- Genitourinary wins with pay increase of **+18%** in 2026, cardio follows with a **+12%** increase. Only eye procedures see a decrease in 2026 **(-2%)**. The total change for specialty groups is +2%.

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