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CY 2026 Outpatient Prospective Payment System and Ambulatory Surgery Center Payment System Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) recently issued the Calendar Year (CY) 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule, which includes a rate increase of 2.4%. Other provisions signify a shift towards allowing physicians more latitude in determining the appropriate site of care for services based on the specific circumstances.

KEY TAKEAWAYS

- *Rate increase of 2.4% for OPPS and ASC (before quality reporting penalties or sequestration)*
- *Three-year phase-out of the Inpatient Only List*
- *285 services removed from the Inpatient Only List for 2026, and 547 procedures added to the ASC Covered Procedures List*
- *Significantly accelerated recoupment of 340B overpayments from 2018-2022*
- *Drug administration provided at off-campus provider-based locations paid at physician-office rates*
- *Enhancements to Price Transparency filing requirements for hospitals.*

Payment Rate

The rule includes an increase of 2.4% for both the OPPS and ASC payment rates. This rate is based on a market basket increase of 3.2%, reduced by a 0.8 productivity adjustment. The payment rate will be reduced by 2% for hospitals and ASCs that fail to comply with applicable quality reporting requirements. Accordingly,

the **OPPS conversion factor for 2026 is $91.747** (or $89.958 for hospitals that fail to meet OQR requirements), and the **ASC conversion factor is $56.207** (or $55.109 for ASCs that do not meet the quality reporting requirements). CMS estimates that the rate increases and other budget neutrality adjustments, including estimated changes in enrollment, utilization, and case mix, will result in an **aggregate payment increase of $8.1 billion from 2025 OPPS payments**, and **an increase of $480 million from 2025 ASC payments.**

As a result of the OPPS rate increase and other budget neutrality adjustments, CMS estimates that **urban hospitals will see a 2.6% increase in payment** while **rural hospitals come in slightly lower at a 2.5% increase**. Nonteaching hospitals are expected to yield a 2.6% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 2.8% and 2.3% increases, respectively.

CMS estimates that the overall impact of the ASC payment updates will be dramatically different depending on the specialty:

Surgical Specialty	Estimated Payment Increase
Genitourinary	18%
Cardiovascular	12%
Gastrointestinal	3%
Nervous System	3%
Musculoskeletal	1%
Eye	-2%

Derived from Table 113 in the CY 2026 Medicare Hospital OPPS and ASC Payment System Proposed Rule.

According to an explanation provided in the rule, the significant increase in cardiovascular and genitourinary procedures is a result of higher ambulatory payment classification (APC) level assignment in the OPPS of newer peripheral vascular procedures and prostate biopsy procedure codes compared to prior codes for such procedures.

The proposed rule also provides the expected payment changes for the thirty ASC procedures receiving the highest estimated aggregate Medicare payments in 2025. As shown below, the estimated payment swings vary drastically, from an increase of 16% to a decrease of 16%.

Selected Procedures	Short Description	Estimated Payment Change
15823	Revision of upper eyelid	16%
65820	Relieve inner eye pressure	7%
66991	Xcapsl ctrc rmvl insj 1+	6%
0627T	Perq njx algc fluor lmbr 1st	6%
29827	Sho arthrs srg rt8tr cuf rpr	5%
63685	Ins/rplc spi npg/rcvr pocket	5%
C9740	Cysto impl 4 or more	5%
G0105	Colorectal scrn; hi risk ind	5%
G0121	Colon ca scrn not hi rsk ind	5%
36902	Intro cath dialysis circuit	4%
45380	Colonoscopy and biopsy	4%
45385	Colonoscopy w/lesion removal	4%
62323	Njx interlaminar lmbr/sac	4%
64628	Trml dstrj ios bvn 1st 2 l/s	4%
27130	Total hip arthroplasty	3%

Selected Procedures	Short Description	Estimated Payment Change
64635	Destroy lumb/sac facet jnt	3%
64721	Carpal tunnel surgery	3%
27447	Total knee arthroplasty	2%
64483	Njx aa&/strd tfrm epi l/s 1	1%
64493	Inj paravert f jnt l/s 1 lev	1%
66821	After cataract laser surgery	1%
63650	Implant neuroelectrodes	0%
64555	Implant neuroelectrodes	0%
64561	Implant neuroelectrodes	0%
43239	Egd biopsy single/multiple	(1%)
23472	Reconstruct shoulder joint	(4%)
27279	Arthrd si jt perq/min nvas	(4%)
66982	Xcapsl ctrc rmvl cplx wo ecp	(5%)
66984	Xcapsl ctrc rmvl w/o ecp	(5%)
64590	Ins/rpl prph sac/gstr npg/r	(16%)

Derived from Table 114 in the CY 2026 Medicare Hospital OPPS and ASC Payment System Proposed Rule.

In its March 2025 *Report to the Congress: Medicare Payment Policy*, MedPAC noted that fee-for-service (FFS) Medicare payments to hospitals continued to be lower than hospitals' costs in 2023. The report notes that the

FFS Medicare margin remained relatively unchanged, from -13.1% in 2022 to -13% in 2023. Even the hospitals the report referred to as "relatively efficient" experienced a FFS Medicare margin of -2% in 2023. To combat this, MedPAC recommended that Congress update the 2026 Medicare base payment rates for hospitals by the amount specified in current law plus 1%. Of course, the rule issued by CMS must adhere to current law and therefore does not reflect MedPAC's recommended increase – that could only be implemented through legislative action.

Sequestration Impact

It should be noted that the payment rates reflected in the OPPS/ASC proposed rule are prior to any reduction for sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a given year results in an increase in projected budget deficits. The recently enacted OBBBA would trigger PAYGO in 2026 without additional Congressional action. PAYGO cuts to Medicare benefit payments would be capped at 4%. However, neither PAYGO nor any subsequent legislation includes details on how the two sequesters would be implemented together.

The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

Changes to IPO & ASC Covered Procedures Lists

CMS is proposing significant changes, including a three-year phase-out of the Inpatient Only (IPO) List. Five of the existing general exclusion criteria for the ASC Covered Procedures List (ASC-CPL) would be eliminated and instead considered "nonbinding physician considerations for patient safety." These are criteria address surgical procedures that:

- Generally result in extensive blood loss,
- Require major or prolonged invasion of body cavities,
- Directly involve major blood vessels,
- Are generally emergent or life-threatening in nature, or
- Commonly require systemic thrombolytic therapy.

The rule notes several factors influencing this change, such as surgical advances (including increased use of minimally invasive procedures), improved perioperative anesthesia, and improvements to pain management and other post-operative processes. The remaining three general exclusion criteria for the ASC-CPL would remain in place:

- Services designated as requiring inpatient care (i.e., on the IPO List).
- Services that can only be reported using a CPT unlisted surgical procedure code, or
- Services otherwise excluded by CFR 42 §411.15.

For 2026, the proposed rule would remove 285 services from the IPO, most of which are musculoskeletal services. The rule seeks feedback regarding the continued phase-out of services for 2027 and 2028; specifically. The stated goal is for the IPO list to be permanently eliminated by January 1, 2029.

The proposed rule would a total of 547 codes to the ASC-CPL for 2026, including 271 that are currently on the IPO as well as 276 additional codes deemed appropriate for an ASC setting using the updated criteria described above.

Items removed from the IPO list would be exempted from certain medical review activities related to the two-midnight rule. These services would be exempted from site-of service claim denials, referrals to Recovery Audit Contractors (RAC) for persistent noncompliance with the two-midnight rule, and RAC reviews for "patient status" until there is sufficient claims data to demonstrate that the services are more commonly billed in the outpatient than the inpatient setting.

Remedy for the 340B-Acquired Drug Payment Policy

In 2018, CMS changed its methodology for determining payments for outpatient drugs acquired through the 340B program. The change in methodology resulted in a significant decrease in payments to hospitals. On June 15, 2022, the Supreme Court ruled that the payment rates paid by CMS in 2018 and 2019 were inappropriate, as the Department of Health and Human Services (HHS) did not have the authority to vary payment rates among groups of hospitals without a survey of the hospitals' acquisition costs. A survey was not conducted until 2020. Accordingly, CMS must make hospitals whole for the pay cuts they experienced in 2018 and 2019, which were around $1.6 billion annually in aggregate.[1]

The 2024 OPPS and ASC final rule adopted an approach whereby CMS would make lump-sum payments, totaling around $9 billion, to each of the approximately 1,700 hospitals that were impacted by the inappropriate payments. Notably, CMS maintained its position that the remedy has a statutory requirement for budget neutrality. To accomplish this, CMS decided to reduce future payments for non-drug items and services by reducing the OPPS conversion factor by 0.5% starting in 2026 and continuing until the full $7.8 billion budget neutrality adjustment is offset, which was expected to take 16 years. The proposed rule makes a significant change to this approach.

CMS notes that "after subsequent reconsideration of balancing these two goals" of "restoring hospitals to their financial position had the original 340B policy never existed, while avoiding burdening them with an immediate single year recovery," a shorter recovery timeframe is desired. "In particular," the rule notes, "the further away from CY 2018 through CY 2022 the adjustments extend, the less likely that relative hospital utilization of non-drug items and services will correlate to the relative hospital utilization of non-drug items and services from 2018 through 2022." In other words, "the longer it takes for us to fully recover the $7.8 billion, the less likely that the relative burden on hospitals from the adjustments will match the relevant benefits those hospitals previously received." Accordingly, the rule proposes to apply a **2% payment reduction** to the conversion factor each year beginning in 2026. CMS estimates that by doing so, the full amount would be recouped by 2031. CMS estimates that **the 340B remedy offset will reduce payments by $1.1 billion in 2026 for affected providers**.

Payment for Skin Substitutes

Historically, skin substitutes have been paid as biologicals instead of supplies, using a payment methodology based on average sales price plus 6%. However, Part B spending for skin substitutes increased dramatically from $250 million to over $10 billion in just five years (2019 to 2024), while the number of patients receiving such products merely doubled over the same period. To address this, CMS proposes to treat certain groups of skin substitute products as incident-to supplies beginning in 2026 when they are used during a covered procedure paid under OPPS. Incident-to supplies are subject to cost-based reimbursement rather than sales price. The proposed rule seeks to create site-neutral payment for skin substitutes under the OPPS and the

[1] *American Hospital Assn.* v. *Becerra,* 596 U. S. ___ (2022)

Physician Fee Schedule (PFS) for services provided in a non-facility setting. Accordingly, the OPPS proposed rule establishes three clinical APCs for skin substitutes, based on their FDA regulatory categories, which would be subject to a payment rate of $125.38:

- APC 6000 – PMA Skin Substitute Products
- APC 6001 – 510(k) Skin Substitute Products
- APC 6001 – 361 HCT/P Skin Substitute Products

This policy would be adopted in non-facility, ASC, and outpatient hospital settings.

Site Neutrality

The proposed rule seeks to apply the PFS-equivalent rate for any drug administration services provided at off-campus provider-based departments. (Sole Community Hospitals would be exempt from this policy.) CMS points to the "high volume" and "magnitude of rate differences" between physician office and hospital outpatient settings as drivers that have been pushing these services to the outpatient setting.

As an example, the rule notes that the volume of HCPCS code 96413 (chemotherapy administration, up to one hour) billed in provider-based departments increased almost 70% from 2011 to 2023. With a 2025 payment differential of $222 ($119 in a physician office vs. $341 in a hospital outpatient setting), this results in a considerable difference. In fact, "the chemotherapy administration codes represent some of the highest cost and most frequently billed services within the drug administration APCs." Not only does this lead to higher payments by Medicare, but it also subjects beneficiaries to a higher cost-sharing burden.

The proposed change is estimated to reduce spending by $280 million in 2026, including $210 million from Medicare and $70 million from reduced beneficiary coinsurance. The rule also requests information on expanding this policy to on-campus clinic visits.

CMS is also seeking information on **"the development of a systematic process for identifying ambulatory services at a high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and adjusting payments accordingly**." These requests for information suggest that the shift to site-neutral payment could be expanded in future rulemaking.

Price Transparency

Under the proposed rule, hospitals would have heightened requirements relating to price transparency. Beginning January 1, 2026, hospitals would be required to disclose the tenth percentile, median, and ninetieth percentile allowed amounts in machine-readable files when standard charges are based on percentage or algorithms. They would also be required to provide the count of allowed amounts. CMS provides specific direction regarding the methodology and lookback periods to be utilized in calculating these amounts. The rule would also require stronger accountability by the individual overseeing price transparency requirements.

CMS also introduces a policy in which hospitals found to be in violation of price transparency requirements may reduce assessed civil monetary penalties by 35% if they waive their rights to a hearing. This is intended to facilitate efficient enforcement.

Partial Hospitalization and Intensive Outpatient Programs

In light of heightened awareness of the need for mental health services, CMS established a payment structure for partial hospitalization services and intensive outpatient services effective beginning in 2024. CMS describes a partial hospitalization program (PHP) as an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for patients with acute mental illness, including substance use disorders. A PHP may be provided by a hospital or a community mental health center (CMHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other

than the patient's home or an inpatient or residential setting. A physician must determine that each PHP patient requires a minimum of 20 hours of services each week, with redetermination occurring at least monthly.

An intensive outpatient program (IOP) is similar to a PHP but has a lower threshold – a minimum of 9 hours per week – for which a physician determines that a patient needs psychiatric services. IOP services may be provided by a hospital, a CMHC, a federally qualified health center (FQHC), or a rural health clinic (RHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other than the patient's home or an inpatient or residential setting. A physician must redetermine the need for IOP services at least every other month.

The payment structure for 2024 and 2025 utilized separate per diem amounts for IOP and PHP services provided by hospitals or CMHCs. The rates are based on either three services per day, or four or more services per day. For 2026, CMS proposes to change the CMHC payment rates to 40% of the corresponding hospital-based PHP and IOP costs to address anomalies in current payment rate calculations, due in part to the small number of CMHCs that bill for PHP and IOP services.

Other Provisions

Quality Reporting Programs

As previously noted, the final rule applies a 2% reduction in the OPPS and ASC payment rates for failure to meet quality reporting requirements. CMS is implementing certain cross-program modifications to the quality reporting programs for hospital outpatient departments, rural emergency hospitals (REHs), and ASCs. The revisions include the removal of quality measures relating to COVID-19 vaccination coverage among healthcare personnel, health equity, and screening for social drivers of health.

Specific to the Hospital Outpatient Quality Reporting Program, CMS proposes several changes, including

- Adoption of the Emergency Care Access and Timeliness eQCM (one year of voluntary reporting in 2027, followed by mandatory reporting starting in 2028 for payment determination starting in 2030), to replace the following measures:
    - Median Time from Emergency Department (ED) Arrival to ED Departure, and
    - Left Without Being Seen measure.
- Modification of the Excessive Radiation eQCM to remove the mandatory reporting requirement beginning with the 2027 reporting period and instead make reporting voluntary in 2027 and in subsequent years.

The Rural Emergency Hospital Quality Reporting Program would be modified to also adopt the Emergency Care Access and Timeliness eQCM beginning with 2027 reporting / 2029 payment determination. REHs would have the option to report either Emergency Care Access and Timeliness or Median time from ED Arrival to ED Departure in 2027.

For the ASC Quality Reporting Program, CMS proposes adopting the Patient Understanding of Key Information Related to Recovery after a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure. Reporting would be voluntary in 2027 and 2028, with mandatory reporting beginning in 2029 for 2031 payment determination.

Quality Star Rating

To emphasize the importance of safety, CMS is proposing an update in the methodology used to calculate the Overall Hospital Quality Star Rating. In 2026, a hospital would be limited to a maximum of four stars on the five-star scale if it performed in the lowest quartile of the Safety of Care measure group. Beginning in 2027, the Star Rating for any hospital in the lowest quartile of the Safety of Care measure group would be reduced by one star, to a minimum one-star rating.

Industry Response

The American Hospital Association (AHA) released a statement expressing disappointment in "an inadequate Medicare outpatient hospital payment update as many hospitals – especially those in rural and underserved communities – operate under challenging financial pressures. Specially, the AHA expressed opposition to the site-neutrality provisions and elimination of the IPO List, as well as the proposal accelerating recoupment of 340B overpayments.

Conversely, the Ambulatory Surgery Center Association (ASCA) was supporting of the changes. also weighed in. In particular, the ASCA noted that the 276 procedure CMS proposed to add to the ASC-CPL based on the revised criteria include many of the codes ASCA had requested. The three measures proposed to be removed from the ASC Quality Reporting Program also aligned with the recommendations ASCA had made to CMS.

JTaylor's healthcare consulting team includes experienced professionals who focus on strategy and operations for all types of providers. If you are interested in finding out how the CY 2026 OPPS/ASC Payment System proposed rule may impact reimbursement or your facility, we can help. Our team can also support you from a strategic perspective as you determine how to respond to the proposed changes in Medicare reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Fact Sheet: CY 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule (CMS 1834-P) (15 July 2025).
- Proposed Rule: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency. (90 Fed. Reg. 33476. (17 July 2025).
- *2025 Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission. (13 March 2025).
- *AHA Statement on CY 2026 OPPS Proposed Rule*, American Hospital Association (15 July 2025).
- *ASCA Applauds CMS' 2026 Proposed Rule that Vastly Expands ASC-CPL*, Ambulatory Surgery Center Association (15 July 2025).