Medicare Payment Updates – 2026 Proposed and Final Rules

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Louisiana HFMA Summer Institute, September 8, 2025

Holland & Knight

Agenda

- IPPS Final Rule
- OPPS Proposed Rule
- Deeper Dive on 2-Midnight and Site Neutrality Issues
- Practical Path Forward
- Questions

IPPS Final Rule

Highlights & Notable Changes Effective January 1, 2026

IPPS Final Rule Core Topics

Wage Index

Uncompensated Care & Reduction Programs

GME

Wage Index

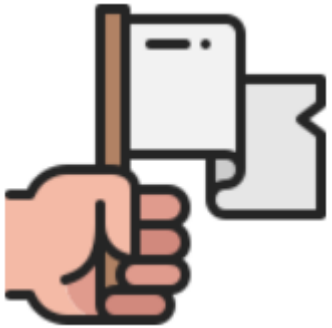
CMS's Low Wage Index Policy

- FY 2020 IPPS Rule: Hospitals in the lowest quartile for wage index had their wage index increased by the average of their actual value and the 25th %-ile value. ***Why?***

High-wage-index hospitals were winning:

- Higher Medicare payments
- Higher wages
- Easier time recruiting

Balancing the scales!

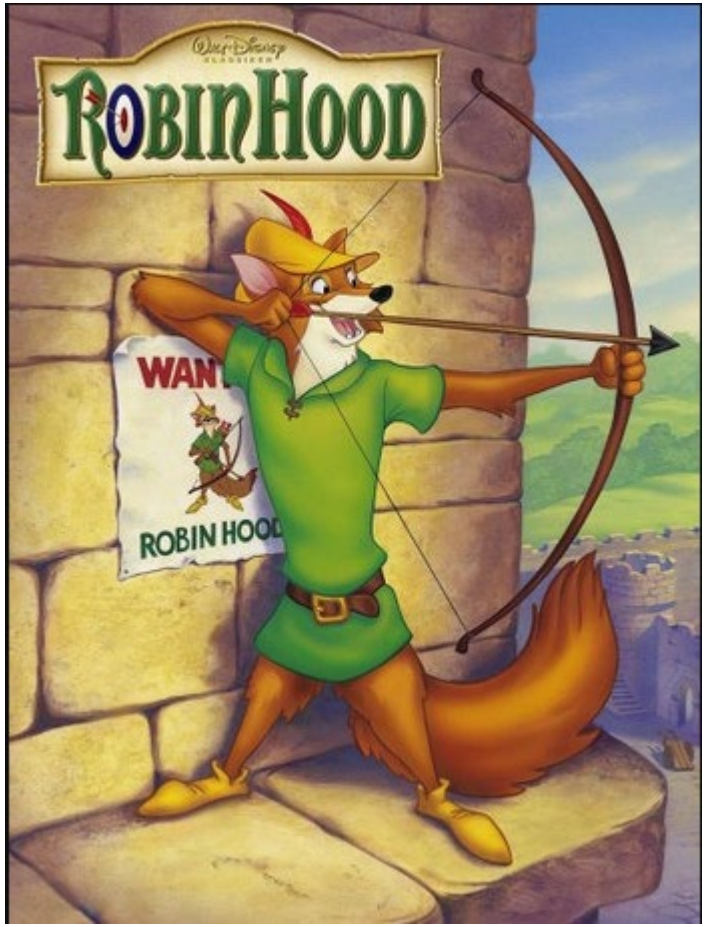


Low-wage-index hospitals couldn't catch up:

- Wage index lag meant higher wages weren't recognized for years
- Couldn't compete

Bridgeport Hospital

- So what's the problem? ***Budget neutrality!***
  - Effect was a 0.2% reduction in the national standardized Medicare rate for all hospitals
- 25 plaintiff hospitals sued alleging $3.6 million in underpayments
- D.C. Circuit Court vacated CMS's low wage index policy in July 2024
  - Social Security Act requires wage index adjustments to be based on market wage surveys
- CMS terminated the policy effective 9/30/2024, resulting in lower wage indexes for the lowest quartile hospitals in FY 2025
  - Wage index decreases were capped at 5% for FY 2025



FY 2026 Wage Index Policies

- CMS discontinued its low wage index policy for FY 2026 forward
  - No more budget neutrality factor applied to the standardized amounts, *except…*
  - Budget-neutral narrow transitional exception for low wage index hospitals significantly impacted in FY 2026
    - All hospitals have a 5% cap on WI decreases from the prior FY
    - This means, the WI decreases for the hardest-hit hospitals cannot go lower than 90.25% of their FY *2024* WI (i.e., 95% * 95%)—max reduction of 9/75% (~52 hospitals)
    - Budget neutrality is achieved through a -0.03% adjustment to the standardized amount
- CMS to continue the following WI policies:
  - Rural floor: WI for urban hospitals cannot be lower than the WI for rural hospitals in the State (~565 hospitals)
  - Imputed floor: Implies a minimum WI for States that are entirely urban
  - State frontier floor: Hospitals in frontier states cannot have a WI < 1.0000 (23 hospitals in MT, ND, SD, and WY)
  - Out-migration adjustment: Increases the WI for hospitals in counties whose residents work largely at hospitals in other counties with a higher WI

Reclassifications

- Urban to Rural (§ 412.103):
  - SCH
  - RRC
  - MDH
  - GME
  - DSH
  - 340B

- MGCRB Reclassification: Rural to Urban for wage index purposes
- ***Why not do both?***
- Dual Reclassifications are getting some negative attention on the Hill!

U.S. House Ways & Means, Health Subcommittee Noticed:

RESEARCH ARTICLE | HOSPITALS

HEALTH AFFAIRS > VOL. 44, NO. 8: MEDICARE ADVANTAGE, YOUTH MENTAL HEALTH, & MORE

Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23

Yang Wang, Jared Perkins, Christopher M. Whaley, and Ge Bai

AFFILIATIONS

PUBLISHED: AUGUST 2025 No Access https://doi.org/10.1377/hlthaff.2025.00019

VIEW ARTICLE PERMISSIONS SHARE TOOLS

Wage Index FY 2027 Geographic Reclass Deadlines

- **Deadline to submit an application for a FY 2027 MGCRB reclassification and a request for cancellation of a withdrawal or termination (reinstatement):** September 2, 2025.
- Note: While the deadline listed in the FY 2027 IPPS/LTCH PPS Final Rule is not later than 13 months prior to the start of the fiscal year for which reclassification is sought (usually by September 1), the Board has historically allowed submission up to the first business day in September.
- **Date of FY 2027 Wage Index Reclassification Determinations Issued by the MGCRB**: To Be Announced
- **Deadline for Hospitals to appeal FY 2027 MGCRB Wage Index Reclassification Determinations:** To Be Announced (Per 412.278, 15 days after Determinations Issued by the MGCRB)
- **Deadline to withdraw an application or terminate an approved 3-year MGCRB reclassification (must be received by the MGCRB with a copy to CMS at wageindex@cms.hhs.gov within 45 days from the date of public display of NPRM):** To Be Announced
- **Deadline to waive Lugar/accept out-migration adjustment or reinstate Lugar/cancel outmigration adjustment (must send written notification to CMS at wageindex@cms.hhs.gov within 45 days from the date of public display of NPRM):** To Be Announced
- To ensure proper accounting, we request hospitals to include their CCN, and either “waive Lugar” or “reinstate Lugar”, in the subject line of these requests.
- **Deadline for hospital to be treated as rural in the FY 2027 wage index and budget neutrality calculations (412.103 lock in, 60 days after NPRM is displayed):** To Be Announced
- **Deadline for hospitals to cancel 412.103 rural reclassification by submitting a request to the CMS regional office, effective with next FFY:** June 2, 2026 (not less than 120 days prior to the end of a Federal fiscal year and not less than 1 calendar year after the effective date of the rural reclassification).

Uncompensated Care & Reduction Programs

Uncompensated Care

Uncompensated Care Payment = (Factor 1 x Factor 2) x Factor 3

FY 2026 Numbers vs (2025):

- Factor 1: $12.4B ($10.5B)
- Factor 2: 62.14% (54.29%)
- Factor 3: hospital specific

FY 2026 factors 1 & 2 = UC pool of **$7.713B** vs $5.705B in FY 2025

Factor 1 (UC pool distributed amongst eligible hospitals)

75% x estimated DSH under pre-ACA methodology

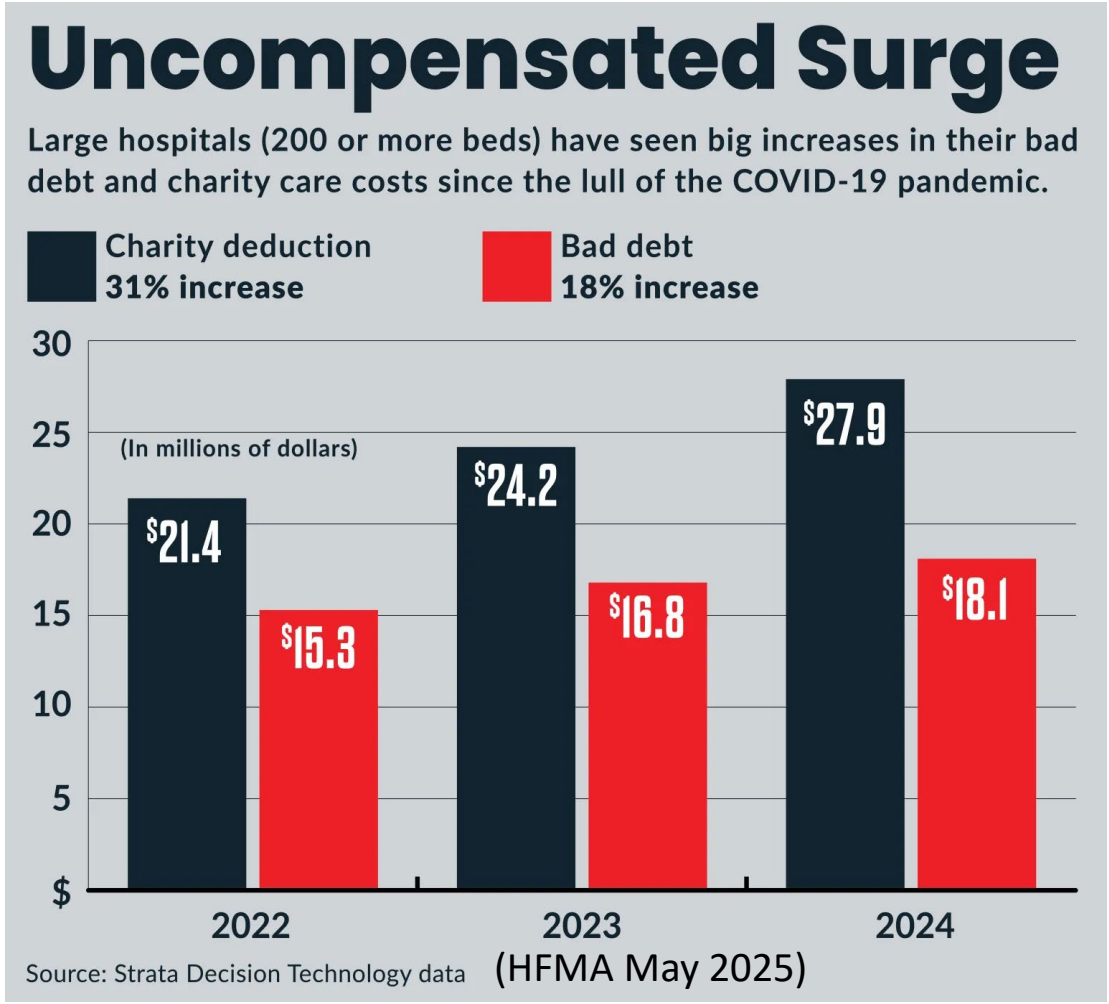
Factor 2 (reduction based on change in national uninsured rate)

$$1 - \left(\frac{\text{Change in national uninsured rate}}{\text{Uninsured rate in 2013}}\right)$$

Factor 3 (hospital's portion of national total of UC)

$$\frac{\text{Hospital's uncompensated care amount}}{\text{Total uncompensated care for all DSH hospitals}}$$

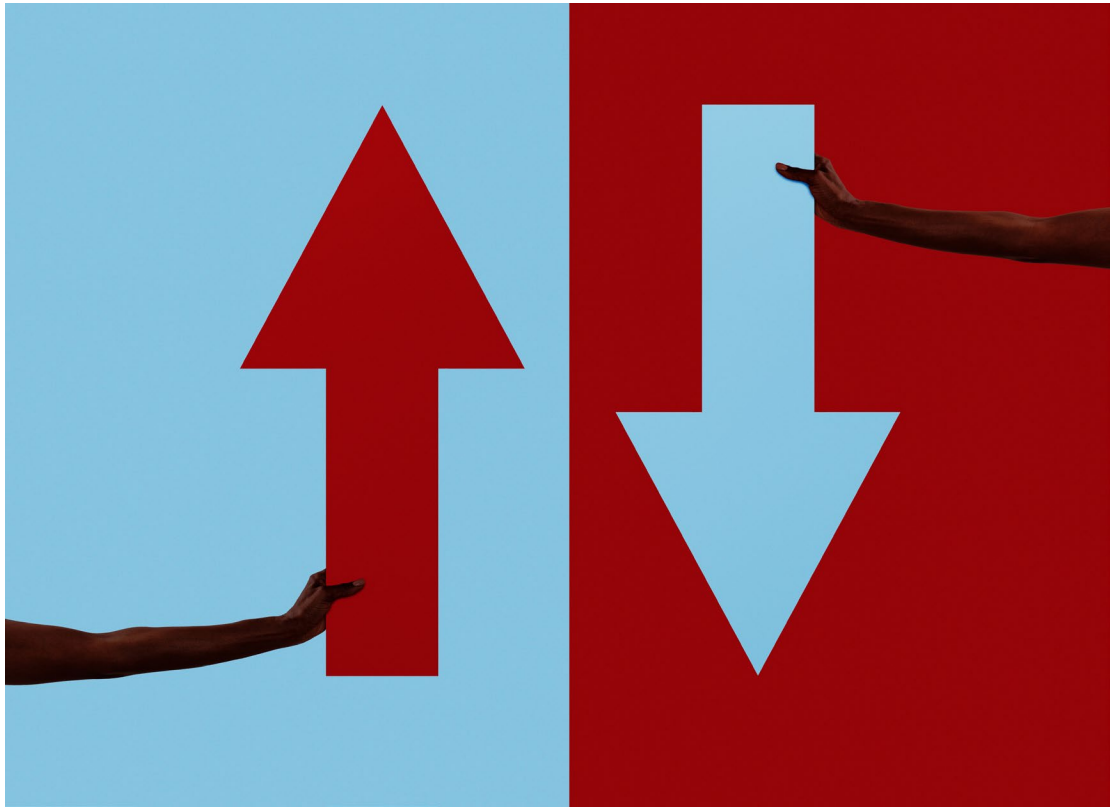
Uncompensated Care



Reduction Programs

- **Hospital Readmission Reductions Program**
  - Adding **Medicare Advantage** beneficiaries to the six Hospital Readmissions Reduction Program (HRRP) measures beginning with the FY 2027 program year.
  - Not finalizing proposal to include payment data for MA beneficiaries in the calculation of aggregate payments for excess readmissions.
  - Reducing the applicable period from 3-years to 2-years beginning with the FY 2027 program year.
  - "Technical update" to remove the COVID–19 exclusion from all six readmission measures.

- **Hospital-Acquired Condition Reduction Program**
  - Making a technical update to the NHSN Healthcare Associated Infection (HAI) measures baseline.
  - Finalizing proposal to update and codify the Extraordinary Circumstances Exception (ECE) policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital with a modification.



GME

Graduate Medical Education (GME) Payments

Direct GME (DGME) Formula:

Total DGME	=	Hospital's PRA	×	FTE resident count	×	Hospital's Medicare patient load

Indirect Medical Education (IME) Formula:

$$\text{Total IME} = 1.35 \times \left[\left(1 + \text{IRB}\right)^{0.405} - 1\right] \times \text{MS-DRG Pmts}$$

GME FTE Counts – *Clarification for Short CRPs*

Unweighted DGME FTE Count

$$\frac{\text{Allowable Days in Rotation}}{\text{Total Days in Rotation}} \times \frac{\text{Total Days in Rotation}}{\mathbf{365}}$$

IME FTE Count

$$\frac{\text{Allowable Days in Rotation}}{\text{Total Days in Rotation}} \times \frac{\text{Total Days in Rotation}}{\mathbf{\text{Days in CRP}}}$$

EXAMPLE: In a 92-day cost reporting period, residents complete a 28-day rotation, with 3 weeks spent at the Provider performing patient care activities and 1 week spent offsite in non-patient care research

Unweighted DGME FTE Count

$$\frac{21}{28} \times \frac{28}{\mathbf{365}} = 0.06$$

DGME FTEs are based on a 12-month equivalent, just like the PRA

IME FTE Count

$$\frac{21}{28} \times \frac{28}{\mathbf{92}} = 0.23$$

IME FTEs are based on the CRP itself, just like the bed count and DRG payments

GME FTE Caps – *Clarification for Short CRPs*

DGME FTE Cap Must Be Prorated:

$$\text{Regular FTE Cap} \times \frac{\text{Total Days in CRP}}{\mathbf{365}}$$

Similarly:

- DGME FTE caps have to be prorated for a 12-month period, whereas IME FTE caps do not
- DGME allowable resident counts in the prior and penultimate years must be prorated to align with the current short CRP

No change to existing policy; just a "clarification"

Provider-Operated Nursing & Allied Health Education

Net Costs Formula Change Not Finalized

- **Issue**: Determination of eligible pass-through costs under §§ 413.85 and 413.87
- **Historically**: CMS offset tuition and other direct income from direct expenses before cost finding (i.e., allocation of indirect costs)
- ***St. Vincent* Decision**: Tuition offset should occur *after* cost finding
  - *Holding: plain reading of the regulations text at 42 CFR 413.85(d)(2)(i) is consistent with the providers' interpretation of the order of operations*
- **Proposal**: Align the regulation to the historic practice and the cost reporting instructions:
  - Deduct tuition expense from direct costs *before* allocation of indirect costs (cost finding)
  - Limit allocable indirect costs to costs the provider incurs as a consequence of operating the approved educational activities
- **Impact**: Lower direct costs → fewer indirect costs → lower total reimbursement
- **Not finalized**: "Due to the number and nature of the comments that we received…"

OPPS Proposed Rule

Key Proposals - Comments Due September 15, 2025

OPPS Final Rule Core Topics

Two-Midnight Rule/ Short Stays

Site Neutrality

340B

Key Requests for Information

Two-Midnight Rule/Short Inpatient Stays

Background of Two-Midnight/Short Inpatient Stay Issues

Implemented in FY 2014, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient.

Controversial roll-out initiated with a number of RAC audits and claw backs. CMS later confidentially settled with a number of hospitals on the issues surrounding the RAC audits and conversion of days from inpatient to outpatient.

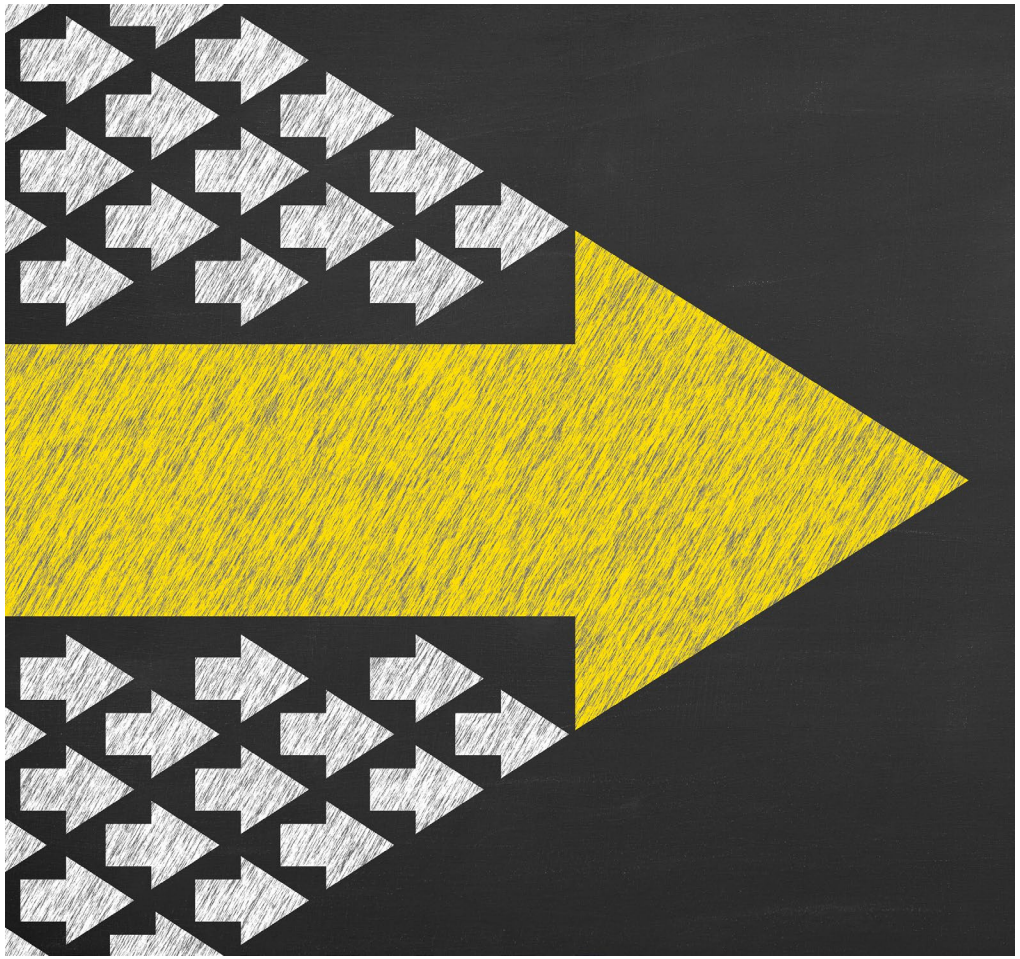
CMS created an inpatient only (IPO) list under OPPS – which protected (somewhat) hospitals from site-of-service claim denials. IPO list limited data of claims more routinely billed as inpatient. In concept, supposed to be more complex procedures requiring advanced level care and recovery.

Recent rule requires Medicare Advantage plans to similarly scrutinize inpatient short stays. Uptick in hospital disputes with MA plans on these issues and misapplication of 2-midnight rule.

Recent rule requires clarification of MA beneficiary appeal rights for patient status classification.

Fast Forward – Return of the Two-Midnight/Short Inpatient Stay Issues

- Audit activities were relatively quiet until more recently.
- OIG issued another report last year about the effect inappropriate classification of inpatient status for short inpatient stays (i.e., stays that lasted less than two midnights).
- Now – return of more audits, increased payer reliance on AI tools to identify claims for review – leading to more disputes of what should be inpatient vs. outpatient stay. Documentation is key.
- CMS reiterates the importance of clinical decision making for the site of service determination for the patient; however, critical review of records and what the physician included and why, and was it sufficient enough to warrant the decision making for an inpatient stay at the time of hospital admission.



OPPS Proposals – Return of the Two-Midnight/Short Inpatient Stay Issues

- OPPS proposal to phase out IPO list over a 3-year period, beginning with removing 285 mostly musculoskeletal procedures for CY 2026
- Halt of certain medical review activities to assess compliance with the 2-midnight rule within the 2 calendar years following their removal from the IPO list. These procedures would be exempted from site-of-service claim denials under Medicare Part A, eligibility for Beneficiary and Family- Centered Care Quality Improvement Organizations (BFCC–QIOs) referrals to Recovery Audit Contractors (RACs) for noncompliance with the 2-midnight rule, and RAC reviews for ‘‘patient status’’ (that is, site-of-service)
- During this 2-year period, BFCC–QIOs would have the opportunity to review such claims in order to provide education for practitioners and providers regarding compliance with the 2-midnight rule, but claims identified as noncompliant would not be denied with respect to the site-of- service under Medicare Part A

Two-Midnight Impact on Cost-Allocation Process

- **Inpatient Days Are Critical in Cost Reporting**
  - Total inpatient days are a critical statistical metric used to:
    - ✓allocate indirect costs to hospital departments and calculate the average cost per day for routine services (e.g., allocating overhead to patient care areas,
    - ✓calculate DSH/uncompensated care payments
    - ✓average cost reporting
    - ✓statistical reporting (e.g., Worksheet S-3, Part I)
  - This process is crucial for determining how much Medicare will reimburse a hospital for patient care.

Site Neutrality

Site Neutrality – Where It All Began…

- **Flashback:** Section 603 of the 2015 Bipartisan Budget Act…
- **SSA § 1833(t)(21)**: Services furnished by an off-campus outpatient department of a provider are paid at MPFS equivalent rates (by applying a "PFS relativity adjuster" of 40% to OPPS payment rates), *except for*—
  - Dedicated emergency departments; and
  - "Excepted Off-Campus Provider-Based Departments" (PBDs), which include:
    - On-campus PBDs within 250 yards of the provider's main buildings
    - PBDs within 250 yards of a remote location (a secondary campus's inpatient facility)
    - Established off-campus PBDs that were billing for hospital services before November 2, 2015
- **Impact:** New PBDs are less profitable, but still highly relevant for 340B

Site Neutrality is the New Black!

- **CY 2019 OPPS Final Rule:**
  - **HCPCS G0463** (Outpatient Clinic Visit) is subject to site neutrality rules at *all off-campus locations* (even "excepted off-campus PBDs" located *off-campus*), except for rural SCHs
  - ***Why?*** *"to control unnecessary increases in the volume of the clinic visit services furnished in excepted off-campus [PBDs]"*
  - **Not budget-neutral**

Site Neutrality – CY 2026 Proposal

- To “control for unnecessary growth … in the volume of OPD services driven by site of service payment differentials … that seek to take advantage of financial incentives created by payment policy rather than clinical need”
- CMS cites:
  - Volume growth for these APCs despite Medicare FFS reduced enrollment
  - Concerns about increased beneficiary cost sharing
- **Proposal:** Drug administration services—e.g., chemotherapy infusion—will receive the PFS relativity adjuster (40%), except for rural SCHs
  - Applies to drug admin at *off-campus* “excepted off-campus PBDs” (i.e., those billing the “PO” modifier, which only applies *off-campus*)
  - Levels 1 – 4 Drug Administration APCs: 5691, 5692, 5693, and 5694 (61 HCPCS codes)
  - **Not budget-neutral**

Site Neutrality – The Next Frontier

- CMS has its sights on—
  - On-campus outpatient clinic visits **(RFI at 90 Fed. Reg. 33691)**
  - Imaging without contrast
  - Services predominantly performed in ASCs and physician offices **(RFI at 90 Fed. Reg. 33692)**

340B

340B Drug Payments: Flashback

- In CY 2018, CMS changed OPPS reimbursements for drugs purchased at 340B discounts from **ASP *plus* 6%** to **ASP *minus* 22.5%**
  - *Why 22.5%?* MedPAC estimated this to be the average minimum 340B discount on separately payable OPPS drugs
  - Budget neutral!
- **Supreme Court Decision**: Under the Social Security Act, CMS can only change its drug reimbursement rate based on a *survey of hospitals' drug acquisition costs*
  - CMS had not done a survey!
  - *Am. Hosp. Ass'n* v. *Becerra,* 142 S. Ct. 1896 (June 15, 2022)
- Hospitals received an estimated $10.6 billion *less* in 340B drug payments between CY2018 and the policy's demise on September 27, 2022

340B Drug Payments: The Original Fix

- Final Remedy for 340B-Acquired Drug Payment Policy published November 8, 2023:
  - **1-time lump sum payment** to 340B hospitals in early 2024 equal to the difference between what they actually received and what they would have received if the policy had not been in place all those years
  - **Prospective offsets** to recoup the estimate $7.8 billion of increased non-drug payments while the policy had been in effect:
    - *Starting in CY 2026,* CMS would reduce the conversion factor for non-drug items and services to all OPPS providers by 0.5 percent each year until the total offset was reached
    - Estimated to take ~ 16 years

340B Drug Payments: The Proposal

- Increase the OPPS conversion factor reduction for non-drug items and services from **0.5%** to **2.0%**
- Estimated to take ~ **6 years**
- *Why?*
  - A shorter-term remedy is more likely to align with historic utilization patterns?
  - The 16-year plan "insufficiently" accomplished the goal of "implement[ing] the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018"
- Estimated to reduce payments to applicable providers (see Addendum R) by $1.1 billion in CY 2026

Other Areas for Comment/Requests for Information

- Software as a Service
- Wellbeing and Nutrition for proposed measure sets, for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs
- Hospital Quality Star Rating
- Price Transparency

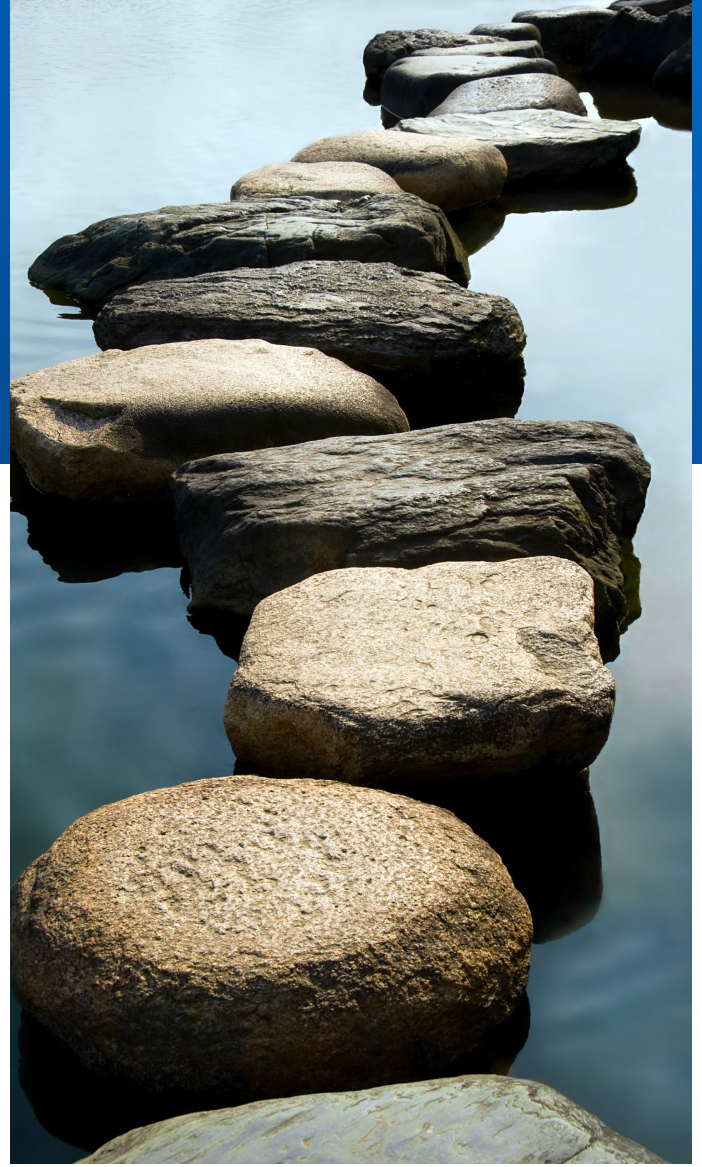
Practical Path Forward

Spotting Issues Around the Corner & How to Prepare

In the Words of Oz

Roadblocks to Payment

- X Prior Authorizations
- X Medicaid Eligibility
- X Short Stays
- X MA Patients



Stepping Stones to Implement Process & Proof BEFORE Payment

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Thank You!

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