CMS Moves Forward On Site Neutrality In HOPD

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CMS seeks to advance site neutrality pay in its draft calendar year 2026 outpatient hospital payment rule, proposing to pay doctors who administer Part B drugs at the Medicare physician fee rate, which the agency says would save about Medicare $210 million and beneficiaries another $70 million a year.

Other proposals aim to increase beneficiary choices and lower costs, boost transparency, and safeguard the Medicare Trust Fund from fraud, waste and abuse, CMS says.

The rule also proposes to update the Hospital Prospective Payment System (OPPS) by 2.4% in CY2026, which is based on a projected 3.8% market basket update reduced by a 0.8% productivity adjustment. Ambulatory Service Centers would also be updated by 2.4%.

“We are building on our efforts to modernize Medicare payments by advancing site neutrality, simplifying hospital billing, and ensuring real prices -- not estimates -- are available to patients,” said Chris Klomp, deputy administrator and Medicare director at CMS. “These changes help make hospital care more predictable, accountable, and affordable.”

The site-neutral policy, and the savings, mirror a policy included in the Lower Cost More Transparency Act, which passed the House last year before the bill stalled.

Premier Inc. quickly blasted the rule in a release. “Not only is reimbursement failing to keep up with the cost of providing care, the proposed policies contained in this rule will further degrade the critical healthcare infrastructure patients rely on,” Souma Saha, Premier’s senior vice president of government affairs, says. “Transforming healthcare is a must do. However, putting forward policies in isolation does more harm than good. Premier urges the Centers for Medicare & Medicaid Services to engage patients and providers to collectively and holistically design the future of healthcare that is accountable, transparent, saves federal taxpayer dollars -- and most importantly, puts the patient first.”

Site-neutral

A key proposal that CMS says will save money for beneficiaries and Medicare is the expansion of a 2019 policy allowing the agency to prevent beneficiaries from paying more for services provided in an excepted off-campus setting than in a physician setting, the agency says.

For CY 2026, CMS is proposing to expand this policy to include drug administration services furnished in excepted off-campus provider-based department.

“Specifically, CMS is proposing to use the agency’s authority under section 1833(t)(2)(F) of the Act to apply the Physician Fee Schedule equivalent payment rate for any HCPCS codes assigned to the drug administration ambulatory payment classifications (APCs) when provided at an off-campus (provider-

based department) excepted from section 603 of the Bipartisan Budget Act of 2015," a fact sheet explains.

For CY 2026, CMS estimates the provision would reduce OPPS spending by $280 million, with $210 million of the savings accruing to Medicare, and $70 million saved by Medicare beneficiaries in the form of reduced beneficiary coinsurance.

The agency also wants feedback on potentially expanding its site-neutral policy.

Inpatient-Only List

In a policy shift the agency says will give beneficiaries more choice on where to get care, the agency proposes to phase out the "inpatient-only" list over a three-year period, first removing 285 "mostly musco-skeletal" procedures in CY2026.

"CMS believes that the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time," the rule says. The policy will allow those services to be paid in an outpatient setting, giving doctors more flexibility in determining the most appropriate site of service.

New codes

The rule also would add 271 codes removed from the IPO to the ASC's covered procedure list, and would revise the CPL criteria and add another 276 procedures to the list.

"These policies will maintain safety for Medicare beneficiaries through the physician considerations for patient safety, while allowing physicians to exercise their medical judgment and increasing flexibility for patients to choose from more settings of care for surgical procedures," CMS says.

The Ambulatory Surgery Center hailed the 547 new codes.

"The proposed expansion in surgical procedures that may be performed in ambulatory surgery centers reflects our longstanding belief that the clinical judgment of the medical community is the proper determinant for where patients can receive their care," said ASCA Chief Executive Officer Bill Prentice. "This approach, if finalized, will allow many more Medicare beneficiaries to receive safe and effective care in surgery centers and lower costs for both patients and the Medicare program."

The agency also proposes to continue a policy in which procedures removed from the IPO list would be exempted from certain medical review activities related to the two-midnight policy.

Price transparency

In a release on the rule, the agency highlights proposals to boost hospital price transparency rules by mandating they post "real, consumer-useable prices" instead of estimates and provided data in standard formats.

"Hospitals that fail to comply could face civil monetary penalties," the agency notes.

Quality program

CMS also proposes a two-stage update to the overall hospital quality program. First, starting in CY2026, CMS would limit the maximum ratings for hospitals in the lowest-performance quartile to four stars instead of five. Starting in CY2027, CMS would reduce the rating of hospitals in the bottom quarter by 1 star. These proposals address acute concerns about hospitals getting the highest possible 5-star ratings despite performing in the lower quartile in the Safety of Care measure, and they emphasize patient safety more broadly, CMS says. -- *Amy Lotven* (alotven@iwpnews.com)